

1. Introduction

The Turks and Caicos Islands (TCI) is an archipelago of approximately 40 islands and cays located at the southeastern tip of the Bahamas archipelago. The 8 major islands are dispersed between the two groups of islands, the Turks Islands and the Caicos Islands. Together they comprise a landmass of 193 square miles (417 sq. km). The principal islands in the Turks group are Grand Turk (the nation's capital) and Salt Cay, and in the Caicos group are South Caicos, East Caicos, Middle Caicos, North Caicos, Providenciales, and West Caicos. The island nation is located 575 miles south of Miami, FL and 90 miles North of Haiti.



Figure 1: Map of the Turks and Caicos Islands.

The TCI, a United Kingdom Overseas Territory in the English-speaking Caribbean, was settled by Europeans in 1678 when British colonists from Bermuda established a salt-panning industry. Over the centuries the TCI has enjoyed governmental linkages with other regional colonial governments, namely The Bahamas and Jamaica, before becoming a Crown Colony in the 1960s. Despite being discovered by Europeans in the sixteenth century, the TCI was not settled until the seventeenth century, and salt production for export was the nation's economic mainstay until the industry stopped operations in 1964. It has now been replaced by fishing, tourism, and offshore banking.

The TCI has been described as one of the fastest growing economies in the region (1). This economic growth is also accompanied by marked demographic changes. The 2007 population estimates of 34,862 marks a 57% increase over 2001 Census figures (2). The majority of the increase is due to an influx of immigrants (legal and illegal), many of whom are from Haiti and the Dominican Republic, in search of economic opportunities.

HIV/AIDS prevalence rates in Haiti and the Dominican Republic are among the highest in the Caribbean. Together, they are responsible for approximately three-quarters of the HIV cases in the region. Compelling evidence, primarily from work-permit applicants, and antenatal clinic HIV-tests, show that these countries also feature prominently in the HIV/AIDS profile of TCI.

1.1 Status At A Glance

Table 1: Core Indicators for Implementing the Declaration of Commitment on HIV/AIDS

UNGASS Indicators	Note/Comments	Document Reference
1. Domestic and International AIDS spending		Section 3.1
Ministry of Health		
National AIDS Program	\$958,000.00 in 2006 \$1,108,888 in 2007	
Social Welfare Department	Information not available	
National Drug Unit	Information not available	
Ministry of Finance		
National Insurance	Information not available	
2. National Composite Policy Index		Section 3.2
3. Blood Safety: Percentage of donated blood screened for HIV in a quality assured manner.	In 2006, 181 blood samples were tested from donors no HIV positives. 2007, 183 blood samples tested 1 HIV (0.5%) positive.	Section 3.3
4. HIV Treatment/Antiretroviral Therapy (ART): Percentage of adults and children with advanced HIV receiving ART.	59 persons on ART in 2006 79 persons on ART in 2007	Section 3.4
5. Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child transmission.	In 2006 and 2007, 7(78%) and 5(83%) women got ART in TCI antenatal clinics.	Section 3.5
8. HIV Testing in Most-at-risk: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results.	Haitian immigrants and pregnant women identified as most at risk groups.	Section 3.6
11. Life Skills-based HIV Education in Schools: Percentage of schools that provided life skill-based HIV test education in the last academic year.	All public school children receive life skills-based education including HIV prevention education.	Section 3.7
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART.	Approximately 96% (67 of the 70 persons registered) including adults and children survived after 12 months on anti- retroviral	Section 3.8

	treatment.	
25. Percentage of infants born to HIV-infected mothers who are infected and are HIV infected.	One child (16.7%) was born HIV-infected in 2006.	Section 3.9
3. Percentage of transnational companies that are present in developing countries and have workplace HIV policies and programs.		Section 3.9

Comment [k1]:

2. Overview of the HIV/AIDS Epidemic in TCI

HIV/AIDS became a part of the health landscape of the TCI in 1985 when the first case was diagnosed. Surveillance efforts began in earnest when, amid much debate and controversy, HIV testing became a prerequisite for work permit issuance in the TCI. In 1986 the Government of the TCI formed the National AIDS Committee to function as an advisory body to the Ministry of Health. This Committee evolved into what is currently known as the TCI National AIDS Program (NAP). Table 1 chronicles hallmarks of NAP's response to HIV/AIDS during the period 1985-present.

In TCI the HIV/AIDS epidemic is concentrated in the most populous islands of Providenciales and Grand Turk, which are also the primary recipients of immigrants in search of work. In 2006 and 2007, respectively, Haitian women accounted for the majority of HIV-positive pregnant women in antenatal clinics (Section 3.5).

In 2006 it was estimated that approximately one quarter of the 250,000 persons living with HIV/AIDS in the Caribbean resided in countries other than Haiti and the Dominican Republic, which includes TCI. However, geographically the TCI is situated in close proximity to Haiti and the Dominican Republic where approximately three-quarters of persons living with HIV in the Caribbean reside. TCI is also the recipient of immigrants (legal and illegal), in increasing numbers from these French and Spanish-speaking neighbours.

Since its inception, HIV testing of work permit applicants and pregnant women has been the primary means by which information on HIV/AIDS in TCI is obtained. National HIV testing campaigns held in 2005 and 2006 throughout the TCI provided the local population with additional opportunities for Voluntary Counselling Testing. Prevalence rates in the region range from 0.1% in Cuba to 2% - 4% in the Bahamas, Haiti, and Trinidad and Tobago (3). Based on available data, prevalence rates for TCI for the period 1995-2005 range from 0.2 % - 0.7% (4). Prevalence rates for this reporting period (2006 and 2007) were 0.6% and 0.7%, respectively. However, the true rates are difficult to determine in the absence of sound

epidemiological data, and because stigma, discrimination, and confidentiality concerns prevent people who may be at risk from seeking counselling and testing.

Reportedly, heterosexual contact is the primary mode of transmission of HIV in the TCI, with the infection concentrated in immigrant groups, mainly from Haiti. Heterosexual activity is believed to be the primary mode of transmission. This is consistent with the profile of the epidemic in the rest of the Caribbean. The extent to which other factors contribute to HIV transmission in TCI is unknown. In the TCI, immigrant groups from Haiti and the Dominican Republic are believed to be at greatest risk. This could create a false sense of security, which could easily put the indigenous population at risk for HIV infection from non-immigrant groups, if HIV is erroneously perceived to be solely an immigrant problem. The number of new cases for the last 13 years (1995 – 2007) ranged from 13 to 58 per year, with an average incidence of 21 cases per year.

During the time-period (1985 – 2007), the cumulative total of HIV/AIDS cases reported in the TCI was 344. Of this number, 59 and 79 received treatment in TCI Primary Health Care System in 2006 and 2007, respectively, and 88 (26%) died in the TCI (an average of 3.8 per year). The number of HIV/AIDS deaths recorded in TCI seems to be on the decline with only 2 deaths recorded in 2006 and 1 death in 2007. This could be interpreted as follows:

1. Persons with HIV are living longer.
2. Since many of the HIV/AIDS persons in TCI are immigrants, perhaps they return home to die, and the death is not registered in the TCI.
3. Intervention programs such as treatment regimens and health promotion activities emphasizing safe sex practice are working.

Table 2: HIV/AIDS Epidemic and the TCI Response

Year	Activity
1985	First case of AIDS diagnosed.
1985	Testing of work-permit applicants introduced with much debate and controversy.
1986	National AIDS Committee formed as advisory body to the Minister of Health.
1987	ELISA testing is introduced in TCI. Prior to 1987 specimens were sent to CAREC.
1988	AIDS became a notifiable disease.
1989	Medium term plan developed, in collaboration with PAHO and CAREC, to form National Response to HIV and target HIV-positive persons.
1990	First knowledge, attitudes, practices and behaviour (KAPB) study conducted.
1991	Testing all pregnant women for HIV at clinics introduced.
1992	Post of National AIDS Coordinator became vacant.
1993	Government assumes financial responsibility for the AIDS program.
1994	National AIDS Policy drafted.
1994	First set of school peer educators trained, this continues on a yearly basis.
1995	Review of KAPB.
1996	PMTCT programs started. AZT prescribed for HIV-positive pregnant women.
1996	Seroprevalence study conducted for pregnant women with HIV, HBV, and Syphilis.
1997	NAP helped to develop Healthy Lifestyle Curriculum for schools incorporating

	HIV/AIDS prevention into the curriculum.
1997	Annual youth debate introduced.
2000	New National AIDS Committee formed.
2001	National Strategic Plan Developed.
2002	National Hospice Started
2002	Additional support staff assigned to the National AIDS Program
2002	Rapport Youth Initiative started with funding from DFID.
2003	Treatment and care plan developed.
2003	Access to Antiretrovirals (ARV) introduced.
2003	First National Youth Summit in which 300 youth participated.
2004	National AIDS Policy redrafted. Dr. Reid started treating TCI HIV-positive patients.
2005	Program Officer assigned to NAP.
2005	Buddy program started.
2005	VCT Needs Assessment conducted and VCT introduced. (2 groups of service providers trained).
2006	VCT needs assessment report submitted to NAP.
2007	Second batch of VCT service providers trained.
2007	Campaign to raise awareness to stigma and sensitisation launched.
2007	Nap website launched with financial and technical support from The Turks and Caicos AIDS Awareness Foundation.
2007	First World AIDS Day Telethon sponsored by telecommunications company Digicel raised in excess of \$100,00.00 for HIV/AIDS treatment.

In the TCI it is very difficult to know the exact number of HIV-positive persons, and equally difficult to track HIV-positive persons known to the health care system for the following reasons:

1. The majority of HIV-positive tests identified are from immigrants applying for work permits. Hence the numbers may fluctuate markedly from year to year (e.g. between 2006- 2007) based on the volume of immigrant applications.(See Figure 2.) Also, from pregnant women primarily from Haiti who attend antenatal clinic. In many instances, once a HIV-positive result is communicated to an immigrant, the individual returns they either return to the homeland or go underground and evade health and immigration authorities.
2. Some persons on receiving a positive test challenge the accuracy of the test and repeatedly get retested by the National Laboratory and in private sector laboratories, thereby leading to duplicate counting.
3. It is rumoured that the TCI nationals, in order to preserve their anonymity, if they are financially able, they do not have HIV tests performed locally. Some of those who test positive may travel abroad for treatment. Hence, these cases never get reported to local TCI authorities.

Figures 2-3 show the total number HIV-positive tests and number of HIV/AIDS deaths reported in TCI.

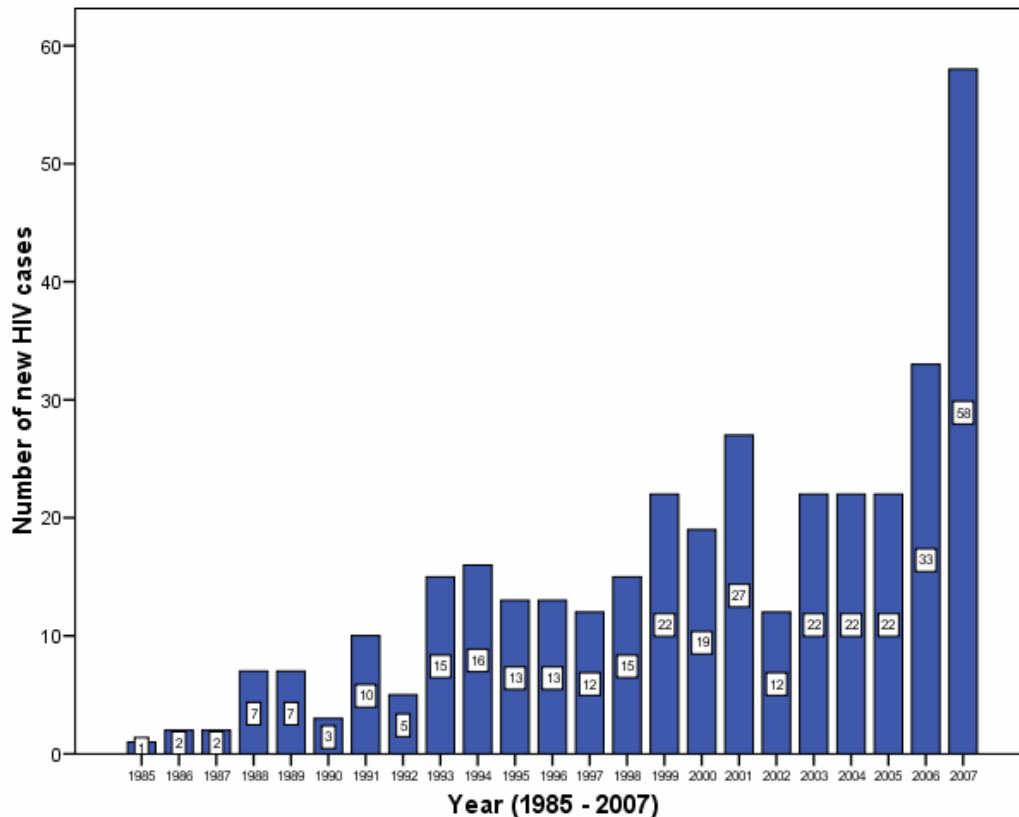
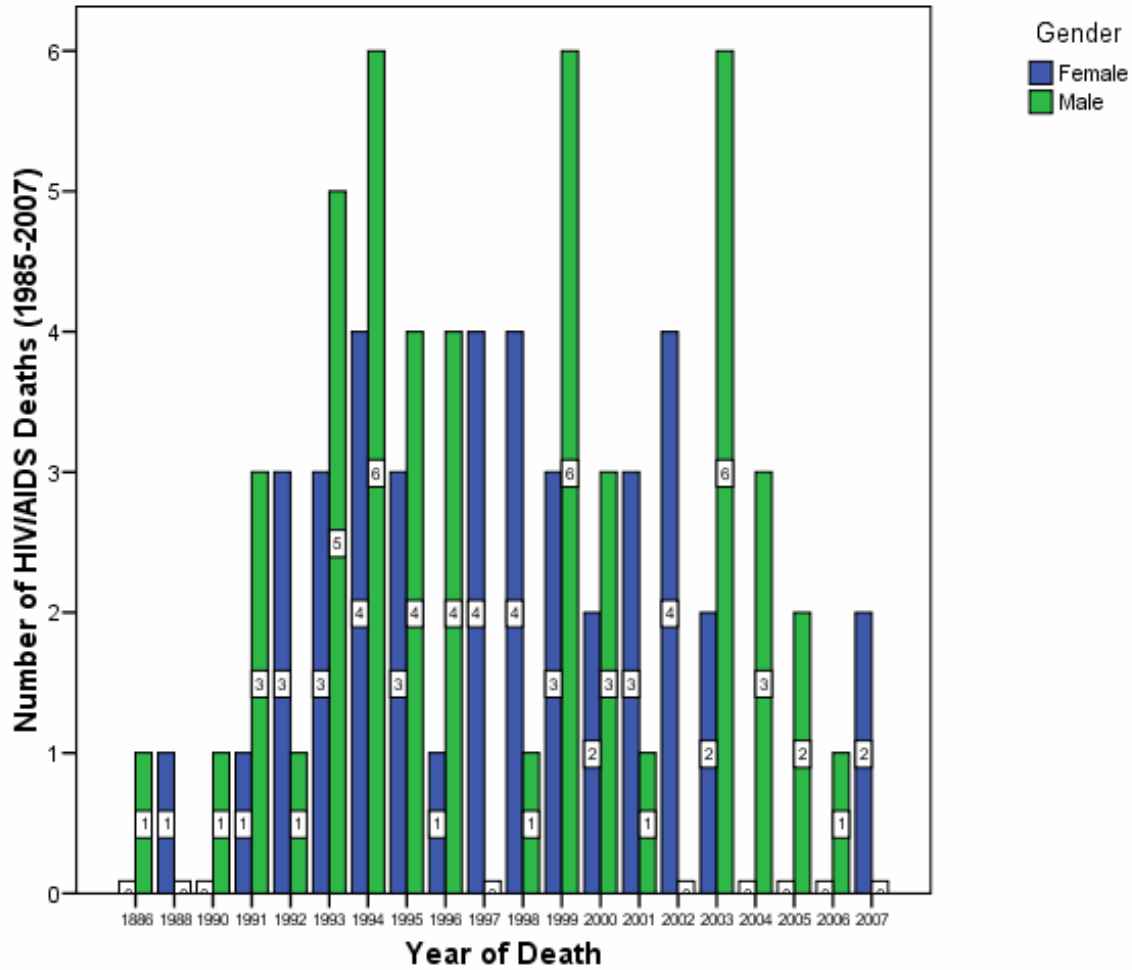


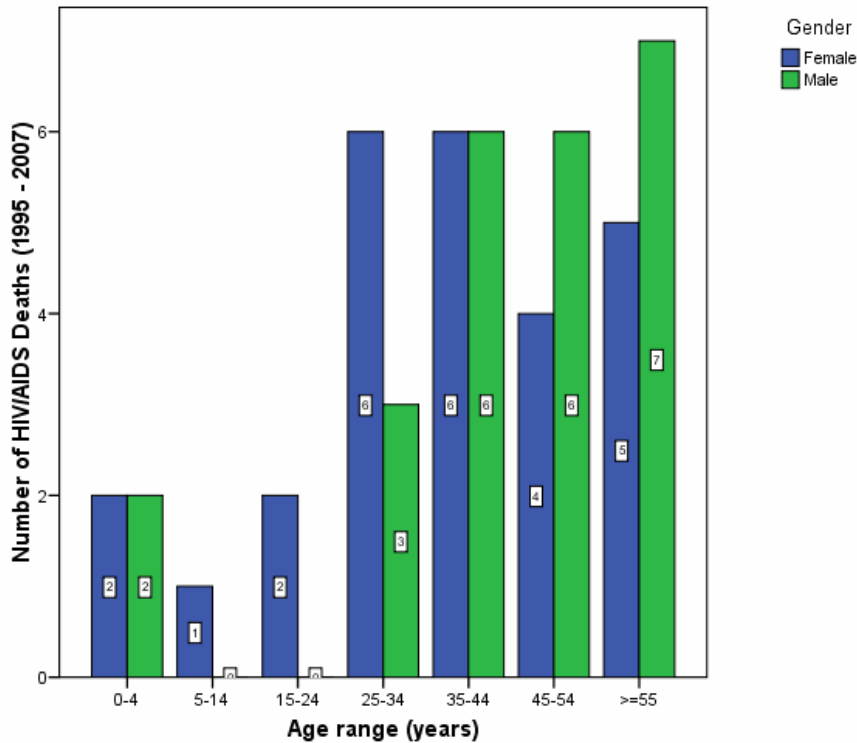
Figure 2: Number of new HIV-positive tests (1985-2007)

Figure 3: Number of HIV/AIDS Deaths (1985-2007) by Gender



During the period 1995 – 2007 a total of 50 HIV/AIDS deaths were registered in the TCI (Figure 4). The overall female to male ratio is approximately 1:1. However, among persons 0 – 34 years the ratio was 2.2 to 1 and among persons >=35 years the ratio was 0.8 to 1. The majority of deaths 43 (86%) were of persons aged >= 25 years.

Figure 4: Age and Gender distribution of HIV/AIDS in TCI (1995-2007)



HIV/AIDS is listed as a leading cause of death for the TCI. The first AIDS death was recorded in 1986. Since then HIV/AIDS, as a proportion of total TCI deaths, peaked at 23.1% in 1999. However, on average for the period 1985 to 2006, HIV/AIDS has accounted for 7.4% of deaths in TCI per year. Only 3 HIV/AIDS deaths were recorded in TCI for the period covered by this report (2006 -2007). Of the 3 deaths recorded, 1 occurred in 2006 and 2 to date (December 20, 2007) in 2007.

3. National Response to HIV/AIDS in the Turks and Caicos Islands (TCI)

3.1 Leadership and coordination

Optimizing the use of resources while simultaneously improving the response to HIV/AIDS at the national level is the primary goal of the TCI. In 2000, the 13th International Conference on AIDS and STIs in Africa approved a set of guiding principles, known as the “Three Ones” to facilitate achieving this goal. Specifically, these principles are aimed at improving efficiency and maximizing the “bang” achieved for each “buck” spent on HIV/AIDS by reducing duplication of efforts by key stakeholders/partners in areas such as planning, financing, programming and monitoring. This essentially enforces the concept that unity is

strength and encourages collaboration between key stakeholders. The principles are as follows:

- One agreed AIDS action framework that provides basic for coordinating the work of all partners.
- One national AIDS coordinating authority, with a broad-based multisectoral mandate.
- One agreed country-level monitoring and evaluation system.

Subsequent to the adoption of the “Three Ones,” the TCI response to HIV/AIDS has been consistent with these principles. The ensuing pages within this section will outline the evolution of the TCI response to HIV/AIDS, including the successes and the challenges encountered during this period.

3.1.1. One AIDS Action Framework ---- The National AIDS Program (NAP).

The National AIDS Program (NAP), like its predecessor, the National AIDS Committee, which was formed in 1986 as an advisory body to the Ministry of Health and Human Services, is mandated by the TCI Government to provide the action framework through which the national response to HIV/AIDS in the TCI is mounted. It is the primary government agency that is charged with ensuring a comprehensive and integrated HIV/AIDS/STI Prevention and Control Program is in place in the TCI. It is also the agency within the Ministry of Health and Human Services that has been charged with the responsibility of ensuring that the practices outlined in the Three Ones Principles are adhered to.

NAP serves as the main coordinating body and is responsible for designing, implementing, monitoring and evaluating the National HIV/AIDS response. In addition, NAP serves as a venue and conduit for intensive policy discussion between government and other stakeholders to ensure that policies formulated and actions taken respond to HIV/AIDS within the context of HIV/AIDS being a social development issue requiring multisectoral attention. Hence, the extent to which NAP can achieve the aforementioned TCI goal with regards to HIV/AIDS is predicated on strong collaborative partnerships between various governmental agencies e.g., the Ministry of Health and Human Services, the Ministry of Finance, other national stakeholders such as corporate entities in the private sector, religious and civic organizations in the broader TCI community, regional partners such as the Caribbean Epidemiology Centre (CAREC), and the Caribbean Regional Network for People Living with HIV/AIDS (CRN+), Coalition of National AIDS Program Coordinators and international partners such as UNAIDS, and Pan American Health Organization (PAHO), World Health Organization (WHO) and Department for International Development (DFID). NAP is, therefore, charged with fostering commitment, coordination, cooperation and collaboration among stakeholders and the TCI community. Also to develop within the TCI a

comprehensive and effective HIV/AIDS service that is safe, accessible, and affordable for all nationals and recognizes the legal and human rights of people living with HIV/AIDS, with the ultimate goal of mitigating the impact of HIV/AIDS on TCI society.

As published on the website at www.tcinationalaidsprogram.com, the vision for NAP is to create a fully empowered nation where diverse individuals and groups work together to prevent HIV transmission and minimize the impact on persons who are infected and affected in particular and the nation in general.

The Ministry of Health and Human Services provides core funding for HIV/AIDS; the National AIDS Program's budget for 2006 and 2007 was US\$ 958,000 and \$1,108,880.00, respectively. This amount does not include funds spent on HIV-positive persons and their families by the Social Welfare Department of the Ministry of Health and Human Services, the health care system in the TCI locally and through the TCI treatment abroad program, and benefits paid out by National Insurance Program. NAP's budget makes provisions for administrative, preventive, and clinical/ treatment services as well as special projects related to HIV/AIDS throughout the TCI archipelago e.g., training workshops, Voluntary Counselling and Testing campaigns. Collectively, these activities help to raise awareness in the general population about HIV/AIDS while emphasizing the importance of prevention, early detection, and care, as well as minimizing stigma and discrimination.

NAP serves as the primary advocate for individuals and families impacted by HIV/AIDS. It is responsible for implementing a program consistent with its goal of providing comprehensive services and support to reduce the spread of HIV in TCI. It is guided by the following strategic initiatives:

1. Advocacy, policy development and legislation
2. Treatment, Care and support for people living with HIV and AIDS
3. Prevention, especially for young people and vulnerable groups
4. Coordination, program design, implementation, monitoring and evaluation.

Table 3 lists the various categories of expenditure on HIV/AIDS in TCI. However, it is incomplete as in many instances, services are provided abroad and it takes a long time to be billed and for the accounting system to get caught up to reflect the payment. Additionally, to preserve confidentiality, some services to HIV/AIDS affected persons e.g., National Insurance and the Social Development Program are provided without necessarily knowing the recipients' HIV/AIDS status. All these factors make it difficult to provide a reasonably accurate indication as to how much was spent on HIV/AIDS in a given time period.

Table 3: TCI Expenditure on HIV/AIDS (2006 and 2007)

Category	Year	
	2006*	2007*
Prevention and Education	\$3,500.00	\$ 5,925.00
Surveillance	Information unavailable	Information unavailable
Research	Information unavailable	Information unavailable
Inpatient medical care (in TCI)	Information unavailable	Information unavailable
Treatment abroad	\$ 11,718.00	\$7,704, 50
Medications	\$66,219.00	\$10,200.00 (as of Oct'07)
Outpatient care	Information unavailable	Information unavailable
Monitoring and Evaluation	Information unavailable	Information unavailable
Program support	Information unavailable	Information unavailable
Laboratory Services	Information unavailable	\$21, 317.92
Training and Technical Assistance	\$100,736.59	\$97,757.63
Equipment and capital outlay to improve facilities (e.g., lab)	-	\$51, 883.00

*Data incomplete as total charges for services (e.g., treatment abroad) in all categories dating back to 2006 have not yet been billed.

Figure 5 shows the inputs and outflows of NAP. It emphasizes the importance of inter-sectoral collaboration and partnerships as inputs (e.g., Primary Health Care, Laboratory Services, Non-Governmental Organizations, and International Agencies) to NAP's optimal functioning and production of outflows (e.g., prevention and education programs, surveillance, research, youth programs and treatment programs locally and abroad).

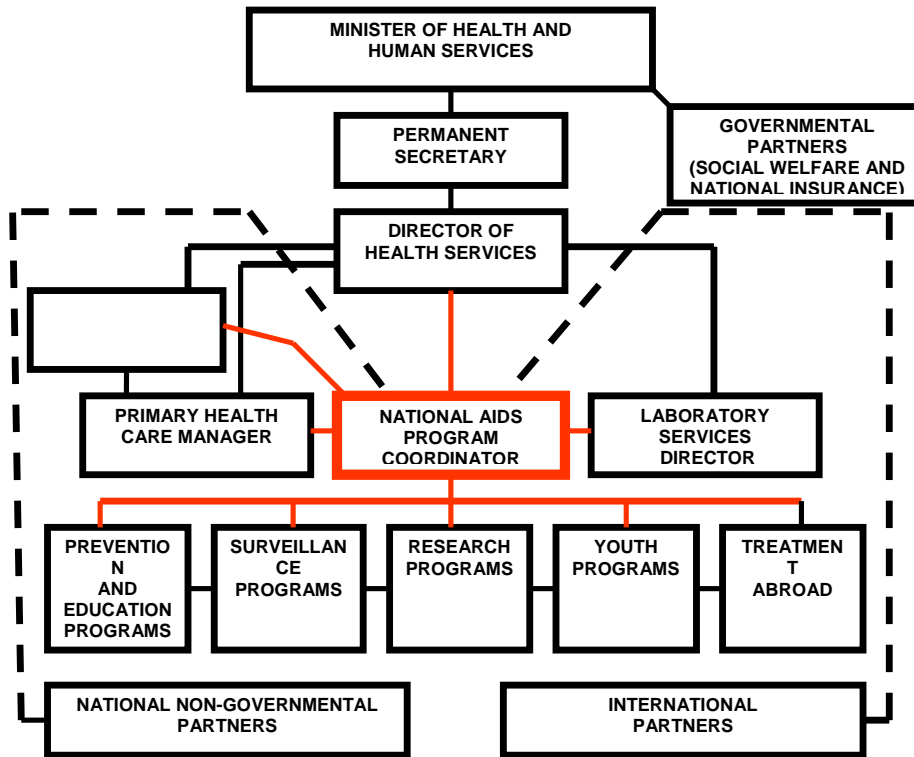


Figure 5: Inputs and Outflows of National AIDS Program

3.2 TCI Government HIV and AIDS Policies.

In an effort to evaluate the TCI Government HIV and AIDS Policies, key stakeholders (five representatives each from Government Agencies and Civil Society) were asked to complete Parts A and B, respectively, of the interview/questionnaire included in (Appendix 7- Guidelines on Construction of Core Indicators). The questionnaire was designed to determine the National Composite Policy Index for TCI from the perspective of government officials and Civil Society. Questionnaires from three Government officials and five Civil Society representatives were completed.

Most representatives, especially from the TCI Government, felt that the timing was bad because of end-of-year deadlines e.g., drafts of departmental budgets and staff shortages due to persons on vacation for the Holidays which adversely impacted their ability to complete the document in a timely manner. Summaries of findings from both sets of interviews are as follows:

Part A – Response from Government Officials.

When asked if the TCI has a national multisectoral strategy/action framework to combat AIDS, 2 (66.7%), respondents agreed and indicated that the strategy had been in place for 3 and 10 years, respectively, and included the following sectors: Health, education, women, young people and persons living with HIV/AIDS. Two of these sectors, health and young people, had a specific budget for HIV-related activities while funding for the others was appropriated through NAP. This strategy/action framework addressed the following target populations, which were identified through a process of needs assessment: Women and girls, young women/young men, specific vulnerable sub-populations, and orphans and other vulnerable children. It also addressed workplace, school and prison settings and cross cutting issues such as HIV/AIDS and poverty, human rights protection, PLHIV involvement, addressing stigma and discrimination, and gender empowerment and/or gender equality.

Respondents felt that target populations in TCI included PLHIV, migrant workers, youth and women. In TCI an operational plan existed and included formal program goals, clear targets and/or milestones, detailed budget of costs per programmatic area, indications of funding sources, and monitoring and evaluation framework. TCI has ensured full involvement and participation as well as moderate to active involvement of civil society in the development of the multisectoral strategy/action framework, largely developed in house after meetings and consultations with organizations/ groups such as religious leaders and women's groups. The TCI multisectoral strategy/action framework has been endorsed by external development partners. Two respondents (66.7%) felt that external development partners have aligned and harmonized their HIV and AIDS programs to the national multisectoral strategy/action framework. Two respondents (66.7%) felt that the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, Respondents felt that the following policy areas were included in the development plans: HIV Prevention, treatment of opportunistic infections, antiretroviral therapy, care and support (including social security or other schemes), AIDS impact alleviation, reduction of stigma and discrimination, and women's economic empowerment. One respondent felt that the TCI has evaluated the impact of HIV/AIDS on its socioeconomic development for planning purposes, and on a scale of 0 to 5, rated the extent to which this evaluation has informed resource allocation decisions as a 3.0.

All three respondents agreed that TCI has a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc and has implemented the following programs: Behavioural change communication, condom provision, HIV counselling and testing (CT), STI services, and care and support. It was felt that the TCI approach to CT is two pronged; it is voluntary with the exception of persons seeking work permits to work in the TCI, when it is mandatory.

It was agreed that the TCI followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006 and has revised the National Strategic Plan/Operational Plan, the national AIDS budget, and estimates of size of the target population, to reflect this. It was felt that TCI has reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy. However, this was not broken down by gender but broken down by sub-population. Also, that the HIV/AIDS program coverage is being monitored by gender and sub-group, e.g., immigrant workers in the various districts/islands.

It was also felt that the country has developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs. Overall, the TCI strategy planning efforts in the HIV/AIDS program in 2007 and in 2005 were rated as 6.0 for both years, on a scale of 0 to 10. It was felt that since 2005, efforts have been made to educate the TCI population about HIV through the various media houses and distribution of pamphlets. Also, plans have been implemented to collect scientifically sound data to better inform policy and planning efforts.

All respondents felt that strong political support exists. This is evidenced by top government officials and political leaders speaking out publicly and favourably about AIDS efforts in major domestic fora at least twice a year, regularly chairing important meetings, allocating national budgets to support the AIDS programs, and effective use of government and civil society organizations and processes to support effective AIDS programs. Two of the three respondents felt that the country had an officially recognized national multisectoral AIDS management/coordination body, the National AIDS Program since 1986, which promotes interaction between government and various groups including people living with HIV, civil society and the private sector for implementing HIV/AIDS strategies/programs. These groups have terms of reference, defined memberships, action plans, functional secretariat and holds regular meetings. They count fund raising for AIDS programs and a youth centre, awareness, and advocacy, among their achievements and list the level of human and financial resource and public support as limitations. Two respondents felt that 20% of the national HIV/AIDS budget was spent on activities implemented by civil society in the past year.

It was felt that NAP provided implementing partners, especially civil society organizations with support in the following areas: Information on priority needs and services, technical guidance/materials, drugs/supplies procurement and distribution, coordination with other implementing partners, and capacity building. It was also felt that TCI has reviewed policies and legislation to determine if any were inconsistent with National AIDS Control policies, but did not find any. Overall, on a scale of 0 to 10 the strategy planning efforts in HIV and AIDS program in TCI were rated as 6.0 in 2005 and 2007.

All 3 respondents felt that the country has a policy or strategy that promotes information, education and communication (IEC) of the following key messages on HIV to the general population: Be sexually abstinent, delay sexual debut, be faithful, reduce the number of sexual partners, use condoms consistently, engage in safe(r) sex, avoid commercial sex, fight against violence against women, greater acceptance and involvement of people living with HIV, greater involvement of men in reproductive health programmes, stigma and discrimination and promotion of HIV counselling and testing.

All respondents indicated that in the last year the country did not implement an activity or programme to promote accurate reporting on HIV by the media. When asked about the country's policy or strategy promoting HIV-related reproductive and sexual health education for young people, it was felt that HIV education was part of the curriculum in primary schools and secondary schools, and young men and young women were provided with the same reproductive and sexual health education. Also that TCI has an HIV education strategy for out-of-school young people, a group called RAPPORT.

Respondents felt that 2 groups, MSM and prison inmates were beneficiaries of prevention interventions, education and communication in the following areas: targeted information on risk reduction and HIV education, stigma and discrimination reduction, condom promotion, HIV testing and counselling, and reproductive health, including STI prevention and treatment vulnerability reduction (e.g. income generation). Overall, policy efforts in support of HIV prevention in 2007 and in 2005 were rated at 6.5 on a scale of 0 – 10 for both years. One respondent felt that the areas of stigma and discrimination, and training and counselling were areas that showed improvement between 2005 and 2007.

The following programs were identified as needed in all areas/districts: Blood safety, universal precautions in health care settings, prevention of mother-to-child transmission of HIV, IEC on risk reduction, IEC on stigma and discrimination reduction, Condom promotion, HIV testing and counselling, risk reduction for men who have sex with men, programmes for other vulnerable subpopulations, reproductive health services including STI prevention and treatment, school-based AIDS education for young people, programs for out-of-school young people, and HIV prevention in the workplace.

Overall, efforts in implementing HIV prevention in 2007 and in 2005 were rated, on a scale of 0 – 10, at 6.0 in 2005 and 6.5 in 2007. The training of peer educators in high schools to interact and influence their peers was cited by one respondent as a major improvement over the two-year period. It was felt that the areas of stigma and discrimination, and training of peer educators and VCT counsellors were areas that showed improvement between 2005 and 2007.

All respondents agreed that the TCI has a policy or strategy to promote comprehensive HIV treatment, care and support which gives sufficient attention to barriers for women, children and most-at-risk populations. The TCI has identified areas in need and have implemented the following HIV/AIDS treatment, care and support services throughout the TCI: Antiretroviral therapy, nutritional care, paediatric AIDS treatment, sexually transmitted infection management, psychosocial support for people living with HIV and their families, home-based care, palliative care and treatment of common HIV-related infections, HIV testing and counselling for TB patients, TB screening for persons living with HIV, TB preventive therapy for persons living with HIV, TB infection control in HIV treatment, and care facilities, Cotrimoxazole prophylaxis for persons living with HIV, post-exposure prophylaxis, (e.g. occupational exposures to HIV, rape), HIV treatment services in the workplace or treatment referral systems through the workplace, HIV care and support in the workplace (including alternative working arrangements).

Two of three respondents felt that TCI has a policy for using generic antiretroviral drugs and condoms. One respondent felt that TCI had access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms and substitution drugs.

It was felt that policies were in place to define and address the needs of orphans and other vulnerable children (OVC). Efforts to meet the needs of OVC were rated as 7.0, on a scale of 0 – 10, in 2005 and 2007. It was also disclosed that a home for orphans and vulnerable children in TCI (Providenciales) was established.

TCI did not conduct Monitoring and Evaluation exercises in the past year. One respondent indicated that efforts are being made to have this done in the near future.

Part B – Response from Civil Society.

When asked about the availability of Human Rights laws to protect persons living with HIV/AIDS, and non-discrimination laws or regulations to protect vulnerable subpopulations, 2(40.0%) responded in the affirmative.

One (20%) respondent felt that TCI had laws, regulations or policies that present obstacles to effective HIV-prevention, treatment, care and support for vulnerable sub-populations. Additionally, all of the respondents felt that human rights was not explicitly mentioned in HIV policy or strategy in TCI, and there was no mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations. Also, none of the respondents felt that the TCI Government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and program implementation.

All respondents agreed that the TCI has a policy of free services for HIV prevention, anti-retroviral treatment, and other HIV-related care and support interventions. However, only 3(60.0%) felt that a policy was in place to ensure equal access to prevention, care and support for men and women, especially non-pregnant women. Only 1(20.0%) felt that a policy was in place to ensure equal access of most-at-risk populations to prevention, care and support. None of the participants felt there was a difference in approach for different most-at-risk populations.

Four (80.0%) felt that the TCI does not have a policy prohibiting HIV screening for general employment purposes. None of the respondents felt that TCI has a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee.

With regards to the existence of various human rights and monitoring and enforcement mechanisms, none of the respondents felt that TCI had independent, national institutions for the promotion and protection of human rights including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work. Similarly, none of the respondents felt that focal points existed within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment. None of the respondents felt that performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts were in place; 1(20.0%) felt such indicators/benchmarks existed for reduction of HIV-related stigma and discrimination.

Only 1 (20.0%) respondent felt that members of the judiciary (including labour courts/employment tribunals) have been trained/ sensitized to HIV and AIDS and human rights issues that may come up in the context of their work. None of the respondents felt that the legal aid systems for HIV and AIDS casework, private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV were available in TCI. One respondent, however, felt that programs existed to educate and raise awareness among people living with HIV concerning their rights were available in TCI.

Four (80.0%) felt that TCI has programs such as media, school education, and persons regularly speaking out, designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance.

On a scale of 0 – 10, where 0 represents poor and 10 represents good, respondents rated the availability of policies, laws and regulations to promote and protect human rights in relation to HIV and AIDS in 2007 with an average score of at 4.2 and 2.9 in and in 2005. One respondent commented that between 2005 and 2007, people were more sensitive to the rights

of persons living with HIV. A similar rating system was used to rate the effort to enforce the existing policies, laws and regulations in 2007 and in 2005 in TCI, and 2007 received an average score of 3.7 and 2005 received an average score of 2.8.

On a scale of 0 – 5, where 0 represents low and 5 represents high, respondents rated:

- (a) The extent to which civil society has contributed to strengthening the political commitment of top leaders and national policy formulation at 3.2.
- (b) The extent to which civil society representatives have been involved in the planning and budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts) at 2.3
- (c) The extent to which services provided by civil society in areas of HIV prevention, treatment, care and support are included in both the National Strategic Plans and national reports at 2.3; and in the national budget at 2.7.

Only 1 (20.0%) respondent felt that the country included civil society in a National Review of the National Strategic Plan. Again, on a scale of 0 – 5, respondents rated the extent of civil society's representation in HIV-related efforts is inclusive of its diversity at 2.5.

Respondents rated, on a scale of 0 – 10 the extent to which civil society is able to access adequate financial support to implement its HIV activities at 6.0; and adequate technical support to implement its HIV activities at 4.7. One respondent commented that large corporations in TCI (e.g., Scotia Bank and Digicel) and groups such as AIDS Awareness have become more involved in HIV/AIDS prevention and treatment activities.

Four (80.0%) respondents identified the following as needs to be addressed in all HIV/AIDS prevention programs in all islands: blood safety, universal precautions in health care settings, prevention of mother-to-child transmission of HIV, IEC on risk reduction, IEC on stigma and discrimination reduction, condom promotion, HIV testing & counselling, harm reduction for injecting drug users, risk reduction for MSM, risk reduction for sex workers, programs for other most-at-risk populations, reproductive health services including STI, prevention & treatment, school-based AIDS education for young people, programs for out-of-school young people, HIV prevention in the workplace.

Overall, on a scale of 0 -10, respondents rated efforts in the implementation of HIV prevention programs in 2007 at 7.2 and in 2005 at 7.0.

Four (80.0%) of respondents felt the nationwide, varying degrees of the following HIV and AIDS treatment, care and support services were needed: Antiretroviral therapy, nutritional care, paediatric AIDS treatment, sexually transmitted infection management, psychosocial support for people living with HIV and their families, home-based care, palliative care and treatment of common HIV-related infections, HIV testing and counselling for TB patients,

TB screening for persons living with HIV, TB preventive therapy for persons living with HIV, TB infection control in HIV treatment and care facilities, cotrimoxazole prophylaxis for persons living with HIV.

Overall, on a scale of 0 -10, respondents rated efforts to implement HIV treatment, care and support programs in 2007 at 7.6 and in 2005 at 6.6.

Civil society was thought to be responsible for 25-50% of prevention programs for youth as well as < 25% of the following programs: prevention for vulnerable sub-populations, counselling and testing, clinical services (OI/ART), home-based care, and programs for OVC.

Three (60.0%) respondents felt the country does not have a policy or strategy to address the additional HIV/AIDS-related needs of orphans and other vulnerable children (OVC). The third respondent felt the question was not applicable in the TCI context.

3.3 Blood Safety

Blood products are routinely screened for HIV. The National Laboratory on Grand Turk with a subsidiary on Providenciales screen all blood donations prior to use in government owned and operated health facilities in TCI. In 2006, blood samples from all 35 donors on Grand Turk and South Caicos were screened for HIV infection; none was found to be HIV-positive and for the same period in Providenciales blood samples from 146 donors were screened for HIV, none of these was found to be HIV infected.

A total of 142 blood samples were taken from all donors in Providenciales for the period 2007, these were tested for the presence of HIV infection. Of the persons screened, 1 person or (0.7%) was found to be infected. In Grand Turk (2007) 41 blood samples were tested from potential blood donors and none were found to be HIV-positive.

3.4 HIV Treatment/Antiretroviral Therapy (ART)

The total number of persons being treated with ART in 2006 was 59 (54 adults, 3 children and 2 infants), and in 2007 were 79 (70 adults, 3 children and 6 infants). However, the percentage of those being treated that had advanced HIV was not available.

Dr. Reed's assumption, in 2004, of the role of clinical supervisor for people on ART was an important boost to TCI's treatment program. Even though Dr. Read lives in Canada, he visits the Bahamas and TCI on a bi-monthly basis for a few days at a time. During his visits he sees clients on the treatment program. He is also available via phone, and during his absence patients are referred to internists and general practitioners for management. However, major changes to clients' regimens and dosages are only done by Dr. Read. NAP has advertised for

an on-site Clinical Care Coordinator.

3.5 Prevention of Mother-to-Child Transmission

From the outset, the focus of the TCI National AIDS Program has been on prevention of HIV transmission while simultaneously caring for persons affected by HIV. In an effort to eliminate mother-to-child transmission of HIV, all pregnant women attending antenatal clinics within the Primary Health Care network of clinics in TCI are HIV-tested. If HIV-infected, they are referred to NAP and other health care providers as necessary for further evaluation, counselling, treatment and follow-up. HIV-infected pregnant women are given AZT during the second trimester of pregnancy and during delivery, and AZT is given to the newborn for six weeks. The Primary Health Care System and the National AIDS Program follow-up the progress of both the mother and the infant post delivery. The HIV-infected mother is counselled regarding the risk of HIV transmission through breast-feeding.

In 2006 a total of 9 pregnant women tested positive for HIV. Of these 7 (78%) were put on ART, the other 2 refused treatment. In 2007, a total of 6 pregnant women tested positive for HIV. Of these 5 (83%) were put on ART, the other 1 refused treatment. The majority of HIV-infected pregnant women were Haitian immigrants.

In 2006 one HIV-infected child was born to an HIV-infected mother. In 2007 no HIV-infected children were born to mothers who obtained antenatal care at TCI Primary Health Care Clinics.

3.6 HIV Testing in Most-at-risk: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results

Pregnant women and immigrant groups, primarily immigrants from Haiti and the Dominican Republic, have been identified as at-risk groups in TCI. The TCI continues to be the recipient of immigrants (legal and illegal) from its neighbours, Haiti and the Dominican Republic. Historically, a disproportionate number of cases of HIV in TCI have been found among this group of persons. For legal immigrants, the issuance of a work permit is contingent on the results of a HIV test performed in TCI. Hence, persons tested usually return for the results of the tests. Similarly, all immigrant pregnant women attending antenatal clinic usually return for their HIV test results. So, most legal immigrants seeking employment, and pregnant women attending antenatal clinic know their HIV status. It is not known what percentage of the immigrant population is represented by work permit requests and pregnant women, who are not TCI belongers. It is difficult to track the immigrant community as they only approach the health care system when they absolutely need to do so.

Within the Government-run Health Care System, on Grand Turk laboratory personnel who also provide pre and post-test counselling communicate the results of HIV tests directly to the client. On Providenciales public health nurses who provide pre and post-test counselling also communicate the results of HIV tests to the client. Persons who test positive are referred to the Primary Health Care System and the National AIDS Program for follow-up.

In 2006 work permit applicants accounted for 77% of the 1927 HIV tests performed at the National Laboratory in Grand Turk and 50% of the lab's 10 HIV-positive results. The other 5 positive tests were among persons referred by physicians for whom no additional information is available regarding immigrant status. Information on the number of persons who had voluntary testing done is also not available at this time. As indicated in the previous section on mother-to-child transmission, all pregnant women who present at antenatal clinic for care are tested for HIV. None of the HIV tests performed for antenatal clients at the Grand Turk Laboratory in 2006 and 2007 returned a positive result.

3.7 Life Skills-based HIV Education in Schools: Percentage of schools that provided life skill-based HIV test education in the last academic year.

In 1997 NAP helped to develop Healthy Lifestyle Curriculum for schools thereby incorporating HIV/AIDS education and prevention into the curriculum of all public schools in TCI. Additionally, the Health/Nursing Educator in the Ministry of Health visits public high schools at least once per academic year and has interactive discussions with the student body on health issues, including HIV/AIDS. It should also be noted that the program has trained 100 secondary school students as peer educators to assist with the prevention of the spread of HIV infection among young persons. In addition to this, the NAP and Dr. Wise, a volunteer HIV/AIDS educator, visit schools to conduct sessions.

3.8 HIV Treatment: Survival After 12 Months on Antiretroviral Therapy: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy. -

Approximately 96% (67 of the 70 persons registered) including adults and children survived after 12 months on anti- retroviral treatment.

3.9 Reduction in Mother-to-child Transmission: Percentage of infants born to HIV-infected mothers who are infected.

In 2006 and 2007, 2 and 6 infants, respectively, were born to HIV-infected mothers. One child (16.7%) was born HIV-infected in 2006 and none in 2007.

3.10 Workplace HIV Control: Transnational Companies. Percentage of transnational companies that are present in developing countries and that have workplace HIV policies and programs.

The local office of Scotia Bank, a Canadian financial institution with operations in TCI and other Caribbean countries, is in the process of preparing a workplace HIV policy for its TCI facilities. Although there is no written policy, in one hotel employers who are HIV positive are given tasks that will make them less at risk for opportunistic infections.

4 Challenges and Successes

4.1 Funding

Adequate funding to address the growing needs and increasing costs for services needed by persons with HIV/AIDS continues to pose a challenge, especially within the context of the explosive growth of the TCI immigrant population. It is estimated that non-belongers now comprise > 60% of the TCI population. Even so, in many island communities in TCI, assuring persons in need of services offered by the program of confidentiality continues to be a challenge.

Stakeholders in TCI continue to support the program. Civic organizations as well as regular citizens continue to provide invaluable in-kind contributions to many of NAPs initiatives. Private sector organizations also continue to be good corporate citizens. As part of the recently concluded World AIDS Day 2007 celebrations, a telethon sponsored by the telecommunications company Digicel exceeded the \$90,000 target set and instead received in excess of \$100,000 in cash and pledges for HIV/AIDS treatments.

The Turks and Caicos AIDS Awareness Foundation, is a Non-Governmental Organisation with a mission to support the work of the National AIDS Program, the Foundation provided the technical and financial support for design and construction of the National AIDS Program website and continues to provide financial and in-kind support for the Program. To this end the Foundation has adopted the Youth Arm of the NAP and is in the process of providing a Youth Centre, which will support efforts to prevent the spread of the HIV especially among young persons.

4.2 Voluntary Counselling and Testing (VCT)

Confidential HIV testing as well as pre and post-test counselling services are provided to persons who either request a HIV test or are considered to be engaging in risky behaviour by health providers. A total of 52 service providers were trained in 2005 and 2007 respectively

in VCT the service is now being conducted at Government-run medical laboratories and Health Centres in TCI. All persons with confirmed positive tests are referred to the primary health care system and NAP for further evaluation, treatment and follow-up.

A report of a VCT needs assessment completed for NAP in 2005 concluded that there appeared to be a low level of awareness on the part of health care providers and community members regarding the number of HIV/AIDS cases in TCI. It cited issues with the validity and reliability of data as reasons why HIV statistics are not widely disseminated. These issues still remain to some degree and need to be resolved as quickly as possible. The report acknowledged the ongoing educational media campaigns in English and Creole sponsored by NAP and other groups, yet misconceptions about HIV transmission still persisted.

HIV testing occurs in TCI in both the public and private sector, with the private sector also offering CT for work permits at a cost of \$40.00. Private sector providers cite clients concern over confidentiality in the public sector as the reason why persons obtain HIV testing from private providers, even though the fee is \$10.00 more than the fee charged at the National Laboratory. HIV testing of pregnant women takes place at the time of “booking” (registering) and again at 32 weeks. Finally, a small number of persons, compared to those seeking work permits, come in voluntarily for HIV counselling and testing.

4.3 Contact tracing

Issues regarding the ethics of whether or not health care providers should notify the contacts of HIV-positive individuals about their possible exposure to HIV are still unresolved and pose a challenge for health care workers. NAP hopes to be able to resolve these issues and have a contact-tracing program in place in the near future.

4.4 Surveillance and Reporting

Even though HIV testing is performed by both the private sector and the government-run National Laboratory, the surveillance data for HIV in TCI is based primarily on the public sector reports, as acquiring information from private sector providers is sporadic. They do not consistently notify public health authorities of HIV-positive clients. In the existing system, positive results should be reported to the NAP, by name and other information through the Primary Health Care officials. The laboratories should submit reports indicating the number of tests and the number of negative and positive results, without identifying names. This information is subsequently reconciled by the NAP. However, there are numerous bottlenecks in the system including duplicate reporting from the laboratory when persons take the test more than once. Therefore, without consistent, accurate and adequate client information from private providers, and issues in the public sector with regards to chain of custody (i.e. who gets what and when), therefore surveillance remains a challenge. NAP is aware of the challenges and is exploring options to address the problem.

4.5 Community Support for Persons Living With HIV/AIDS (PLWHA)

There are community groups organized to provide support for persons living with HIV/AIDS. The Turks and Caicos Islands Persons for Positive Action (TCIPPA+) is comprised of members from Grand Turk, Providenciales, South Caicos and Salt Cay. The group represents 46% of Persons Living with HIV/AIDS in the Turks and Caicos Islands and acts as a support group for PLWHA. The group is an affiliate CRN+ and has representation on the current board (2007). In addition, the Social Welfare Department of Social Services assists PLWHA and their families with food and housing.

Other corporate citizens make regular monetary and material donations to the clients and to the Hospice.

4.6 Stigma and Discrimination and Confidentiality

Grave concern exists over confidentiality in the TCI small, island community settings. Maintaining confidentiality continues to be a challenge and is believed to be the reason why allegedly some TCI citizens who are HIV-positive refuse to access care in TCI. In 2007 a Campaign to raise the awareness of stigma and discrimination was launched. The print media, television and radio were utilized to carry the messages against stigma and discrimination. Messages were also posted in Health Centres and other public places nationwide. However, it is believed that even though stigma and discrimination have significantly decreased in recent times, they still exist.

5. Abbreviations

ART	Antiretroviral Therapy/Treatment
CAREC	Caribbean Epidemiology Centre
CCNAPC	Coalition of National AIDS Program Coordinators
CRN+	Caribbean Regional Network for People Living With HIV/AIDS
CT	Counselling and Testing
DFID	Department for International Development
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
M&E	Monitoring and evaluation
MSM	Men having sex with men
NAP	National AIDS Program
NGO	Non Governmental Organization
OI	Opportunistic infections
OVC	Orphans and other vulnerable children
PLWHA	Person Living with HIV/AIDS
PLWHIV	Person Living with HIV
STI	Sexually Transmitted Infection
TCAAF	Turks and Caicos AIDS Awareness Foundation
TCI	Turks and Caicos Islands
TCIPPA+	Turks and Caicos Islands Persons for Positive Action
UNAIDS	Joint Program for HIV/AIDS
VCT	Voluntary Counselling and Testing

6. Bibliography

1. CIA The World Factbook. Available at: <http://www.cia.gov/cia/publications/factbook/geos/tk.html>. Last accessed on 10/26/06.
2. Department of Economic Planning and Statistics, DEPS Website, Turks and Caicos Islands. Available at: <http://www.depstc.org/>. Last accessed on 12/20/07.
3. National AIDS Program Headquarters, Grand Turk, Turks and Caicos Islands.
4. Social Indicators and Trends 2005. Department of Economic Planning and Statistics. Turks and Caicos Islands; May 2006.