# National HIV and AIDS Spending Assessment

## *An Assessment of HIV and AIDS Financing Flows and Expenditure 2002 - 2006.*

Trinidad and Tobago National AIDS Coordinating Committee


NATIONAL AIDS COORDINATING COMMITTEE (NACC)

January 2009

Prepared by:

Mr. Andrew Fearon, Deputy Technical Director, National AIDS Coordinating Committee

**Acknowledgements:**

This project was made possible with the support of all the institutions, whether public or private, multilateral, bilateral or non-governmental, collaborating with the NACC by providing the necessary information. In addition, this consolidated document was prepared with data collected and reported by the following: Marie Luisa Diagre, Christian Aran Fernandez, Dr Daniel Aran Mantero, Dr Diego Cortina de la Fuente, Aparna Kollipara, Sandra Vokaty, Anthony Smith, Mariam Jupiter and Georgette Koo.

## Acronyms

| | |
|---|---|
| **AIDS** | Acquired Immunodeficiency Syndrome |
| **ART** | Antiretroviral Therapy |
| **ARV** | Antiretroviral |
| **CAREC** | Caribbean Epidemiology Centre |
| **CDC** | Centers for Disease Control and Prevention |
| **CMS** | Commercial Marketing Strategies |
| **CRN+** | Caribbean Network of People Living with HIV/AIDS |
| **CSW** | Commercial Sex Workers |
| **DCU** | Disease Control Unit |
| **FHI** | Family Health International |
| **GDP** | Gross Domestic Product |
| **HDI** | Human Development Index |
| **HIPC** | Heavily Indebted Poor Countries Initiative |
| **HIV** | Human immunodeficiency virus |
| **IEC** | Information, education and communication |
| **MAP** | Multi-country HIV/AIDS Programs |
| **MDAs** | Ministries, Departments and Agencies |
| **MoH** | Ministry of Health |
| **MSM** | Men who Have Sex with Men |
| **MSWM** | Men who Have Sex with Women and Men |
| **MSW** | Men who Have Sex with Women |
| **WSM** | Women who Have Sex with Men |
| **NAA** | National HIV/AIDS Accounts |
| **NACC** | National AIDS Coordinating Committee |
| **NADAPP** | National Alcohol and Drug Awareness Prevention Programme |
| **NAP** | National HIV/AIDS Program |
| **NASA** | National AIDS Spending Assessment |
| **NSF** | National Strategic Framework |
| **NSP** | Five Year National HIV/AIDS Strategic Plan |
| **PAHO** | Pan American Health Organization |
| **PLWHA** | People Living with HIV/AIDS |

| | |
|---|---|
| **PMTCT** | Prevention of Mother-to-Child Transmission |
| **PPP** | Purchasing Power Parity |
| **QPCC&C** | Queens Park Counselling Centre and Clinic |
| **SIDALAC** | Regional Initiative on HIV/AIDS for Latin America and the Caribbean |
| **SIFRAS** | Financial Information System of the National Response to HIV/AIDS |
| **STI** | Sexually Transmitted Infection |
| **TB** | Tuberculosis |
| **TT$** | Trinidad and Tobago Dollar |
| **UNAIDS** | Joint United Nations Programme on HIV/AIDS |
| **USAID** | United States Agency for International Development |
| **US$** | United States Dollars |
| **UWI** | University of West Indies |
| **VCT** | Voluntary Counselling and Testing |

# TABLE OF CONTENTS



# LIST OF TABLES

# 1 Introduction

The GORTT in its efforts to prevent and control the spread of the HIV/AIDS epidemic has developed a five year National Strategic Plan 2004-2008 (NSP) as the guide to the Trinidad and Tobago national response to HIV/AIDS. The NSP has two overarching goals:

- to reduce the incidence of HIV infections and,
- to mitigate the negative impact of HIV/AIDS on persons infected and affected.

**Priority Areas**

To achieve these goals the NSP proposes five priority areas of intervention:

- Prevention,
- Treatment, care and support,
- Advocacy and human rights,
- Surveillance and research
- Programme management, coordination and evaluation

**Priority Area** 1 Prevention: Interventions within this Priority Area are geared towards suppression of the spread of the epidemic. The overall goal of the Prevention Priority area 1 is therefore to reduce the susceptibility of the population of Trinidad and Tobago to HIV. To achieve this goal, six (6) Strategic Objectives for the nation are identified with specific strategies and strategic activities for achieving each objective as follows:

- Objective 1: To promote safe and healthy sexual behaviours among the general population.
- Objective 2: To promote healthy sexual attitudes, behaviour and practices among vulnerable / high risk populations.

- Objective 3: To reduce the rate of mother to child transmission.
- Objective 4: To increase the population's knowledge of its serostatus.
- Objective 5: To reduce the probability of post exposure infection.
- Objective 6: To improve the management and control of CSTI's.

**Priority Area 2** Treatment Care & Support: This Priority Area focuses on providing HIV/AIDS treatment and care to the PLWHA community inclusive of the administering of anti-retroviral drug therapy - and on the provision of required socio-economic support to the infected and affected population. Two broad Treatment, Care & Support Strategic Objectives are identified for the nation as follows:

- Objective 1: To improve access to treatment and care for HIV/AIDS.
- Objective 2: To reduce the incidence of HIV/AIDS and Tuberculosis Co-infection.

**Priority Area 3** Advocacy & Human Rights: The overall goal of this Priority Area is to heighten national interest in HIV/AIDS issues and to ensure the upholding of human rights principles as they relate to PLWHA, CSW, MSM, families of PLWHA and other affected groups. Two Strategic Objectives are identified as follows.

- Objective 1: To reduce stigma and discrimination against PLWHA.
- Objective 2: Ensure human rights for PLWHA and other groups affected by HIV/AIDS.

**Priority Area 4** Surveillance & Research: Interventions aimed at improving the surveillance system and undertaking applied research into HIV/AIDS and related issues are presented hereunder. The Surveillance and Research Strategic Objectives are identified as:

- Objective 1: To strengthen the surveillance systems for CSTI/HIV/AIDS.
- Objective 2: To undertake and participate in effective clinical and behavioural research on HIV/AIDS and related issues.

**Priority Area 5** Programme Management, Coordination and Evaluation: All activities related to the management, implementation and evaluation of the nation's expanded response is incorporated under this Priority. The three Programme Management/Coordination and Evaluation Strategic Objectives identified for the nation are as follows:

- Objective 1: To achieve national commitment, support and ownership of the expanded response to HIV/AIDS.
- Objective 2: To monitor the implementation of the expanded response.
- Objective 3: To build capacity among critical stakeholders in the expanded national response. [1]

## THE FIVE YEAR NATIONAL HIV/AIDS STRATEGIC PLAN

**Table 1 NSP Implementation Costs TT$ (US$) Millions**

| Priority Area | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | TOTAL |
|---|---|---|---|---|---|---|
| ***Priority Area I:*** **Prevention** | 25.2 (4.00) | 27.22 (4.32) | 26.7 (4.25) | 27.46 (4.36) | 26.01 (4.13) | **132.67 (21.06)** |
| ***Priority Area II:*** **Treatment, Care and Support** | 60.6 (9.62) | 70.87 (11.25) | 68.42 (10.86) | 77.8 (12.34) | 91.98 (14.60) | **369.62 (58.67)** |
| ***Priority Area III:*** **Advocacy and Human Rights** | 0.63 (0.10) | 0.63 (0.10) | 0.63 (0.10) | 0.63 (0.10) | 0.63 (0.10) | **3.21 (0.51)** |
| ***Priority Area IV:*** **Surveillance and Research** | 4.85 (0.77) | 10.52 (1.67) | 3.72 (0.59) | 3.21 (0.51) | 3.72 (0.59) | **26.01 (4.13)** |
| ***Priority Area V:*** **Programme Management, Coordination and Evaluation** | 7.56 (1.12) | 7.62 (1.21) | 7.62 (1.21) | 7.62 (1.21) | 7.62 (1.21) | **37.55 (5.96)** |
| **TOTAL** | **98.34 (15.61)** | **115.86 (18.55)** | **107.16 (17.01)** | **116.67 (18.52)** | **130.03 (20.64)** | **569.1 (90.33)** |

[2]

[1] The Five Year National HIV/AIDS Strategic Plan. 2004-2008
[2] Exchange Rate TT$6.3:US$1

The NSP indicated that in order to be effective in meeting the two overarching goals a total of TT$569m had to be spent over the five year period split between the priority areas as indicated in the Table 1. The majority of the budget would be directed towards Treatment Care & Support at TT$369.6m followed by Prevention TT$132.6m. With regard to priority area three Advocacy & Human Rights a relatively small budget was allocated at TT$3.21.

## Introduction 2

National AIDS Spending Assessments (NASA) is designed to help answer the key question of whether there are sufficient resources being expended by the Government, Private and International sectors in the response to HIV/AIDS. These questions are important because the Five Year HIV/AIDS National Strategic Plan (NSP) outlines as a target, the level of resources and the likely impact on the epidemic that these resources should produce. Information however goes deeper than to identify just the total resource envelope but to also to ascertain the key populations that are being 'targeted' by the interventions. As the biggest impact should be seen if resources are targeted to those populations most at risk/need, NASA can be utilised to aid the measurement of projects and to provide a comparative analysis on resource allocation between priority populations.

The aim is to collect data from all stakeholders involved in the response to HIV/AIDS; from those providing the funds to those providing the services and from the International Community to the Community Based Civil Society Organizations. This process is conducted through the utilisation of the UNAIDS National AIDS Spending Assessment Methodology in a modified form to meet the reporting requirements set out in the NSP. [3]

[3] National AIDS Spending Assessment: A Notebook on Methods, Definitions and Procedures for the Measurement of HIV and AIDS Financing Flows and Expenditures at Country Level. UNAIDS 2006

There are, however, limitations in collecting information on expenditure on HIV/AIDS. These are:

1. Some organisations are unwilling or unable to provide financial information
2. Some information is not available and has to be assessed – i.e. outpatient or inpatient cost data
3. Private household expenditure is extremely difficult to estimate.

The National AIDS Coordinating Committee has for the period 2002 to 2006 conducted the National AIDS Spending Assessments and reported each year against the prescribed methodology set out in the NASA notebook. Whilst this approach provided excellent information into the strategic planning cycle problems were encountered in that the NASA reporting format differed from that indicated in the NSP. Whilst the NASA reporting format is not a radically different approach, there are, when compared to the format of the NSP differences require any clarification in order for comparisons to be made between NSP budget and NASA report. This report therefore attempts to resolve this problem through the re-classification of the NASA methodology in order that this can fit into the reporting requirement of the NSP. The report therefore:

1. Reports on the National AIDS Spending Assessment by utilising the methodology as set out in the Five Year National HIV/AIDS Strategic Plan.
2. Consolidates all the previous NASA reports into one document thereby giving comparative data of expenditure changes over the period.

# 2 Epidemiological Data

It was in 1983 that the first AIDS cases were reported among homosexual men in Trinidad and Tobago. By the end of 2007, 18,378 HIV positive cases, 5,835 AIDS cases and 3,604 deaths due to AIDS had been reported to the National Surveillance Unit. The estimated number of deaths due to AIDS in 2006 was 113.

The epidemic continues to grow most rapidly in both sexes between the ages of 15 and 49 with 71.8% of new HIV infections occurring in this age group for the period 2003 to 2007. Of particular concern is how the epidemic has impacted upon women during this period. Between the ages 15 and 49, 48.8% of new infections have occurred in women. However, if we look at impact of the epidemic on women between the ages 15 and 29 the picture that emerges is significantly worse. For the period 2003 -2007 64.2% of new infections have occurred in women. [4]

Outlined in the following tables is the epidemiological data which includes the breakdown between the number of new infections between male, female and not reported. [5]

[4] UNGASS Country Progress report: Trinidad & Tobago: Reporting Period January 2006-December 2007. National HIV/AIDS Coordinating Committee. January 2008.
[5] HIV New Cases and HIV New Infections Report. National Surveillance Unit, Ministry of Health

**Table 2 : New Infections 2003-2007 Male**

| # HIV NEW CASE S | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|
| Age Group | Male | Male | Male | Male | Male |
| <1 | 40 | 40 | 42 | 26 | 11 |
| 1 to 4 | 9 | 12 | 10 | 10 | 2 |
| 5 to 9 | 5 | 13 | 7 | 2 | 0 |
| 10 to 14 | 5 | 4 | 0 | 0 | 1 |
| 15 to 19 | 17 | 14 | 8 | 8 | 11 |
| 20 to 24 | 53 | 51 | 51 | 53 | 49 |
| 25 to 29 | 104 | 78 | 84 | 91 | 79 |
| 30 to 34 | 121 | 89 | 111 | 73 | 94 |
| 35 to 39 | 125 | 88 | 104 | 89 | 82 |
| 40 to 44 | 112 | 107 | 93 | 102 | 71 |
| 45 to 49 | 91 | 80 | 91 | 69 | 67 |
| 50 to 54 | 43 | 51 | 48 | 40 | 42 |
| 55 to 59 | 40 | 35 | 41 | 22 | 26 |
| 60 + | 35 | 29 | 32 | 38 | 24 |
| Age not Reported | 52 | 66 | 55 | 77 | 65 |
| | | | | | |
| Total | 852 | 757 | 777 | 700 | 624 |

**Table 3: New Infections 2003-2007 Female**

| # HIV NEW CASES | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|
| Age Group | Female | Female | Female | Female | Female |
| <1 | 50 | 38 | 38 | 27 | 8 |
| 1 to 4 | 14 | 9 | 7 | 10 | 11 |
| 5 to 9 | 7 | 13 | 7 | 2 | 1 |
| 10 to 14 | 4 | 1 | 6 | 3 | 1 |
| 15 to 19 | 50 | 39 | 49 | 44 | 57 |
| 20 to 24 | 147 | 113 | 118 | 97 | 115 |
| 25 to 29 | 141 | 107 | 99 | 123 | 118 |
| 30 to 34 | 103 | 93 | 66 | 76 | 79 |
| 35 to 39 | 71 | 58 | 45 | 64 | 57 |
| 40 to 44 | 64 | 35 | 57 | 53 | 57 |
| 45 to 49 | 48 | 35 | 26 | 40 | 35 |
| 50 to 54 | 30 | 19 | 27 | 31 | 22 |
| 55 to 59 | 18 | 12 | 14 | 17 | 14 |
| 60 + | 14 | 14 | 12 | 13 | 13 |
| Age not Reported | 66 | 49 | 45 | 69 | 49 |
| | | | | | |
| Total | 827 | 635 | 616 | 669 | 637 |

**Table 4: New Infections 203-2007 Sex Not reported.**

| # HIV NEW CASES | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|
| Age Group | Not Reported | Not Reported | Not Reported | Not Reported | Not Reported |
| <1 | 5 | 2 | 3 | 4 | 1 |
| 1 to 4 | 0 | 1 | 0 | 0 | 1 |
| 5 to 9 | 0 | 1 | 0 | 0 | 0 |
| 10 to 14 | 0 | | 0 | 0 | 0 |
| 15 to 19 | 1 | 4 | 3 | 1 | 1 |
| 20 to 24 | 0 | 2 | 5 | 5 | 3 |
| 25 to 29 | 1 | 6 | 1 | 1 | 5 |
| 30 to 34 | 0 | 2 | 1 | 3 | 7 |
| 35 to 39 | 2 | 4 | 3 | 4 | 6 |
| 40 to 44 | 1 | 3 | 2 | 6 | 3 |
| 45 to 49 | 0 | 3 | 3 | 4 | 3 |
| 50 to 54 | 2 | | 2 | 1 | 2 |
| 55 to 59 | 0 | | 1 | 0 | 1 |
| 60 + | 0 | 2 | 0 | 0 | 1 |
| Age not Reported | 27 | 23 | 19 | 21 | 53 |
| | | | | | |
| Total | 39 | 53 | 43 | 50 | 87 |

## Constraints in Tracking the Epidemic

There are gaps however, in the available epidemiological data, as the surveillance system focuses on coverage of the public sector only. (3) It is widely assumed that the actual numbers of HIV cases are significantly higher that is actually reported in the above tables. Some of the reasons why this could be the case have been identified as;

- Stigma and Discrimination remains pervasive particularly against persons living with AIDS and most at risk groups.
- Lack of adequate reporting of services provided in the private sector;
- Systems put in place to ensure confidentiality and the anonymity of persons seeking services may result in duplication of individual records;
- Limited participation of the medical professional associations in supporting reporting;
- Most at risk populations remain cautious about being identified. [6]

[6] UNGASS Country Progress report: Trinidad & Tobago: Reporting Period January 2006-December 2007. National HIV/AIDS Coordinating Committee. January 2008.

# 3 Results

In the following chapter the main findings of the 2002-2006 National HIV and AIDS Spending Assessments are presented, indicating where the funds originate from, on what services they are spent, the types of providers that utilize the funds to convert production factors into services, and the target groups that benefit from such services. The format of this section will be in two parts:

- Part one will paint the overall picture in terms of the spending assessment against the Five Year HIV/AIDS National Strategic Plan.
- Part two will further break down and give more detailed analysis by the Priority Areas of the NSP.

In both sections the format of the tables will be the same in terms of Expenditure, Financial Sources and Beneficiary population.

# 4 Spending Assessment against the NSP

## Expenditure Assessment:-

**Table 5 Summary: Expenditure by Priority Area of the NSP TT$**

| Priority Area | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M | TOTAL $M |
|---|---|---|---|---|---|---|
| **Prevention** | 10.2 | 11.3 | 18.3 | 21.3 | 34.5 | 95.5 |
| **Treatment Care & Support** | 12.6 | 20.8 | 19.3 | 25.1 | 38.6 | 116.4 |
| **Advocacy & Human Rights** | 0.6 | 0.8 | 1.6 | 0.3 | 0.8 | 3.5 |
| **Surveillance & Research** | 1.3 | 1.3 | 0.9 | 0.4 | 1.2 | 5.1 |
| **Programme Management, Coordination and Evaluation** | 0.5 | 1.4 | 10.3 | 9.2 | 10.9 | 32.3 |
| **Total** | **25.2** | **35.6** | **50.4** | **56.3** | **86.0** | **253.5** |

Overall there has been an increase in expenditure between 2002 to 2006 rising from TT$25.2m in 2002 to TT$86m in 2006 and totalling TT$253.5 overall. There has been an increased emphasis placed on Prevention which has seen over a three fold increase during the period. There has been a significant increase in the expenditure on Treatment, Care and Support and the expenditure related to Programme Management and Coordination increased significantly with the commencement of the NACC in 2004. Within Treatment, Care and Support there have been two periods whereby the costs have increased significantly; initially between 2003 and 2004 where the impact can be seen in terms of cost of the free ARV medication to PLWA. Secondly, in 2006 where there is a significant increase in expenditure due mainly to the higher costs of medication witch is associated with the increasing requirement to procure second line ARV therapy.

Expenditure on Advocacy & Human Rights and Surveillance & Research remains low for the period indicating that the main emphasis in the early stages of the response has been on treatment, primarily followed by prevention.

When Table 5 is compared to Table 1, NSP Implementation Costs we see an interesting picture emerge. For the Priority Area Prevention; after the ramp up period between 2002-2004 expenditure began to hit figures similar to those budgeted for in the NSP and even in exceeded these during 2006. With Treatment, Care and Support the picture is very different as expenditure has never come close to those budgeted for in the NSP. There may be reasons for this; for example the changes in ARV costs where the prices of ARV drugs reduced significantly reducing the cost burden during the early part of the study. Expenditure on Priority Area 3 advocacy & Human Rights has produced figures very similar to those budgeted for during the NSP. With Priority Area Four, the expenditure on Surveillance & Research has been very low against the budget and this may represent a missed opportunity in terms of implementing a more aggressive surveillance and research agenda. Expenditure on programme management has exceeded budgeted figures expressed in the NSP especially during the years 2004-2006.

## Financial Sources:

**Table 6 Summary: Financial Sources**

| Financial Source | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| Ministry of Health | 18.2 | 27.4 | 29.5 | 32.6 | 45.0 |
| Office of the Prime Minister / NACC | | 0.8 | 5.4 | 15.9 | 27.9 |
| Other Government | 1.3 | 0.7 | 3.7 | 0.8 | 5.5 |
| Central Government Total | 19.5 | 28.9 | 38.6 | 49.3 | 78.4 |
| International Organisations | 3.9 | 3.9 | 7.4 | 5.2 | 3.4 |
| Private Sector | 1.8 | 2.8 | 4.4 | 1.8 | 4.2 |
| **Total** | **25.2** | **35.6** | **50.4** | **56.3** | **86.0** |

During the period the vast majority of the funding for HIV/AIDS has been sourced from Government and with the main expenditure being made by the Ministry of Health. Although the Ministry of Health is associated with the treatment of HIV/AIDS this table demonstrates that its total level of expenditure is higher than the total expenditure on Treatment as indicated in Table 1. The reason for this is that Ministry of Health is a primary source of funding for HIV/AIDS Prevention activities including HIV testing and provision of Mother to child transmission services. The international community has

been a relatively steady source of funds during the period and the trend from the private sector is generally upwards even to the extent of exceeding the contribution made by the international community in 2006.

## Beneficiary Populations:

**Table 7: Summary Beneficiary Populations: Percentage Share of Total Expenditure Targeted Towards Specific Target Populations**

| Category | 02 % | 03 % | 04 % | 05 % | 06 % |
|---|---|---|---|---|---|
| **People Living With HIV and AIDS** | | | | | |
| Children | | | | 4.12% | 3.64% |
| Adult Females | | | | 0.43% | |
| People Not Disaggregated by Age/Gender | 55.9% | 63.79% | 43.16% | 55.76% | 51.54% |
| **Total Percentage of People Living with HIV and AIDS** | **55.9%** | **63.79%** | **43.16%** | **60.31%** | **55.18%** |
| | | | | | |
| **Most At Risk Populations** | | | | | |
| Injecting Drugs Users & Partners | | | 0.01% | 0.39% | 4.22% |
| Sex Workers & Clients | 0.22% | 0.19% | 0.27% | 0.3% | 0.02% |
| Men Who Have Sex with Men | 0.13% | 0.62% | 1.55% | 0.53% | 0.52% |
| Other Vulnerable Populations / Accessible Populations[7] | 3.02% | 0.61% | 0.45% | 1.38% | 1.00% |
| **Total Most at Risk Populations** | **3.36%** | **1.42%** | **2.28%** | **2.61%** | **5.77%** |
| | | | | | |
| **General Population** | | | | | |
| Children (Not disaggregated by age/gender) | | | 0.13% | 0.22% | 0.09% |
| Young Women (ages 15-29) | 4.28% | 6.36% | 2.92% | 0.16% | 0.08% |
| Youth (Not disaggregated by age/gender) | 2.01% | 0.13% | 0.07% | 0.82% | 0.43% |
| Adult Females ( ages=>29) | | | | 2.54% | 1.76% |
| People (Not disaggregated by | 34.53% | 28.3% | 51.43% | 33.34% | 36.69% |

[7] Accessible Populations are defined as STI Patients, Children & Youth in School, University Students, Migrant Workers, Military & Uniform Services and Workers.

| | | | | | |
|---|---|---|---|---|---|
| age/gender) | | | | | |
| **Total General Population** | **40.64%** | **34.8%** | **54.56%** | **37.08%** | **39.05%** |
| **Total** | **100%** | **100%** | **100%** | **100%** | **100%** |

Table 7 demonstrates that the vast majority of the expenditure has been to the benefit of the target population of People living with HIV and AIDS demonstrating that to date the response has been centred on treatment. Ideally, the data would be able to capture expenditure made towards sub-populations, for example children, or adult females however this data has only been captured sporadically. With the Most at Risk Populations, although in terms of percentages this group appears to have come off poorly in terms of the targeting of resources the actual expenditures have exceeded the NSP Targets by a substantial level. The NSP calls for specific targeting of resources towards these groups in terms of information materials and behaviour change interventions and indicates the following budgeted figure MSM TT$0.82 (US$0.08m); CSW TT$1.45 (US$0.23m), prisoners and drug impact programmes TT$0.32 (US$0.05m each) totalling TT$2.58m (US$0.41m). Total actual expenditure for the period, directed towards key populations has exceeded the NSP target by TT$3.32m, totalling TT$5.9m. However, when consideration is given to the actual expenditure classified by vulnerable group, some groups have not received the benefits of targeted interventions.

Table 7 indicates that there has been little in this way of targeted interventions directed at sex workers and prisoners.

**NSP BUDGET vs ACTUAL EXPENDITURE:**

**Table 8: At Risk Populations: Budget V Actual Expenditure 2002-2006**

| At Risk Population | Budget NSP Target | Actual Expenditure 2002-2006 |
|---|---|---|
| **MSM** | TT$0.82m | TT$1.72 |
| **Sex Workers** | TT$1.45 | TT$0.25 |
| **Prisoners** | TT$0.32 | TT$0.07 |
| **IDU** | TT$0.32 | TT$3.8* |

[8]

There has been significant targeting of resources to the General Population over the period averaging at around 41% of total resources. However, when we consider sub-populations within the general population, for example young women ages 15-29 targeting has reduced from a high of 6.36% in 2003 to 0.08% in 2006. This reduction in targeting is a concern especially when consideration is given to the sharp increase in new infection rates in females between the ages 15 – 34, (Table 3: New Infections 2003-2007 Female).

## Summary of Main Findings

*Targeting*

- *Is heavily directed towards the general population*
- *Is not specifically targeted towards any particular sub-population, within the General population in particular the sub population of young women.*
- *Sex Workers – Very Little targeting which points to this group being very marginalised*

[8] In 2006 there was a significant increase in expenditure on information and behaviour modification programmes for drug users which included a significant component on HIV/AIDS. As such the cost of the programme TT$3.6m has been included within this report.

## *4.1 Prevention*

### EXPENDITURE ASSESSMENT:

**Table 9: Expenditure Assessment Priority Area 1: Prevention**

| Objective | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M | Total |
|---|---|---|---|---|---|---|
| **To Promote Safe & Healthy Sexual Behaviours in the General Population** | | | | | | |
| Heighten Education & Awareness | 1.3 | 1.7 | 1.2 | 11.7 | 18.6 | 34.5 |
| Improve the availability and accessible of condoms | 0.27 | 0.32 | 1.4 | 0.4 | 1.0 | 3.39 |
| **To promote healthy sexual attitudes, behaviour and practices among vulnerable / high risk populations** | | | | | | |
| Introduce behaviour change interventions for young women, youths, MSM and CSWs | 1.2 | 0.5 | 3.3 | 0.1 | 1.1 | 3.2 |
| Reduce the impact of substance abuse on HIV transmission | | 0.07 | 0.15 | 0.22 | 3.6 | 4.04 |
| **To reduce the rate of mother to child transmission** | | | | | | |
| Implement a nationwide MTCT programme | 1.1 | 2.3 | 1.5 | 1.2 | 0.8 | 6.9 |
| **To increase the population's knowledge of its sero-status** | | | | | | |
| Develop a comprehensive national VCT programme | | | | 0.3 | 0.4 | 0.7 |
| Promote VCT services | | | | 0.06 | 1.1 | 1.16 |
| **To reduce the probability of post exposure infection** | | | | | | |
| Ensure the availability of adequate post-exposure services | 0.7 | 0.8 | 1.0 | 1.2 | 1.3 | 5.0 |
| **To improve the management and control of CSTI's** | | | | | | |
| Ensure effective syndromic management of CSTIs | 5.5 | 5.7 | 5.9 | 6.1 | 6.5 | 29.7 |
| **Total Prevention** | **10.2** | **11.3** | **18.3** | **21.3** | **34.4** | **78.5** |

Total expenditure on prevention rose to $34m in 2006 from $10.2 in 2002. The majority of the expenditure was related to the objective of 'To Promote Safe and Healthy Sexual Behaviours among the General Population' which totalled $19.6m in 2006. There was a significant increase in expenditure under the sub-category of 'Heighten Education and

Awareness from 2005 which was a result of expenditure on the HIV and AIDS advertising campaign based around 'What's Your Position' WYP. Expenditure on the objective of 'To promote healthy sexual attitudes, behaviour and practices among vulnerable / high risk populations' has recorded significant variations between years, with 2004 being the highest recorded expenditure related to 'behaviour change in young women, youths, aged 15-29, MSM and CSW'. Once expenditure on HIV/AIDS and substance abuse is considered, 2006 is the highest year of expenditure with $4.7m.

Points of particular note,

- Expenditure on the objective of 'reduce the rate of mother to child transmission' has shown a steady decline from 2003
- Expenditure on Voluntary counselling and Testing commenced in 2005 and increased rapidly in 2006 due to the development expenditure on VCT facilities within the health sector and
- Expenditure on Post Exposure services and syndromic management of CSTI's has shown a steady increase during the period raising from 0.7m in 2002 to 1.3m in 2006.

## NSP BUDGET vs ACTUAL EXPENDITURE

When consideration is given to the breakdown of expenditure against the budgetary figures as expressed in the NSP, the following picture emerges.

Total expenditure is only 59% against the NSP Target and the particularly poorly performing areas are 'HIV Prevention to all sectors' where no expenditure has been identified, 'Develop a comprehensive national VCT programme' which reached only 1.25%of the NSP Target, 'Improve the availability and accessible of condoms' which accounts for 28% of the NSP Target and 'Implement a nationwide MTCT programme' which managed 28% of the NSP Target.

The exceptions to the general pattern of expenditure, when not only was the NSP budget reached but exceeded are: 'Heighten Education & Awareness' in the general population which exceeded the NSP Target by 270%,, 'Reduce the impact of substance

abuse on HIV transmission which exceeded the NSP target by 918%[9] of the NSP Target, and Ensure effective syndromic management of CST which reached 147% of the NSP Target.

Whilst this report has not examined the reasons for any under or over spending against the NSP targets the wide variation in variances against NSP targets with some budgets underperforming and other budgets exceeded the NSP target, and in the case of some by a substantial margin indicates that f the process of monitoring activity against the targets set out in the NSP and making adjustments to ensure strategic objectives are being reached is weak.

[9] In 2006 there was a significant increase in expenditure on information and behaviour modification programmes for drug users which included a significant component on HIV/AIDS. As such the cost of the programme TT$3.6m has been included within this report.

**Table 10: Prevention: NSP Budget vs Actual Expenditure 2002-2006**

| Objective | Budget NSP Target TT$ | Actual Expenditure 2002-2006 TT$ |
|---|---|---|
| **To Promote Safe & Healthy Sexual Behaviours in the General Population** | | |
| Heighten Education & Awareness | 12.76 (US$2.02m | 34.5 |
| Improve the availability and accessible of condoms | 11.97 (US$1.9m) | 3.39 |
| HIV Prevention To all Sectors of Society | 0.32 (US$.05) | |
| **To promote healthy sexual attitudes, behaviour and practices -vulnerable/high risk populations** | | |
| Introduce behaviour change interventions for young women, youths, MSM and CSWs | 6.26 (US$0.99) | 3.2 |
| Reduce the impact of substance abuse on HIV transmission | 0.44 (US$0.07) | 4.04 |
| **To reduce the rate of mother to child transmission** | | |
| Implement a nationwide MTCT programme | 23.94 (US$3.8m) | 6.9 |
| **increase the pop'n knowledge of its serostatus** | | |
| Develop a comprehensive national VCT programme | 56.07 (US$8.9m) | 0.7 |
| Promote VCT services | | 1.16 |
| **To reduce the probability of post exposure infection** | | |
| Ensure the availability of adequate post-exposure services | | 5.0 |
| **To improve the management and control of CSTI's** | | |
| Ensure effective syndromic management of CSTIs | 20.16 (US$3.2m) | 29.7 |
| **Total Prevention** | **132.62 (US$21.05)** | **78.5** |

## Beneficiary Populations

**Table 11: Prevention Expenditure and Beneficiary Populations.**

| Beneficiary Population | 02 % | 03 % | 04 % | 05 % | 06 % |
|---|---|---|---|---|---|
| **People Living With HIV/AIDS** | | | | | |
| Children | | | | 8.03 | 0.11 |
| Adult Females | | | | - | - |
| People Not Disaggregated by Age/Gender | 9.28 | 11.47 | 15.9 | 37.7 | 26.43 |
| | | | | | |
| **Most at Risk Populations** | | | | | |
| Injecting Drug Users & Partners | - | - | 0.01 | 1.01 | 10.53 |
| Sex Workers and Clients | 0.51 | 0.56 | 0.16 | - | - |
| Men who have sex with Men | 0.32 | 1.95 | 3.2 | 1.35 | 1.15 |
| Other Vulnerable Populations / Accessible Populations[10] | 0.72 | 0.2 | 0.16 | - | - |
| | | | | | |
| **General Population** | | | | | |
| Children Not Disaggregated by Age/Gender | - | - | - | 0.59 | 0.22 |
| Young Women (16-24) | 10.62 | 20.05 | 8.11 | 0.43 | 0.16 |
| Youth | 4.99 | 0.42 | 0.09 | 6.65 | 4.71 |
| Adult Females(>=25) | | | | 1.99 | 1.01 |
| People Not Disaggregated by Age/Gender | 67.21 | 63.81 | 72.36 | 42.27 | 55.69 |
| **Total** | **100** | **100** | **100** | **100** | **100** |

The vast majority of prevention expenditure has been targeted towards the general population and this is demonstrated in Table 11 Prevention Expenditure and Beneficiary Populations, which ranges from a high of 72.36% of prevention expenditure in 2004 and a low of 42.27% in 2005. Prevention expenditure targeted at the most at risk populations shows that for sex workers and their clients and other vulnerable populations no expenditure has been identified for 2005 and 2006. Whilst, the most at

[10] Accessible Populations are defined as STI Patients, Children & Youth in School, University Students, Migrant Workers, Military & Uniform Services and Workers.

risk populations will receive prevention messages aimed at the general population, the table below indicates that in order to meet the targets set out in the NSP, specific prevention messages need to be developed for these beneficiary groups.

## Financial Sources

**Table 12: Prevention Expenditure and Financial Sources.**

| Financial Source | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| Ministry Of Health | 8.27 | 9.79 | 11.68 | 8.92 | 12.64 |
| Office of the Prime Minister / NACC | - | - | 1.68 | 9.69 | 19.41 |
| Other Ministries | 0.82 | 0.3 | 1.06 | 0.43 | 0.91 |
| **Government Total** | **9.09** | **10.09** | **14.43** | **19.04** | **32.96** |
| **International Organisations** | **0.99** | **0.95** | **1.50** | **1.22** | **1.30** |
| **Private Sector**[11] | **0.08** | **0.28** | **2.41** | **1.02** | **0.22** |
| **Total** | **10.16** | **11.31** | **18.34** | **21.27** | **34.47** |

The sources of funding for prevention of the National Response in Trinidad & Tobago are overwhelmingly from the Government purse, representing on average of 84% of the total funding With the majority of the expenditure, at $41m being made from the Ministry of Health. With the international based organisations there has been, general a steady increase in funding over the period.

## Summary of Main Findings - Prevention

*Targeting*

- *Is heavily directed towards the general population*
- *Sex Workers – Very Little targeted pointing to this group being very marginalised*

[11] Not designed to be part of the study, however funding was captured especially in relation to the funding of NGO's. Private household/Individual consumption of goods and services related to HIV is not included.

## *4.2 Treatment Care & Support*

### EXPENDITURE ASSESSMENT:

**Table 13: Expenditure Assessment Priority Area 2: Treatment Care & Support**

| Objective | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| **National System for Clinical Management of HIV/AIDS, CSTI's and OI's** | 12.53 | 20.76 | 18.98 | 24.16 | 34.95 |
| **Economic and Social Support for PLWHA** | 0.03 | 0.04 | 0.33 | 0.87 | 3.62 |
| **Total** | **12.56** | **20.8** | **19.31** | **25.03** | **38.57** |

Total expenditure on priority area two of the NSP – Treatment, Care & Support rose from $12.56m in 2002 to $38.57 in 2006. Between 2002 and 2003 there was a 60% increase in expenditure primarily due to a change in priorities by the Ministry of Health in the treatment of patients with HIV and AIDS. During this period there was

- an increase in expenditure of over 140% on ARV's,
- an increase in expenditure of 123% on outpatient care
- a reduction in expenditure of 7.5% on in-patient care.

In addition to the change in "policy", there are in addition 2 significant periods – Initially between 2003 and 2004 where the impact can be seen in terms of cost of the free ARV medication to PLWA. Secondly, in 2006 where there is a significant increase in expenditure due mainly to the higher costs of medication especially second line therapy.

## NSP BUDGET vs ACTUAL EXPENDITURE

**Table 14: Treatment, Care & Support: Budget V Actual Expenditure 2002-2006**

| Objective | Budget NSP Target $m | Actual Expenditure 2002-2006 $m |
|---|---|---|
| **National System for Clinical Management of HIV/AIDS, CSTI's and OI's** | 359.9 (US$57.13m) | 111.38 |
| **Economic and Social Support for PLWHA** | 9.7 (US$1.54m) | 4.89 |
| **TOTAL** | **369.62 (US$58.67m)** | **116.29** |

There has been a generalised underperformance with expenditure when compared to the performance objectives set out in the NSP, with total expenditure being TT$116.29m against a target of TT$369.62m.The NSP identified specific targets for the following areas:

- Expansion & Upgrade of Existing Facilities TT$12.6m,
- Training of Personnel TT$8m,
- ARV TT$146.1m,
- Laboratory Support TT$53.23m and Tobago TT$71.5m.

Performances against these specific objectives are set out in Table 15. Notwithstanding that the costs of training have not been identified, expenditure against the NSP targets have been very low with of the highest performing category being Tobago-specific interventions reaching a high of 30.3% of the NSP target. Expenditure on

- Expansion and Upgrade of existing facilities reached 3.4% of the NSP target,

- ARV medication reached 28.9% of the NSP target
- Laboratory Support reached only 12% of the NSP target.

**Table 15: Treatment, Care & Support: Budget V Actual Expenditure 2002-2006 by specific Treatment, care & Support Target. 2002-2006.**

| Objective | Budget NSP Target $m | Actual Expenditure 2002-2006 $m |
|---|---|---|
| **Expansion & Upgrade of Existing Facilities** | 12.6m (US$2.0m) | 0.43m |
| **Training of Personnel** | 8.0m (US$1.27m) | Not identified |
| **ARV**[12] | 146.1 (US$23.19m) | 42.3m* |
| **Laboratory Support** | 53.23 (US$8.45m) | 6.4m |
| **Tobago** | 71.5m (US$11.35m) | 21.7m |

## BENEFICIARY POPULATIONS:

With the Beneficiary Populations targeted under the priority Area Treatment, Care and Support the significant majority of the expenditure was to the benefit of people living with HIV and AIDS with the substantial majority of the funding being made from the Ministry of Health/ Regional Health Authorities (Table 17). In addition, in 2006 there was a considerable investment in treatment from the private sector of TT$3.9m with the vast majority of this being directed towards orphans and vulnerable children.

[12] Includes the costs of ARV's destined for Tobago

**Table 16: Treatment Expenditure and Beneficiary Populations.**

| Beneficiary Population | 02 % | 03 % | 04 % | 05 % | 06 % |
|---|---|---|---|---|---|
| **People Living With HIV/AIDS** | | | | | |
| Children | | | | 0.02 | 8.01 |
| Adult Females | | | | | |
| People Not Disaggregated by Age/Gender | 97.47 | 97.00 | 92.00 | 92.00 | 88.59 |
| | | | | | |
| **Most at Risk Populations** | | | | | |
| Injecting Drug Users & Partners | | | | | 0.02 |
| Sex Workers and Clients | | | | | |
| Men who have sex with Men | | | | | |
| Other Vulnerable Populations / Accessible Populations | 0.14 | | | 3.00 | 1.00 |
| | | | | | |
| **General Population** | | | | | |
| Children Not Disaggregated by Age/Gender | | | | | |
| Young Women (16-24) | | | | | |
| Youth | | | | | |
| Adult Females(>=25) | | | | | |
| People Not Disaggregated by Age/Gender | 2.39 | 3.00 | 8.00 | 2.00 | 2.02 |
| **Total** | **100** | **100** | **100** | **100** | **100** |

## Financial Sources

**Table 17: Treatment Expenditure and Financial Sources.**

| Financial Source | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| Ministry Of Health/Regional Health Authorities | 9.4 | 17.5 | 14.8 | 20.9 | 29.3 |
| Office of the Prime Minister / NACC | - | - | | 0.8 | 1.01 |
| Territorial | - | - | 2.3 | 0.02 | 3.8 |
| Other Ministries | 0.3 | 0.3 | 0.01 | 0 | 0.2 |
| **Government Total** | 9.7 | 17.8 | 17.11 | 21.7 | 34.31 |
| **International Organisations** | 1.08 | 0.4 | 1.0 | 2.6 | 0.4 |
| **Private Sector**[13] | 1.8 | 2.6 | 1.2 | 0.7 | 3.9 |
| Total | 12.5 | 20.8 | 19.3 | 25.02 | 38.6 |

### Summary of Main Findings

- *Costs associated with the provision of ARV medication have risen considerable, although;*
- *The expenditure on Treatment, care and support has not kept pace with the budgets expressed in the NSP*
- *There have been successes especially in relation to the provision of free ARV medication to PLWA and the success of the PMTCT programme.*

[13] Not designed to be part of the study, however funding was captured especially in relation to the funding of NGO's. Private household/Individual consumption of goods and services related to HIV is not included

## *4.3 Advocacy & Human Rights*

### EXPENDITURE ASSESSMENT

**Table 18: Expenditure Assessment Priority Area 3: Advocacy & Human Rights**

| Objective | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| **Work Place Initiatives** | | | | | |
| **Legal Framework** | | | | | |
| **Capacity Building** | .63 | .82 | 1.62 | .33 | .82 |
| **Total** | **.63** | **.82** | **1.62** | **.33** | **.82** |

Whilst expenditure on Advocacy & Human Rights appears relatively low it has exceeded the overall target by just over TT$1m during the period (Table 19). All the expenditure has been classified within the NSP objective as capacity building with expenditure being made on "Advocacy & Communications' and 'Organisation and Empowerment". Whilst no expenditure is recorded on 'work place initiatives' and 'legal framework' it is critical to note that during the latter years of this study planning of both the National Workplace Policy on HIV/AIDS and the Legal Assessment were being undertaken. Whilst there would have been costs associated with both activities they have both been classified as programme management costs and included with the Objective 5, Programme Management, Coordination and Evaluation.

## ADVOCACY AND HUMAN RIGHTS:

**Table 19: NSP BUDGET vs ACTUAL EXPENDITURE 2002 – 2006 by specific Advocacy and Human Rights Targets**

| Objective | Budget NSP Target $m | Actual Expenditure 2002-2006 $m |
|---|---|---|
| **To Reduce Stigma and Discrimination against PLWHAs** | 2.39 (US$0.38m) | |
| **Ensure Human Rights for PLWHA and other groups affected by HIV/AIDS** | 0.82 (US$0.13m) | 4.22 |
| **TOTAL** | **3.21 (US$0.51m)** | **4.22** |

### BENEFICIARY POPULATIONS

When consideration is given to the groups targeted by the expenditure on Advocacy & Human Rights it can be seen that there is an interesting shift in priorities from 2004 and onwards. During 2002 and 2003 100% of the expenditure was targeted exclusively towards PLWHA and from 2004 there was a significant shift which continued in 2006 of Advocacy & Human Rights interventions targeting the General Population.

**Table 20: Advocacy Expenditure and Beneficiary Populations.**

| Beneficiary Population | 02 % | 03 % | 04 % | 05 % | 06 % |
|---|---|---|---|---|---|
| **People Living With HIV/AIDS** | | | | | |
| Children | | | | | .84 |
| Adult Females | | | | 56 | |
| People Not Disaggregated by Age/Gender | 100 | 100 | 12 | 3 | 1.28 |
| | | | | | |
| **Most at Risk Populations** | | | | | |
| Injecting Drug Users & Partners | | | | | |
| Sex Workers and Clients | | | .43 | | |
| Men who have sex with Men | | | .43 | | |
| Other Vulnerable Populations / Accessible Populations[14] | | | 5 | 3 | 3 |
| | | | | | |
| **General Population** | | | | | |
| Children Not Disaggregated by Age/Gender | | | 1 | | |
| Young Women (16-24) | | | | | 1.99 |
| Youth | | | | | |
| Adult Females(>=25) | | | | | |
| People Not Disaggregated by Age/Gender | | | 81 | 37 | 92.94 |
| **Total** | **100** | **100** | **100** | **100** | **100** |

## Financial Sources

The source of funds for this Priority Area indicates that Advocacy & Human Rights is an agenda predominantly pressed by the International Organisations, especially during the early years of the National HIV response. It is only during 2006 that expenditure by government has exceeded the reducing commitment of the international organisations.

[14] Accessible Populations are defined as STI Patients, Children & Youth in School, University Students, Migrant Workers, Military & Uniform Services and Workers.

**Table 21: Advocacy Expenditure and Financial Sources.**

| Financial Source | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| Ministry Of Health | - | - | - | - | - |
| Office of the Prime Minister / NACC | - | - | - | 0.08 | .65 |
| Territorial | | | .03 | .01 | .01 |
| Other Ministries | .15 | .15 | .01 | - | - |
| **Government Total** | .15 | .15 | 0.04 | .09 | .66 |
| **International Organisations** | .44 | .63 | 1.43 | .22 | .14 |
| **Private Sector**[15] | .04 | .04 | .15 | .02 | .02 |
| **Total** | **.63** | **.82** | **1.62** | **.33** | **.82** |

## Summary of Main Findings

- *The period under review has been a developmental and planning period*
- *The majority of direct expenditure has been financed from the multi-lateral community*

[15] Not designed to be part of the study, however funding was captured especially in relation to the funding of NGO's. Private household/Individual consumption of goods and services related to HIV is not included.

## 4.4 *Surveillance & Research*

### EXPENDITURE ASSESSMENT

**Table 22: Expenditure Assessment Priority Area 4: Surveillance & Research**

| Objective | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| **Strengthen the Surveillance System** | | | | | |
| **Clinical & Behavioural Research** | 1.3 | 1.26 | .96 | .43 | 1.19 |
| **Total** | **1.3** | **1.26** | **.96** | **.43** | **1.19** |

Expenditure on Surveillance and Research has been spent exclusively within the category Clinical and Behavioural Research which totals TT$5.14m over the period 2002-2006. Projects undertaken during the period are within the thematic areas of knowledge attitudes; practices and behaviours surveys; MSM in Trinidad & Tobago; quality of life study for PLWHA; assessment of information and communication activities for HIV prevention; gender and sex work studies, although there has been little identifiable expenditure on clinical research. As the emphasis in the strategic management of National HIV/AIDS responses is moving towards evidence based programming, it appears that the low level of expenditure on the Objective of Clinical and Behavioural Research indicates a lost opportunity during the initial stages of the National HIV/AIDS response.

### NSP BUDGET vs ACTUAL EXPENDITURE

When consideration is given to how the expenditure has been made against the targets indicated in the NSP, (Table 23) it can be seen that there is no expenditure identified against the objective strengthening the Surveillance System and a significant under-spend against the Objective of Clinical and Behavioural Research. However, it is worth noting that during 2006 the procurement was being finalised to introduce a pilot project on the HIV/AIDS/STI Surveillance System. Whilst there would have been costs associated with activities they have both been classified as programme management

costs and included with the Objective 5, Programme Management, Coordination and Evaluation.

As total expenditure on Surveillance and Research has reached only 20% of the budget called for within the NSP indicates a greater need for emphasis placed on this priority area.

**Table 23: Surveillance & research: NSP Budget V Actual Expenditure 2002-2006 by specific surveillance & research Target.**

| Objective | Budget NSP Target $m | Actual Expenditure 2002-2006 $m |
|---|---|---|
| **Strengthen the Surveillance System** | 15.57 (US$2.63m) | |
| **Clinical and Behavioural Research** | 9.45 (US$1.5m) | 5.14 |
| **TOTAL** | **26.1 (US$4.13m)** | **5.14** |

## BENEFICIARY POPULATION

Expenditure on Surveillance & Research has predominantly been targeted towards the general population however with periodic studies associated with marginalised groups in particular Sex Workers and MSM.

As the key drivers of the epidemic are associated with the most at risk population greater emphasis needs to be placed on research with key populations; injected drug users and partners, Sex Workers and Clients, MSM and other key vulnerable populations.

**Table 24: Surveillance & Research Expenditure and Beneficiary Populations.**

| Beneficiary Population | 02 % | 03 % | 04 % | 05 % | 06 % |
|---|---|---|---|---|---|
| **People Living With HIV/AIDS** | | | | | |
| Children | | | | | |
| Adult Females | | | | | |
| People Not Disaggregated by Age/Gender | 4.46 | 4 | 3 | 47 | |
| | | | | | |
| **Most at Risk Populations** | | | | | |
| Injecting Drug Users & Partners | | | | | |
| Sex Workers and Clients | | | .41 | 40 | 1.59 |
| Men who have sex with Men | | | | 3 | |
| Other Vulnerable Populations / Accessible Populations[16] | | | | | |
| | | | | | |
| **General Population** | | | | | |
| Children Not Disaggregated by Age/Gender | | | 4 | | |
| Young Women (16-24) | | | | | |
| Youth | | | | | |
| Adult Females(>=25) | | | | 3 | |
| People Not Disaggregated by Age/Gender | 95.54 | 96 | 92 | 8 | 98.41 |
| **Total** | **100** | **100** | **100** | **100** | **100** |

**FINANCIAL SOURCES:**

Financing of surveillance and research activities have been sourced mainly from the International organisations, totalling TT$3.09m, and from Government, TT$2.01m.

[16] Accessible Populations are defined as STI Patients, Children & Youth in School, University Students, Migrant Workers, Military & Uniform Services and Workers.

**Table 25: Surveillance & Research Expenditure and Financial Sources.**

| Financial Source | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| Ministry Of Health | .48 | .12 | - | - | - |
| Office of the Prime Minister / NACC | - | - | - | .23 | 1.17 |
| Territorial | | | - | - | - |
| Other Ministries | - | - | .01 | - | - |
| **Government Total** | .48 | .12 | .01 | .23 | 1.17 |
| **International Organisations** | .83 | 1.14 | .91 | .19 | .02 |
| **Private Sector**[17] | - | - | .04 | - | |
| **Total** | **1.31** | **1.26** | **.96** | **.42** | **1.19** |

## Summary of Main Findings

- *Whilst there have been some behaviour related research there has been very little clinical based research on HIV and AIDS*
- *The NACC has taken the lead on initiating research projects*
- *More research is required on key vulnerable populations*

[17] Not designed to be part of the study, however funding was captured especially in relation to the funding of NGO's. Private household/Individual consumption of goods and services related to HIV is not included.

## *4.5 Programme Management, Coordination & Evaluation*

**EXPENDITURE ASSESSMENT:**

Total expenditure on priority area five of the NSP Programme Management Coordination and Evaluation rose from $0.54m in 2002 to $10.98m in 2006. The significant increase between 2003 and 2004 is due primarily, but not solely to the creation of the National AIDS Coordinating Committee which represents the body responsible for the coordination of the national response for HIV/AIDS in Trinidad & Tobago. The majority of the expenditure has been made on the areas of "Developing the National Commitment, Support and Ownership of the Expanded National response to HIV/AIDS' which totalled $27.07m over the period and which includes costs within the following categories:

- 'Develop an appropriate management structure for the national expanded response',
- 'Gain wide support for the National Strategic Plan' and
- 'Mobilise adequate and sustained resources to support implementation of the strategic plan'.

**Table 26: Expenditure Assessment Priority Area 5: Programme Management**

| Objective | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| **National Commitment** | .32 | 1.15 | 7.33 | 9.09 | 9.58 |
| **Monitor the implementation** | | | | | .32 |
| **Build Capacity** | .22 | .3 | 2.92 | .16 | 1.08 |
| **Total** | **.54** | **1.45** | **10.25** | **9.25** | **10.98** |

Expenditure on the objective of 'Monitor the Implementation of Policies and Programmes as outlined in the NSP totals $0.32m and expenditure on the objective of "Build Capacity among Critical Stakeholders" totals $4.68m. The total budget as indicated in the NSP

for Programme Management was TT$37.54m (US$5.96) and total expenditure for the period is TT$32.47m.

## FINANCIAL SOURCES

The vast majority of the financial sources, at over 80% come from Government especially from 2005, with the Office of the Prime Minister being the main source of funds.

**Table 27: Programme Management Expenditure and Financial Sources.**

| Financial Source | 02 $M | 03 $M | 04 $M | 05 $M | 06 $M |
|---|---|---|---|---|---|
| Ministry Of Health | | | 3.06 | 2.81 | 3.14 |
| Office of the Prime Minister / NACC | - | .72 | 3.77 | 5.21 | 5.53 |
| Territorial | | | .02 | .01 | .43 |
| Other Ministries | - | .01 | .22 | .23 | .1 |
| **Government Total** | - | .72 | 7.07 | 8.26 | 9.2 |
| **International Organisations** | .54 | .73 | 2.58 | .91 | 1.75 |
| **Private Sector**[18] | - | - | .6 | .07 | .04 |
| **Total** | **.54** | **1.46** | **10.25** | **9.24** | **10.98** |

### Summary of Main Findings

- *Expenditure on developing and managing national commitment to HIV and Aids requires considerable investment.*
- *Government of the Republic of Trinidad & Tobago are the main source of funds for Programme Management Costs.*

[18] Not designed to be part of the study, however funding was captured especially in relation to the funding of NGO's. Private household/Individual consumption of goods and services related to HIV is not included.

# 5 SUMMARY

NASA performs a critical role in the monitoring of achievements against targets as set out in the NSP and contributes to how the expenditure on HIV/AIDS can impact against key target populations. There is a requirement for NASA to be conducted on a regular basis and the results fed into the decision making and policy making process.

From the period under review whilst expenditure has increased it has done so at a significant reduced level than was original requested in the NSP. If consideration is given to how close expenditure on priority areas has been in comparison to the expenditure targets in the NSP it can be seen that the priority has been:

- Advocacy & Human Rights 131% of NSP Target
- Programme Management, Coordination & Evaluation 86% of NSP Target.
- Prevention 59% of NSP Target
- Treatment Care & Support 32% of NSP Target
- Surveillance & research 20% of NSP Target

The key financial source has been generated through government sources and financed primarily through the Ministry of Health and Office of the Prime Minister with funding from the Multi-lateral and Bi-lateral community being restricted to on average well under 10%. The private sector has made an increasing impact on HIV financing and which has even exceeded the financial contribution by the international community during some years.

### Summary of Main Findings - *Targeting*

- *Is heavily directed towards the general population*

- *Is not specifically targeted towards any particular target group, within the General population.*
- *Sex Workers – Very Little targeted pointing to this group being very marginalised*
- *Young women – epi data points to more targeted interventions at this group*

### Summary of Main Findings - Prevention

- *Is heavily directed towards the general population*
- *Sex Workers – Very Little targeted pointing to this group being very marginalised*

### Summary of Main Findings - Treatment, Care and Support

- *Costs associated with the provision of ARV medication have risen considerable, although;*
- *The expenditure on Treatment, care and support has not kept pace with the budgets expressed in the NSP*

### Summary of Main Findings - Advocacy and Human Rights

- *The period under review has been a developmental and planning period*
- *The majority of direct expenditure has been financed from the multi-lateral community*

### Summary of Main Findings – Surveillance and Research

- *Whilst there have been some behaviour related research there has been very little clinical based research on HIV and AIDS*
- *The NACC has taken the lead on initiating research projects*
- *More research is required on key vulnerable population*

### Summary of Main Findings – Programme Management

- *Expenditure on developing and managing national commitment to HIV and Aids re quires considerable investment.*
- *Government of the Republic of Trinidad & Tobago are the main source of funds for Programme Management Costs.*

# 6 RECOMMENDATIONS

As the NASA provides critical information in the monitoring of the key outputs of the National HIV/AIDS Strategic Planning it is imperative that the exercise is conducted annually and that the key findings are used to develop and refine the strategic panning process. However, NASA must also be used with other key evidence based information and should be used as information to support the findings of other output and impact indicators.

The beneficiary populations that have been targeted by the National HIV/AIDS response remain predominantly People Living with HIV/AIDS followed closely by the General Population. Resources targeted towards the Most at Risk populations have in general exceeded the targets as set out in the NSP, with the exception of sex workers and prisoners both of which have received very little in the way of targeted interventions.

- It is therefore recommended that there is greater emphasis placed on the targeting of prevention resources towards specific vulnerable groups including MSM, SW, IDU's and prisoners.

Expenditure on Treatment Care & Support has been very low against the targets set out in the NSP reaching only 32% of the NSP Budgetary Target. There has been a notable success however, especially with regard to treatment and care of PLWHA as expenditure on ARV's has risen by 140%, outpatient care has risen by 123% and in-patient care has reduced by 7.5%.

- It is recommended that there is greater emphasis placed on the management and monitoring of resources within the health sector and the utilisation of information such as NASA to facilitate the strategic planning process. In addition the resources directed towards HIV could be used to develop the overall capacity of the health sector as a whole.

Expenditure on Advocacy & Human Rights has exceeded the budgetary target in the NSP by TT$1m with the majority of expenditure targeted towards the general population. With the exception of 2006 the majority of funding in this category has been sourced from the multi-lateral and bi-lateral sector.

- As the budget has been exceeded it would indicate that the original expectations were set too low. It s recommended to re-evaluate the original targets and develop higher ambitions in respect to the development of and advocacy of Human Rights for those marginalised and minority societal groups.

Expenditure on Surveillance & Research has been the most poorly performing area when comparing actual expenditure to NSP Target reaching only 19.69% of the NSP Budget. It appears that far too little priority has been placed on this area and represents a missed opportunity.

- It is recommended that this area should receive greater priority as a greater emphasis is being placed on evidence based strategic planning. It is recommended that the NACC takes the leadership role in developing a clinical and behavioural research agenda in partnership with key programme implementers.

Expenditure on Programme Management and Coordination has been directed towards developing the national commitment and building capacity. As with the priority area of Surveillance and Research there has been very low expenditure related to Monitoring the Implementation of the National response.

- It is recommended that greater emphasis is placed on monitoring & evaluation especially with respect to all HIV and AIDS programmatic interventions whether this is implemented through key ministries or civil society. Reporting on output indicators and impact indicators should be a standard approach in all HIV programmatic interventions and to focus this on the key risk groups at risk of HIV infection.

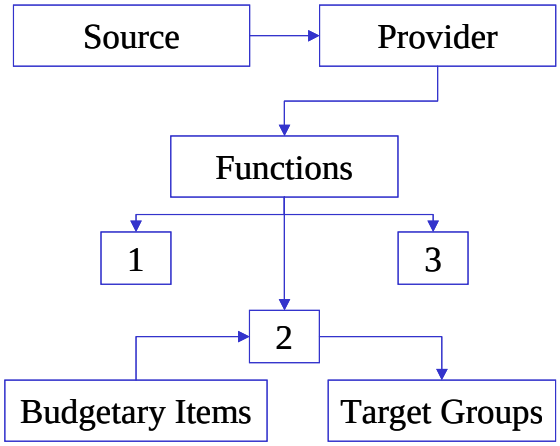
# 7 METHODOLOGY

The National HIV and AIDS spending assessment is a systematic, periodic and exhaustive exercise to measure the level and flow of financing and expenditures in the public and private sectors for addressing the HIV/AIDS epidemic. This accounting must be exhaustive, covering entities, services and expenditures; periodic, i.e. generating annual estimates through continuous recording and analysis; and systematic, based on a framework of uniform categories and records/reports that are consistent over time and comparable across countries.[19]

The financial flows refer to the flow of resources from different financial sources to service providers, through diverse transaction mechanisms. A transaction comprise of all elements of the financial flow, the transfer of resources from a financial source to a service provider, which provides goods and services to specific target groups. In the figure below (figure 8.1.1), the financial flow links the source with the provider that produces the functions. Function '2' illustrates the service delivery process which has inputs here defined as Budgetary items, operating costs, costs of goods and services for example which produce outputs to the target groups.

[19] SIDALAC, Technical Handbook for Estimating the National Accounts on HIV/AIDS. Mexican Health Foundation, 2001 and National AIDS Spending Assessment: A Notebook on Methods, Definitions, and Procedures for the Measurement of HIV and AIDS Financing Flows and Expenditures at Country Level.

**Table 28: Transaction model for National HIV/AIDS Accounts**




## Background research

The first step in the National AIDS spending Assessment was a literature review. Which involves reviewing existing published financial reports, for example the Public Sector Investment Programmes, internal reporting and web based searches which can provide key information about the country, the health system, the HIV/AIDS situation, important statistics, and current initiatives and projects. An understanding of the complexity of the HIV/AIDS situation and the roles of the multiple stakeholders emerged from this initial stage.

## Data collection

In order to collect the data from the different institutions and the different key actors, questionnaires were developed according to the information needed: The financial sources, providers, ambulatory care provided in institutions, ambulatory care provided in private practice, and hospitalisation for opportunistic infections.

The questionnaires were sent by e-mail to all stakeholders. Hard copy and faxed versions of the questionnaires were also distributed to stakeholders without email access. NACC staff and consultants visited with numerous stakeholders in order to provide assistance in completing the questionnaire. All of the organizations that received the questionnaires were contacted by phone after the questionnaires were distributed and support meetings were conducted in order to retrieve the information in a timely manner.

Despite continuous visits with stakeholders, the progress in data collection was very slow, mainly due to the lack of the necessary financial information, lack of staff support to complete the questionnaire, and also due to the reluctance of key agencies and institutions to answer the questionnaire.

Tobago was visited in order to obtain information from the key stakeholders on the island. Several key actors were interviewed including the Hospital Medical Director from the Scarborough Regional Hospital, staff from the Tobago AIDS Society and the Tobago Health Promotion Clinic, the County Medical Officer of Health, the Tobago House of Assembly, the Tobago Health Promotion Clinic, and the Tobago Oasis Foundation, among others.

NACC staff and consultants also visited representatives of local nongovernmental organizations, private providers and private sources of funding and assisted in completing the questionnaire.

### Data processing

The software known as NASA Resource Tracking System (NASA RTS) was developed by UNAIDS to facilitate data processing. The software provides a user-friendly step-by-step guide to conduct the assessment and facilitates monitoring and crosschecking of transactions in different matrices representing sources, providers, functions, budgetary items and target groups using a common classification system.

Before starting the data entry in NASA RTS, the figures from the questionnaires were entered into Excel® spreadsheets in order to classify all the information and avoid mistakes when entered into NASA RTS. All of the information obtained was verified, to

ensure the validity of the estimates from the sources and from the providers of the transaction, reviewing in the process the classification of activities according to the functional breakdown of the NASA classification.

Once the transactions were verified and adjusted, the information was entered in NASA RTS. The NASA RTS outputs (double-entry matrices) were exported to Excel® to produce summary tables, graphics and indicators to present the results of the NASA along with economic, demographic and other financial indicators.

The NASA matrices were then re-profiled to the reporting methodology as indicated in the NSP. The re-profiling was undertaken through the following steps: 1) Compare the description of the each function under NASA to the description of strategies as indicated in the NSP; 2) allocate each function to the corresponding strategy; 3) identify the costs associated with each function and allocate these to the corresponding strategy. The methodology for re-profiling is included in Appendix 1.

### Validation of the results

The preliminary results obtained were highlighted in a validation meeting with representatives from a large number of stakeholders of private, nongovernmental, governmental and foreign agencies, including the National HIV/AIDS Accounts team and the NACC staff. The purpose of the meeting was to identify dubious figures and estimates, gaps and errors, and offer a forum for stakeholders to provide feedback on the preliminary findings. In this final meeting, various interesting observations were made by members of the audience, and have been incorporated into the present report. The participants' contributions helped the team to prepare a more explicit, clear and accurate presentation of the results.

### Limitations

The relevant representatives of each organization were often difficult to contact, which lagged the entire exercise behind schedule. For example, private sector physicians and hospitals were identified to gather data on private sector HIV/AIDS expenditure. Despite numerous attempts, the private sector representatives were unavailable to

speak over the phone or in person. Therefore, this report does not include estimates on HIV/AIDS expenditure within the private sector health care system.

The International Organizations with regional involvement focus on reporting activities for the region and do not have specific information for each country, thus complicating the breakdown of expenditures. Some of these organizations managed to give estimations of the expenditures by taking the total HIV/AIDS expenditure and dividing it by the number of countries in which the organization operates.

The NASA examines data over the period of a calendar year (January 1-December 31). However, many organizations record their accounts on a multi-year and multi-annual basis or the start date of the fiscal year is not January 1. Many organizations found it challenging to estimate HIV/AIDS expenditure for the calendar year due to their varied forms of financial record keeping.

Also, the reluctance of some organizations to share their financial information with the NASA team affected the coverage and accuracy of the estimates. However, greater coverage and higher accuracy is hoped to be achieved by diffusion of results (to encourage feedback and clarification) and undertaking the process annually to provide depth of data for comparison.

# 8 Appendix 1

**Table 29: Re-profiling NASA Functions to NSP Strategies**

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 1.1.1Information for general awareness. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | A. Heighten HIV/AIDS education and awareness |
| FN 1.1.2Information through mass media. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | A. Heighten HIV/AIDS education and awareness |
| FN 1.1.3Teacher training in life-skills-based HIV education in schools. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | A. Heighten HIV/AIDS education and awareness |
| FN 1.1.4Youth in school. | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations. | B. Introduce behaviour change interventions targeted to youths in and out of school |
| FN 1.1.5Youth out of school. | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations. | B. Introduce behaviour change interventions targeted to youths in and out of school |
| FN 1.1.6Workplace Activities. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | A. Heighten HIV/AIDS education and awareness |
| FN 1.1.7Prevention for Specific “accessible” populations. | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | Accessible Populations are defined as STI Patients, Children & Youth in School, University Students, Migrant Workers, Military & Uniform Services and Workers. |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 1.2.1Community mobilization. | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | B. Introduce behaviour change interventions targeted to young Females, youths in and out of school, CSW, MSM, IDU as appropriate |
| | | | |
| FN 1.3.1Voluntary counseling and testing. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | A. Heighten HIV/AIDS education and awareness |
| | | | |
| FN 1.4.1Programmes focused on female sex workers and their clients. | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | D. Introduce behaviour change/ risk reduction programmes for CSWs. |
| | | | |
| FN 1.5.1Programmes focused on male sex workers and their clients. | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | D. Introduce behaviour change/ risk reduction programmes for CSWs. |
| | | | |
| FN 1.6.1Programmes focused on men who have sex with men (MSM). | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | C. Support behaviour change programmes targeted to MSM. |
| | | | |
| FN 1.7.1Programmes focused on transgender individuals. | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | C. Support behaviour change programmes targeted to MSM. |
| | | | |
| FN 1.8.1Harm-reduction programmes for injecting drug users (IDU). | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | F. Reduce impact of substance abuse on HIV transmission. |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 1.9.1Prevention programmes for people living with HIV. | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | A. Heighten HIV/AIDS education and awareness. |
| | | | |
| FN 1.10.1Condom social marketing. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | B. Improve the availability and accessibility of condoms. |
| | | | |
| FN 1.11.1Public and commercial sector condom provision. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | B. Improve the availability and accessibility of condoms. |
| | | | |
| FN 1.12.1Female condom. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | B. Improve the availability and accessibility of condoms. |
| | | | |
| FN 1.13.1Microbicides. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | B. Improve the availability and accessibility of condoms. |
| | | | |
| FN 1.14.1Comprehensive STI-case management for women | Prevention | 6. To improve the management and control of Conventional Sexually Transmitted Infections | B. Ensure effective syndromic management of CSTIs |
| FN 1.14.2Comprehensive STI-case management for men | Prevention | 6. To improve the management and control of Conventional Sexually Transmitted Infections | B. Ensure effective syndromic management of CSTIs |
| | | | |
| FN 1.15.1Prevention of mother-to-child transmission. | Prevention | 3. To reduce mother to child transmission. | *A. Implement a nationwide MTCT programme* |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 1.16.1Blood safety. | Prevention | 5. To reduce the probability of post exposure infection | A. Ensure the availability of adequate post exposure services |
| | | | |
| FN 1.17.1Post-exposure prophylaxis. | Prevention | 5. To reduce the probability of post exposure infection | A. Ensure the availability of adequate post exposure services |
| | | | |
| FN 1.18.1Safe medical injections. | Prevention | 5. To reduce the probability of post exposure infection | A. Ensure the availability of adequate post exposure services |
| | | | |
| FN 1.19.1Universal precautions. | Prevention | 5. To reduce the probability of post exposure infection | A. Ensure the availability of adequate post exposure services |
| | | | |
| FN 1.99.9Prevention not classified elsewhere | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | A. Heighten HIV/AIDS education and awareness |
| | | | |
| | | | |
| FN 3.1.1Education. | Prevention | 1. To promote safe and healthy sexual behaviours among the general population. | A. Heighten HIV/AIDS education and awareness |
| | | | |
| FN 3.2.1Basic health-care support | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |
| | | | |
| FN 3.3.1Family/home support | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 3.4.1Community support | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |
| | | | |
| FN 3.5.1Organization costs | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |
| | | | |
| FN 3.99.9OVC activities not classified elsewhere | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |
| | | | |
| | | | |
| FN 4.1.1Programme Management and Coordination. | Programme Management, Coordination & Evaluation | 1. To achieve national commitment, support and ownership of the expanded strategic response to HIV/AIDS | A. Develop an appropriate management structure for the national expanded response. |
| | | | |
| FN 4.2.1Advocacy and communications. | Advocacy & Human Rights | 1. To reduce stigma and discrimination against PLWHA | A. Promote openness and acceptance of PLWHA in the workplace and in the wider community |
| | | | |
| FN 4.3.1Monitoring and Evaluation. | Programme Management, Coordination & Evaluation | 2. To monitor the implementation of the expanded response. | 2. To monitor the implementation of the expanded response. |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 4.4.1Operations Research. | Advocacy & Human Rights | 2. To undertake and participate in effective clinical and behavioral research on HIV/AIDS and related issues | A. Understand the linkage between psychosocial issues and vulnerability to HIV/AIDS |
| FN 4.5.1Surveillance (serosentinel, behaviour surveillance). | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |
| | | | |
| FN 4.6.1Training. | Programme Management, Coordination & Evaluation | 1. To achieve national commitment, support and ownership of the expanded strategic response to HIV/AIDS | A. Develop an appropriate management structure for the national expanded response. |
| | | | |
| FN 4.7.1Logistic and supply, including transportation. | Programme Management, Coordination & Evaluation | 1. To achieve national commitment, support and ownership of the expanded strategic response to HIV/AIDS | A. Develop an appropriate management structure for the national expanded response. |
| | | | |
| FN 4.8.1Supervision of programmes and programme support for patient tracking. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |
| | | | |
| FN 4.9.1HIV drug resistance surveillance. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |
| | | | |
| FN 4.10.1Upgrading laboratory infrastructure. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008<br>Priority Area | Strategic Objective | Strategies |
|---|---|---|---|
| FN 4.11.1Construction of new health centres. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |
| FN 4.99.9Program development not classified elsewhere | Treatment Care & Support | 1. To achieve national commitment, support and ownership of the expanded strategic response to HIV/AIDS | A. Develop an appropriate management structure for the national expanded response. |
| | | | |
| FN 5.1.1Monetary incentives for doctors. | | Not Relevant | |
| | | | |
| FN 5.2.1Monetary incentives for nurses.. | | Not Relevant | |
| | | | |
| FN 5.3.1Monetary incentives for other staff. | | Not Relevant | |
| | | | |
| FN 5.99.9Human resources not classified elsewhere | | Not Relevant | |
| | | | |
| FN 6.1.1Human Rights. | Advocacy & Human Rights | 2. Ensure human rights for PLWHA and other groups affected by HIV/AIDS | |
| | | | |
| FN 6.2.1Monetary Benefits. | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |
| | | | |

| | | | |
|---|---|---|---|
| FN 6.3.1In kind benefits. | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 6.4.1Social services. | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |
| | | | |
| FN 6.99.9Social mitigation activities not classified elsewhere | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |
| | | | |
| | | | |
| FN 7.1.1Institutional Development. | Programme Management, Coordination & Evaluation | 1. To achieve national commitment, support and ownership of the expanded strategic response to HIV/AIDS | A. Develop an appropriate management structure for the national expanded response. |
| | | | |
| FN 7.2.1Programmes focused on Women. | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | A. Introduce behaviour change intervention programmes targeted to young females. |
| | | | |
| FN 7.3.1Income generation projects. | | Not Relevant | |
| | | | |
| FN 7.4.1HIV and AIDS Advocacy. | Advocacy & Human Rights | 1. To reduce stigma and discrimination against PLWHA | A. Promote openness and acceptance of PLWHA in the workplace and in the wider community |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 7.99.9Community development activities not classified elsewhere | Prevention | 2. To promote healthy sexual attitudes, behaviour and practices among vulnerable/ high-risk populations | B. Introduce behaviour change interventions targeted to young Females, youths in and out of school, CSW, MSM, IDU as appropriate |
| | | | |
| FN 8.5.1Behavioural research, | Surveillance & Research | 2. To undertake and participate in effective clinical and behavioral research on HIV/AIDS and related issues | A. Understand the linkage between psychosocial issues and vulnerability to HIV/AIDS. |
| | | | |
| FN 8.6.1Research capacity strengthening | Surveillance & Research | 2. To undertake and participate in effective clinical and behavioral research on HIV/AIDS and related issues | A. Understand the linkage between psychosocial issues and vulnerability to HIV/AIDS. |
| | | | |
| FN 8.7.1Vaccine-related research. | Surveillance & Research | 2. To undertake and participate in effective clinical and behavioral research on HIV/AIDS and related issues | B. Conduct effective epidemiological research and clinical trials |
| | | | |
| FN 8.99.9Research activities not classified elsewhere | Surveillance & Research | 2. To undertake and participate in effective clinical and behavioral research on HIV/AIDS and related issues | A. Understand the linkage between psychosocial issues and vulnerability to HIV/AIDS. |
| | | | |
| FN 2.1.1Provider initiated testing. | Prevention | 4. To increase the population's knowledge of its Serostatus | A. Develop a comprehensive national Voluntary Counseling and Testing Programme |
| | | | |
| FN 2.2.1Antiretroviral therapy for adults: | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 2.2.2Antiretroviral therapy for children. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |
| | | | |
| FN 2.3.1Nutritional support associated to antiretroviral (ARV) therapy. | Treatment Care & Support | 2. To create an environment that supports the infected and the affected | A. Provide appropriate economic and social support to the PLWHA and to the affected |
| | | | |
| FN 2.4.1Prophylaxis for Opportunistic Infections. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | B. Improve access to medication, treatment and care for persons with opportunistic infections. |
| | | | |
| FN 2.5.1Treatment of Opportunistic Infections. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | B. Improve access to medication, treatment and care for persons with opportunistic infections. |
| | | | |
| FN 2.6.1Hospital treatment and care. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |
| | | | |
| FN 2.7.1Laboratory monitoring. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |
| | | | |
| FN 2.8.1Palliative care. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |

| NASA Function | Five Year National HIV/AIDS Strategic Plan 2004 - 2008 | | |
|---|---|---|---|
| | Priority Area | Strategic Objective | Strategies |
| FN 2.9.1Alternative and informal providers. | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |
| | | | |
| FN 2.99.9Treatment and care not classified elsewhere | Treatment Care & Support | 1. To improve access to treatment and care for HIV/AIDS | A. Implement a national system for the clinical management and treatment of HIV/AIDS |