UNAIDS Global AIDS Response Progress Reporting 2014
Trinidad and Tobago Country Progress Report

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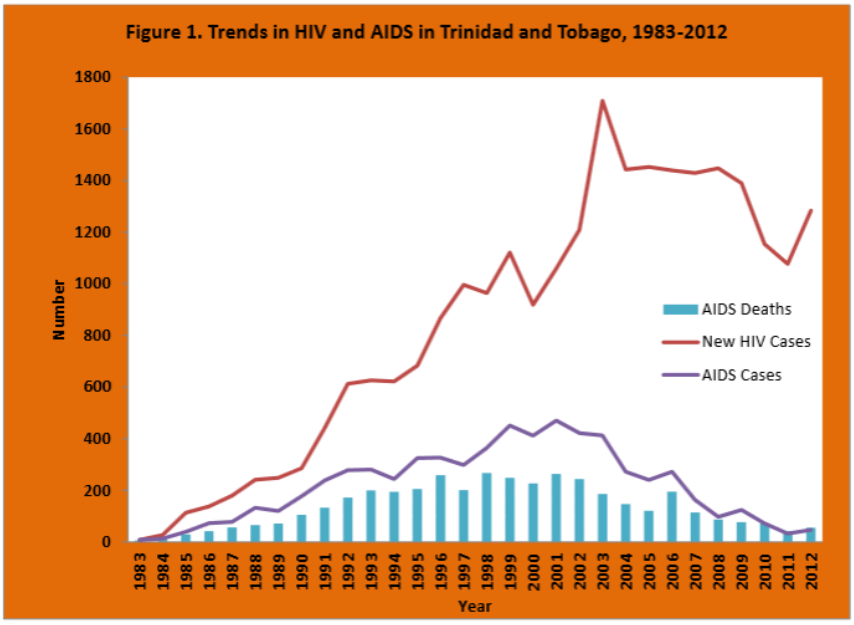
I. Status at a Glance

The report writing and review process consisted of a collaborative multisectoral effort among government ministries, civil society, and UNAIDS, coordinated by the Interim HIV Agency. Government ministries included in this process represented Health, Labour, Education, National Security, People and Social Development, and the Attorney General. Civil society represented groups that work with general and key populations as identified in the national strategic plan 2013-2018. A civil society consultation was held on March 19, 2014 to facilitate the completion of the national commitment policy instrument component of the GARPR and was hosted by UNAIDS Trinidad and Tobago.

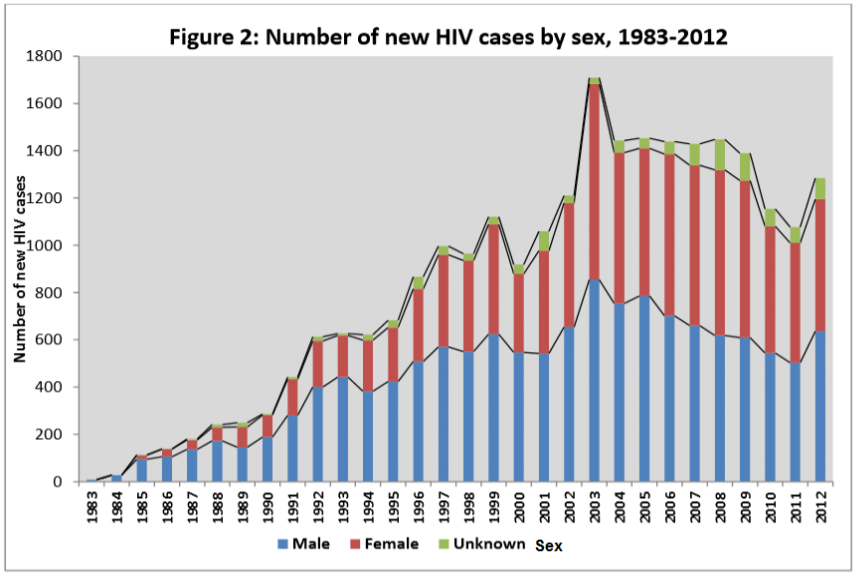
II. Overview of the AIDS Epidemic



Data Source: National Surveillance Unit, Ministry of Health, HIV/AIDS Morbidity and Mortality Reports

In 2012, The HIV prevalence rate was 1.5% indicating that Trinidad and Tobago is categorized as having a generalised epidemic. Since the start of the epidemic in 1983 to December 2012, there were 22,085 persons (estimated) diagnosed with HIV. During 2011- 2012, there was an increase in newly diagnosed HIV cases from 1077 in 2011 to 1284 in 2012, an increase in AIDS cases from 33 in 2011 to 47 in 2012, and an increase in AIDS related deaths from 42 in 2011 to 55 in 2012. Given that Figure 1 indicates that the previous trend has shown a decrease in new HIV cases, AIDS cases, and AIDS-related deaths, more research needs to be done to determine whether this increase is a cause for concern or whether this is attributable to increase prevention efforts, increased reporting due to increase testing sites, data quality, or some other issue.

The main mode of transmission is through sexual contact. In 2012, males accounted for 49.5% of new HIV cases while females accounted for 43.5% and 7% were of unknown sex as indicated by Figure 2.



Data Source: National Surveillance Unit, Ministry of Health, HIV/AIDS Morbidity and Mortality Reports

In 2012, the 30-44 age group accounted for majority of new HIV cases, that is, 35.5% followed by the under 30 age group(32.8%) and the 45 and older age group(23.1%) based on HIV/AIDS Morbidity and Mortality reports. However, 8.6% were of unknown age. These statistics represent data from the public health sector and some of the private labs that comply with reporting to the Trinidad Public Health Laboratory. There are currently data strengthening activities in process to improve on apparent data gaps as current data many not be completely reflective of characteristics of the epidemic in certain risk groups.

III. National Response to the AIDS Epidemic

In 2010, consultants were hired to develop the national strategic plan. Consultations were held seeking input from various multi-sectoral stakeholders to develop the National Strategic Plan 2013-2018 (NSP). The NSP was finalized and launched in 2013 and focused on five priority areas: Prevention; Treatment, care and support; Advocacy, human rights, and an enabling environment; Strategic information; and Policy and programme management. The goals of the NSP are 1) To reduce the incidence of HIV infections in Trinidad and Tobago; 2) To mitigate the negative impact of HIV and AIDS on persons infected and affected in Trinidad and Tobago; and 3) To reduce HIV related stigma and discrimination in Trinidad and Tobago.

The NSP also includes 18 strategic objectives and a two-year operational plan 2013-2014.

The strategic objectives of the NSP:

1. To improve sexual health knowledge, attitudes and behaviours of men and women aged 15-49
2. To increase the % of the population who have had an HIV test and know their results
3. To promote healthy sexual health attitudes and practices in youth aged 15 to 24 years
4. To improve the availability and acceptability of condoms as part of good sexual health practice
5. To reduce high risk HIV behaviours and infection in key populations
6. To eliminate mother to child transmission of HIV
7. To improve accessibility and availability of sexual health and HIV services through integrated health services
8. To increase the % of eligible adults and children receiving ART and care
9. To increase adherence to taking ARV medication
10. To improve national and regional laboratory services
11. To improve the care and treatment of people living with HIV who develop other infections
12. To improve the quality of services provided to people living with HIV
13. To ensure the rights and dignity of people living with HIV and key populations
14. To improve the evidence related to the nature and causes of poor sexual health and HIV infection amongst the general and key populations
15. To strengthen the national HIV/AIDS surveillance system
16. To establish a comprehensive monitoring and evaluation system for the national HIV response that informs decision makers
17. To Establish a Policy Framework for Facilitating the National HIV Response, Reducing New Infections and Mitigating the Adverse Impact of HIV
18. To improve the capacity of the Interim HIV Agency and implementing partners for an effective HIV response

The NSP also focuses on general and key populations that include children born to HIV positive women, Men who have Sex with Men (MSM), prisoners, sex workers, substance abusers, and youth.

A legal and policy framework that protects the rights of key populations provide an enabling environment for their access to HIV prevention, treatment, care, and support, human rights, and strategic information related services. In 2013, the process began to revise and finalize the draft national HIV Policy. Consultations were held to revise the national HIV counselling and testing policy, and national sexual and reproductive health policy has been drafted. In 2014, there are also plans to review certain laws, regulations, and policies and propose amendments to protect key populations from discrimination such as the Equal Opportunity Act to include HIV status discrimination, and to review the Human rights desk.

The Ministry of Labour and Small and Micro Enterprise Development through its National HIV/AIDS Workplace Advocacy and Sustainability Centre (HASC) has signed Memoranda of Understanding (MOU) with twenty enterprises to-date from a variety of sectors ranging from trade unions, private sector, non-governmental organisations (NGOs), public sector and the informal economy. The signing of these MOU's signals managerial commitment to treating HIV and AIDS as a workplace issue and demonstrates dedication on behalf of the participating organisations to addressing issues of HIV-related stigma and discrimination. HASC will provide technical support to each enterprise by assisting them to develop an HIV and AIDS workplace policy and programme and training HIV and AIDS peer educators within each organisation. In

2014, HASC will aim to double the amount of enterprises that are currently developing HIV and AIDS workplace policies by offering policy development workshops, sector based sensitisation sessions, outreach activities and developing its own HIV and AIDS workplace peer education programme. Additionally, the HASC will work alongside the Interim HIV Agency to advocate for legislation to protect persons living with and affected by HIV in the workplace from discrimination.

Civil society also facilitated a number of initiatives to implement the national HIV response in 2013, through peer education training, outreaches, training and sensitizations workshops, provision of HIV counselling and testing services, HIV treatment and care, strategic information activities, and HIV advocacy and human rights activities. The national coordinating agency partnered with The University of the West Indies (UWI) to assess and build the capacity of civil society to implement the national response and includes a communication and monitoring and evaluation component, this project should roll out in 2014.

Prevention

The number of persons counselled and tested increased from 52,393 in 2011 to 55,221 in 2012 but declined to 53,186 in 2013. Although testing and counselling in large volumes has been a challenge, there have been improvements in community access of testing and counselling between 2012 and 2013.

During 2012-2013, the number of HIV counselling and testing sites increased from 43 to 57 HIV counselling and testing sites with one new site in Tobago. Available data on HIV counselling and testing sites represent public sector, civil society, and academia but does not include the private sector. Civil society and government ministries implemented a number of initiatives to increase HIV awareness and education in the general population and in key populations.

The national coordinating agency supports the work of civil society and their prevention efforts (as they focus on key populations) through the availability of funding and provision of IEC materials and other items. While HIV related information was communicated to populations through the internet via Interim HIV website, and the development and distribution of IEC materials at outreaches and sensitization sessions, a behaviour change communication (BCC) plan, policy, and strategy needs to be developed and implemented to aid in translating HIV knowledge, and attitude to safe HIV behaviours and practice. In 2013, the process was initiated to develop a BCC plan and this should be completed in 2014. However, in the interim, some HIV Coordinators in the government ministries and representatives from civil society organizations received training in BCC in 2013.

In 2013, the national coordinating agency hosted a youth symposium to actively engage and involve youth and organizations that focus on youth in the implementation of the national HIV response. The Family Planning Association of Trinidad and Tobago (FPATT) established the first and only youth friendly site “De Living Room” that provides reproductive and sexual health services to youth a site, and has further expanded concept to reach the youth in their communities through “rovin caravan”. However, the implementation of Health and Family Life Education (HFLE) curriculum in primary and secondary schools remains a challenge to HIV prevention efforts for in school youth (key population).In 2013, The Ministry of Education collaborated with UNFPA to assess the implementation of HFLE in secondary schools and a preliminary draft report has been produced.

Advocacy and Human Rights

According to UNAIDS, HIV and AIDS related stigma and discrimination are hindering efforts to reduce new HIV infections, increase access to HIV care, treatment and support, and are impeding the rights of persons living with or affected by HIV and AIDS to lead productive lives(http://www.unaids.org/en/resources/presscentre/featurestories/2014/april/20140411zcaribbean/). This is particularly true in Trinidad and Tobago as there is a deficit of laws to protect the human rights of PLHIV and myths and misconceptions about HIV and AIDS are rampant and fuel stigma and discrimination. Due to high levels of HIV-related stigma and discrimination, coupled with the lack of legislation to provide avenues for redress for PLHIV in critical areas such as employment, housing and health services for example, cases of discrimination remain primarily anecdotal. Those living with and affected by HIV are hesitant to bring formal complaints to the courts and/or the Equal Opportunities Commission as HIV is not a prohibited grounds of discrimination in the Equal Opportunities Act or any other law that seeks to protect the basic human rights of citizens. Such legislative deficiencies make cases of HIV-related discrimination difficult to address and formal complaints are few. In addition to a weak legislative framework, PLHIV are hesitant to lodge formal complaints for fear of facing further discrimination from public disclosure of their status. Personal stories of disownment by family, loss of employment and/or housing based on disclosure are common yet often not officially recorded.

In 2013, the Advocacy and Human Rights (AHR) Subcommittee started to address some of the above challenges by reviewing gaps in legislation and developing proposals for legislative amendments. The AHR Subcommittee met with representatives from the Office of the Chief Parliamentary Council to seek guidance on the process for making requests for amendments to legislation and is currently focusing on proposing changes to the Equal Opportunities Act. Before any concrete amendments are proposed however the AHR Subcommittee will facilitate stakeholder consultations. Guiding documents being used by the AHR Subcommittee for this initiative include a legislative assessment conducted by the National AIDS Coordinating Committee in 2009 (Reference: Legislative Assessment – HIV and AIDS: Law, Ethics and Human Rights in Trinidad and Tobago, Sept 2009), and a Legal Gap Analysis conducted by the International Labour Organization (ILO) in collaboration with the Ministry of Labour and Small and Micro Enterprise Development in 2013. The ILO Gap Analysis examined gaps and deficiencies in employment and other related laws of Trinidad and Tobago in relation to guidelines set by ILO Recommendation Concerning HIV and AIDS and the World of Work, 2010 (No.200) and made specific recommendations.

Plans for the AHR Subcommittee for 2014 include the development of a national campaign on stigma and discrimination. The campaign will focus on dispelling myths and misconceptions about HIV and AIDS that prevail throughout the general population and which exacerbate HIV-related stigma and discrimination. Sensitisation sessions will be held with a focus on parliamentarians, media personnel and the judiciary and proposals for the implementation of a desk to assist persons with human rights related complaints will be undertaken. A human rights desk is important as it will provide a confidential means of reporting cases of discrimination and will document the types and number of complaints. Support will be provided to the National HIV/AIDS Workplace Advocacy and Sustainability Centre (HASC), Ministry of Labour and Small and Micro Enterprise Development, to strengthen the workplace response to HIV and AIDS. In 2014, a high-level meeting will be carded to discuss the National Workplace Policy on HIV and AIDS with union leaders in an effort to garner support for the inclusion of HIV and AIDS Workplace Policies as an essential component of the collective bargaining process.

Treatment, care and support

In 2011/2012 period, the Ministry of Health removed stavudine, indinavir, and didanosine and DD1 ARVs from the national formulary /list of approved ARVs and added 3rd line HIV treatment to the approved list. HIV treatment and care is provided by the Government of Trinidad and Tobago, one of the few countries regionally whose programme is not dependant on external funders. The estimated percentage of adults and children on anti-retroviral treatment reduced from 73% in 2011 to 67% in 2012, to 48.0% in 2013 although the number receiving treatment increased from 4991 to 5565 to 6134 during the same period. The Spectrum computer program determines the denominator, the total number of eligible adults and children for ARV treatment: 6817 in 2011, 8359 in 2012 and 12,776 in 2013. The assumptions of the Spectrum model are not always reflective of the current national situation and may result in an overestimate or underestimate in some cases in its calculations. Moreover, the change of the CD4 requirement from 200 to 350 adults resulted in a larger group of people being in need of ARV with implementation of this guideline only occurring fully in late 2011 into 2012. Using the national approved treatment guidelines, in 2013 the percentage of adults and children on ARV treatment was 72.3% where the denominator was 8,413 PLHIV.

Trinidad and Tobago is close to eliminating mother to child HIV transmission. The national target for the elimination of infections among children entails two components (1) reduce the transmission of HIV from HIV+ pregnant women to their infants to 2% or less and (2) the reduction of the Incidence of mother-to-child transmission of HIV to 0.3 cases or less per 1000 live births.

The estimated number of children who were newly HIV infected due to mother to child transmission in was 2 cases in 2012 indicating a 60% reduction from the baseline figure of 5 cases in 2011. During 2006 to 2011, the percentage of HIV positive women who received anti-retrovirals to reduce the risk of mother to child transmission increased from 68.1% to 85.9%.

Nationally, psychosocial support is provided for the general population through the Ministry of People and Social development who provide counselling and social welfare grants (This covers housing, household items, domestic help, nutrition, clothing, funeral, disability, education for children under 18 and special needs, pharmaceutical, senior citizens, public assistance, and urgent temporary assistance). The assistance provided is neither limited to nor specific to PLHIV.

Civil society provides psychosocial support to key populations. In an attempt to strengthen the psychosocial support within the Health Sector, some civil society groups have partnered with Ministry of Health to establish a peer support programme, to provide psychosocial support for newly diagnosed persons living with HIV (PLHIV) clients and their partners through referrals and access to HIV treatment and services. In 2012, seven civil society groups signed a Memorandum of Understanding (MOU) with the Ministry of Health and the Regional Health Authorities.

However, challenges remain related to availability and access to treatment and care sites through integration into primary care, decentralisation of services, and the development of public partner partnerships particularly in rural areas to service the wider PLHIV community. The negative stigma associated with accessing services through public health system that still exists is also a challenge.

In addition, there is a greater need to increase pharmacological monitoring systems, increase awareness of psychosocial support services available to PLHIV persons and increase accessibility to social support inclusive of social and welfare grants. Many of these activities are temporary and/or have stipulations , which do not completely service the needs of PLHIV.

Other challenges include the increased cost of ARV's due to the new PAHO treatment guidelines that increased CD4 threshold treatment level to 500, attracting sufficient medical personnel, the expansion of the

prevention programme for PLHIV, and the additional systems and monitoring tools to support the additional persons of sustained ARV therapy.

Knowledge and behaviour change

Although the Multiple Indicator Cluster Survey 2011 is the most recent related national survey that provides information on the HIV knowledge, attitudes, practices, and behaviours (KAPB) on national population, it is limited to women and child; and the report will be finalized this year. The last national HIV related KAPB on the general population was conducted in 2007. However, there are plans to conduct a national AIDS Indicator survey (AIS) for the general population in 2014. Similarly, few national HIV-related KAPB studies have been conducted on key populations and vulnerable populations. However, a biological and behavioural surveillance study (BBSS) on men who have sex with men was conducted in 2013 and is still in progress. Similarly, there are plans to conduct a BBSS on female sex workers in 2014. In 2013, the process was initiated to conduct a synthesis of all the studies conducted on HIV and AIDS since the start of the epidemic in 1983. This study should also provide information on changes in HIV knowledge and behaviours over time.

IV. Best Practices

PMTCT Programme

Programmatically the PMTCT (Prevention of Mother To Child Transmission) programme is well integrated into the ANC system and serves a link between primary care screening and transition to tertiary treatment and care sites. Regular meetings facilitate discussion between the public health and treatment site teams, allowing for interventions for difficult cases and migration of patients between clinics. PMTCT nurses work together with ANC nurses and Primary care nurse managers to achieve documented high screening rate of patients, achieving 96% screening for HIV in the public sector in 2012. The PMTCT nurse also follows patients into the treatment care sites. Patients are then followed by a multidisciplinary team, inclusive of the PMTCT nurse, at the tertiary level antenatal clinics and treatment sites to ensure initiation of antiretroviral therapy, ANC follow up, social worker follow-up and follow up of infant post-partum. The programme was able to achieve 84% adherence to ARV by pregnant women and 93% screening of HIV exposed infants with 1% transmission rate in 2012.

Establishment of national HIV/AIDS Workplace Advocacy and Sustainability Centre

The National HIV/AIDS Workplace Advocacy and Sustainability Centre (HASC), was established in the Ministry of Labour and Small and Micro Enterprise Development in 2009 and formally launched in 2011 to implement the National Workplace Policy on HIV and AIDS.The HASC advocates that eliminating stigma and discrimination of any kind in the workplace is critical to creating a safe, healthy and productive work environment and ensures that the fundamental rights of workers are met. This is directly linked to the work of the HASC whose primary objectives are to:

1. Reduce employment related stigma and discrimination against persons living with or affected by HIV and AIDS
2. Reduce behaviours that put workers at risk of contracting HIV (and other sexually transmitted infections), by providing employers and employees with information and behaviour change strategies.

The development of a National HIV/AIDS Workplace Advocacy and Sustainability Centre is considered a best practice because it is a nationally sustained entity and the only organisation of its kind in the Caribbean solely dedicated to coordinating the workplace response to HIV and AIDS. This is achieved through the provision of training, technical support and guidance in HIV and AIDS policy and programme development for employers, employees, government ministries, unions, PLHIV, civil society and other stakeholders.

The establishment of the HASC signalled that the government recognizes the critical role of the workplace in reducing the spread of HIV and curbing its effects on the economically active population. It is recommended however, that countries clearly recognize that in order for such an organization to be successful the following should be considered:

i. HASC-like organizations although coming out of a government policy should be carefully thought out with regards to the restrictions this organization may encounter by nature of its placement in Government Ministries. e.g bureaucratic processes, restrictive policies and procedures. These include and are not limited to sharing of and the prioritizing of funds allotted to the host Ministry and autonomy to make decisions free from political agendas.

ii. The staffing of similar centres or units should be carefully thought out with specific reference to the required skills set and competences of staff.

iii. A clear mandate and plan for sustainability is necessary (i.e. what the organization plans to achieve, how it is going to achieve it, identification of key partners, allocation for capacity building and support for and dissemination of research and research findings.). The Centre or Unit along with the policy needs to be strategically marketed similarly to the way in which Health and Safety Organizations have been established, as it is enshrined as a go to organization for assistance and guidance.

V. Major Challenges and Remedial Actions

One of the main challenges to coordinating and implementing the national HIV response is the management changes to the country coordinating mechanism. In 2010, World Bank funding came to an end and the life of the then coordinating committee, NACC also ended, with plans to restructure the NACC to a statutory authority. Although the Ministry of Health and other Ministries were implementing the response during that period, there was no coordinating body until 2013. The Interim HIV Agency was established in 2013 with a life of two years to transition the NACC into a statutory authority. In September 2013, the ministry responsible for national HIV and AIDS coordination was changed from the Office of the Prime Minister to Ministry of Health. Consequently, the work of the Interim Agency was at a lull until January 2014. This would have delayed the implementation of a number of initiatives including but not limited to the engagement of and partnership with civil society and other key stakeholders in the national response, and the recruitment of additional technical staff in the HIV Secretariat. Now that the work of the Interim HIV Agency has resumed, implementation of some of these initiatives have already taken place or are forthcoming.

Another challenge is promoting a culture of monitoring and evaluating that is results driven and focuses on data utilization. The Ministry of Planning and Sustainable Development has the mandate for monitoring and evaluating progress of national goals and is poised to take the lead in this initiative. In terms of the national HIV response, data reporting tools are being revised to reflect the priorities of the national strategic plan and the requirements of the monitoring and evaluation system and there are plans to promote an M&E

culture through collaborations with stakeholders vis-a-vis training, funding guidelines, and data dissemination and use workshops.

VI. Support from the Country's Development Partners

While the government of Trinidad and Tobago funds the national HIV programme, the Government partnered with UNAIDS, UNFPA, and PANCAP, and PEPFAR through Center for Disease Control, and CARPHA to provide support to coordinate and implement the national HIV/AIDS response in a sustainable manner. Support is needed to complete the National AIDS Spending Assessment (NASA), to develop and finalize the M&E Plan and to strengthen the M&E system, conduct national AIS survey, and develop and implement a BCC plan.

VII. Monitoring and Evaluation Environment

Although Trinidad and Tobago has identified the need for monitoring and evaluation (M&E) evident by the development of a national M&E results-based framework, the national M&E HIV system of Trinidad and Tobago traditionally have been weak. However, there have been improvements to the monitoring and evaluation environment where the current national strategic plan has a monitoring and evaluation framework; there have been improvements in the surveillance system such as the adoption of a case-based surveillance system and improved data collection tools including the prevention of mother to child transmission cohort register system. Reporting formats for the public sector have been drafted and are currently being reviewed.

The M&E plan is currently being developed with assistance from the Caribbean Public Health Agency (CARPHA) and UNAIDS. Consultations will be held with stakeholders including civil society before finalization of document. The M&E technical working group was established in early 2014 with representation from various stakeholders, including civil society aimed at reviewing and finalizing the M&E Plan and improving the national M&E tools and system.

The main challenges to establishing a strong M&E HIV system are related to organizational structure and human resource. An M&E unit is yet to be established in the national coordinating agency and the structure of the national coordinating agency's secretariat has only facilitated one monitoring and evaluation post. In the interim, the national coordinating agency's secretariat would recruit an additional temporary M&E officer and CARPHA and UNAIDS have also offered technical assistance in strengthening the national M&E system.

Coordination and implementation of the national monitoring and evaluation system poses a challenge when key stakeholders in civil society, government ministries, and private sector have limited M&E competency and capacity. In 2013, civil society and the HIV/AIDS Coordinators in government ministries received basic M&E training facilitated by CARPHA in 2013 with plans for an Advanced M&E workshop to be held in 2014. However, many of the civil society groups and government Ministries do not have dedicated personnel to M&E only. Moreover, the majority of the government ministries have one person coordinating HIV in their sector and HIV coordinating units are yet to be established; this is also similar for M&E personnel in government ministries. Currently the required skill sets of M&E personnel in the public sector are being reviewed and the national coordinating agency's capacity building initiative for the civil society should increase their capacity and competency in M&E.

VIII. CHALLENGES IN PREPARING REPORT

There were a number of challenges in preparing this report. The 2014 GARPR guidelines were only made available in early February and included the reporting of new indicators and as such, the country was unable to report on those indicators. Some of the data usually required for the GARPR were either unavailable such as the data on AIDS spending, or if the data was available there were issues of timeliness, completeness, and representativeness. In addition, some of the assumptions of the spectrum model to derive the estimates related to treatment do not reflect the Caribbean context, and may not reflect the national HIV/AIDS situation. The country intends to meet with relevant stakeholders involved in data collection and compilation process to discuss the challenges they faced and the way forward.

INDICATOR TABLE

Target	Indicator	2013/Comments
Target 1: Reduce sexual transmission of HIV by 50% by 2015 General population	1.1. Percentage of young women and men aged 15-24 years who correctly identify ways of preventing HIV and who reject major misconceptions about HIV transmission	Data not available
	1.2. Percentage of young women and men 15-24 years who have had sexual intercourse before the age of 15	Data not available but 27.1% 13-15 year old ever had sex based on 2011 Global school based student health survey
	1.3. Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	Data not available
	1.4. Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of condoms during their last intercourse	Data not available
	1.5. Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Data not available
	1.6. Percentage of young people aged 15-24 who are living with HIV	Data not available
Sex workers	1.1. Percentage of sex workers reached with HIV prevention programmes	Data not available
	1.2. Percentage of sex workers reporting the use of a condom with their most recent client	Data not available
	1.3. Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Data not available
	1.10 Percentage of sex workers who are living with HIV	Data not available
Men who have sex with men	1.11 Percentage of men who have sex with men reached with HIV prevention programmes	Data not available
	1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Data not available
	1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	Data not available
	1.14 Percentage of men who have sex with men who are living with HIV	Data not available
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015	2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	National data for these indicators are not available. Trinidad and Tobago is by and large not an injecting society
	2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	
	2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	
	2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	
	2.5 Percentage of people who inject drugs who are living with HIV	

INDICATOR TABLE

Target	Indicator	2013	Comments
Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths	3.1.Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	**85.8%**	The Cohort Register Data tracks the progress of pregnant women enrolled in the PMTCT programme inclusive of receipt of ARVs, infant birth outcome as well as treatment, HIV exposed infant's status and partner's status. Numerator value represents data on pregnant women confirmed to be HIV-positive who joined the programme during the period with a new pregnancy and received ARVs during 2013. The projection of the estimate from Spectrum was finalized using a 20% downward adjustment of the total fertility rate. Data prior to 2013 were not recorded in the Cohort Register Format hence data for women receiving ARVs didn't represent the cohort of women on ARV treatment during the period.
	3.1.a. Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	Breasting of HIV mothers is not advised in national treatment guidelines	
	3.2.Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	**53.3%**	Numerator: Represents infants tested through the public sector Out of the 121 infant blood samples tested, 90 infants were tested within 2 months of life, 2 samples were diagnosed as positive, 1 sample was rejected and 1 sample was insufficient (Other) Denominator: Spectrum The projection of the estimate from Spectrum was finalized using a 20% downward adjustment of the TFR. Spectrum appeared to be overestimating the denominator value prior although there were fewer women enrolled in the programme during 2013 based on documentation in a Cohort Register Format. The PMTCT programme data from periods prior to 2013 were not recorded in the Cohort Register Format.
	3.3 Estimated percentage of child infections from HIV-positive women delivering in the past 12 months	**6.3%**	The projection of the estimate from Spectrum was finalized using a 20% downward adjustment of the TFR. Data prior to 2013 were not recorded in the Cohort Register Format hence data for women receiving ARVs didn't represent the cohort of women on ARV treatment during the period. R-Spline model was used, however the outputs from this model do not match Country's programme data

Target	Indicator	2013	Comments
Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015	4.1 Percentage of adults and children currently receiving antiretroviral therapy	**48%** Children 78.5% Adults 47.6%	Denominators are based on global criteria – 15+: 12590 and for <15: 186. However, denominator based on national criteria – 15+: 8230 for and <15: 183.
	4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	**93.4 %** Children 100% Adults 93.4%	
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% in 2015	5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Data not available	
Target 6: Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24B in low-middle income countries	6.1 Domestic and international AIDS spending by categories and financing sources	Data not available	Most recent National AIDS Spending Assessment (NASA) conducted in 2009
Target 7: Eliminating gender inequalities	7.1 Proportion of ever married or ever-partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Denominator data not available	Data available for numerator only (424) through routine monitoring from Crime and Problem Analysis Branch, TT Police Service.
Target 8: Eliminating stigma and discrimination	8.1 Discriminatory attitudes towards PLHIV	Data not available	Data not available
Target 9: Eliminate Travel restrictions	Travel restriction data collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed		
Target 10: Strengthening HIV integration	10.1 Current school attendance among orphans and non-orphans aged 10-14	33.3%	Data is limited to orphans in institutions and excludes general population. Data from Children's Authority of Trinidad and Tobago
	10.2 Proportion of the poorest households who received external economic support in the last 3 months	Data not available	