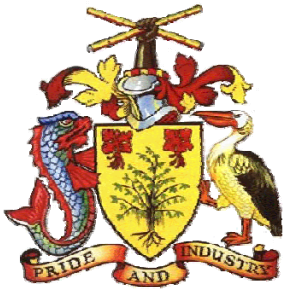

NATIONAL AIDS PROGRAMME

UNGASS COUNTRY PROGRESS REPORT

BARBADOS

Prepared by

THE GOVERNMENT OF BARBADOS

February 2008

UNGASS COUNTRY PROGRESS REPORT

Barbados

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Contents

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Abbreviations

ABBREVIATION	MEANING
ACET	AIDS Care, Education & Training
AFOB	AIDS Foundation of Barbados
AIDS	Acquired Immunodeficiency Syndrome
AMT	AIDS Management Unit
ANC	Antenatal Clinic
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASAP	AIDS Strategy Action Plan
ASOB	AIDS Society of Barbados
AZT	Zidovudine
BANGO	Barbados Association of Non-Governmental Organisations
BCC	Behaviour Change Communication
BCCI	Barbados Chamber of Commerce and Industry
BDS	Barbadian Dollar
BEA	Barbados Evangelical Association
BEC	Barbados Employers Confederation
BHTA	Barbados Hotel and Tourism Association
BIRO	Barbados Inter-Religious Organisation
BSS	Behavioural Surveillance Survey
BWU	Barbados Workers' Union
BXC	Barbados Christian Council
CARE	Comfort Assist Reach out Educate
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community and Common Market
CBO	Community Based Organisation
CCAS	Caribbean Cytometry & Analytical Society
CCNAPC	Caribbean National AIDS Programme Coordinators
CDC	Centers for Disease Control & Prevention
CDERA	Caribbean Disaster Emergency Response Agency
CDRC	Chronic Disease Research Centre
CFNI	Caribbean Food and Nutrition Institute
CHAI	Clinton Foundation HIV/AIDS Initiative
CHART	Caribbean HIV/AIDS Regional Training
CHRC	Caribbean Health Research Council
CIDA	Canadian International Development Agency
COL	Commonwealth of Learning
COMSEC	Commonwealth Secretariat
CPC	Caribbean Programme Coordinator
CRN+	Caribbean Network of People living with HIV/AIDS
CSO	Civil Society Organisation
CTUSAB	Congress of Trade Unions and Staff Associations of Barbados
DfID	Department for International Development of the United Kingdom
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
DYA	Division of Youth Affairs
EPC	Elroy Phillips Centre
EU	European Union

ABBREVIATION	MEANING
FBO	Faith Based Organisations
GDP	Gross Domestic Product
GOB	Government of Barbados
HAART	Highly Active Anti- Retroviral Therapy
HBsAg	Hepatitis B surface antigen
HCV	Hepatitis C Virus
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
HTLV	Human T-cell lymphotropic viruses
IAA	International AIDS Alliance
IBRD	International Bank for Reconstruction and Development
IDU	Injecting Drug User
IEC	Information Education Communication
IEC	Information, Education and Communication
ILO	International Labour Organisation
IT	Information Technology
JHIPIEGO	John Hopkins University Affiliate International Health Organisation
KABP	Knowledge, Attitudes, Beliefs and Sexual Practices
LRU	Ladymeade Reference Unit
LSBE	Life Skills-based Education
M&E	Monitoring & Evaluation
MES	Ministry of Education, Youth Affairs & Sports
MESA	Men's Educational Support Association
MH	Ministry of Health
MIS	Management Information System
MLC	Ministry of Labour and Civil Service
MLS	Ministry of Labour and Social Security
MSM	Men who have Sex with Men
MST	Ministry of Social Transformation
MTI	Ministry of Tourism and International Transport
NACA	National Advisory Committee on AIDS
NAP	National AIDS Programme
NASA	National AIDS Spending Assessment
NCPI	National Composite Policy Index
NCSA	National Council on Substance Abuse
NGO	Non-Governmental Organisation
NHAC	National HIV/AIDS Commission
NIS	National Insurance Scheme
NOW	National Organisation of Women
NSP	National Strategic Plan
NUPW	National Union of Public Workers
ODA	Official Development Assistance
OR	Operations Research
OVC	Orphans and other Vulnerable Children
PAD	Project Appraisal Document
PAHO	Pan-American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PLHIV	Persons living with HIV

ABBREVIATION	MEANING
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
QEH	Queen Elizabeth Hospital
SHIP	Sexual Health Information System
SIDS	Small Island Developing State
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
UGLAAB	United Gays and Lesbians Against AIDS Barbados
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Drug Control Program
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USD	United States Dollars
USDoL	United States Department of Labour
UWI	University of the West Indies
UWIHARP	University of the West Indies HIV and AIDS Response Programme
VCT	Voluntary Counselling & Testing
WHO	World Health Organisation

I. Status at a Glance

Inclusiveness of the stakeholders in the report writing process

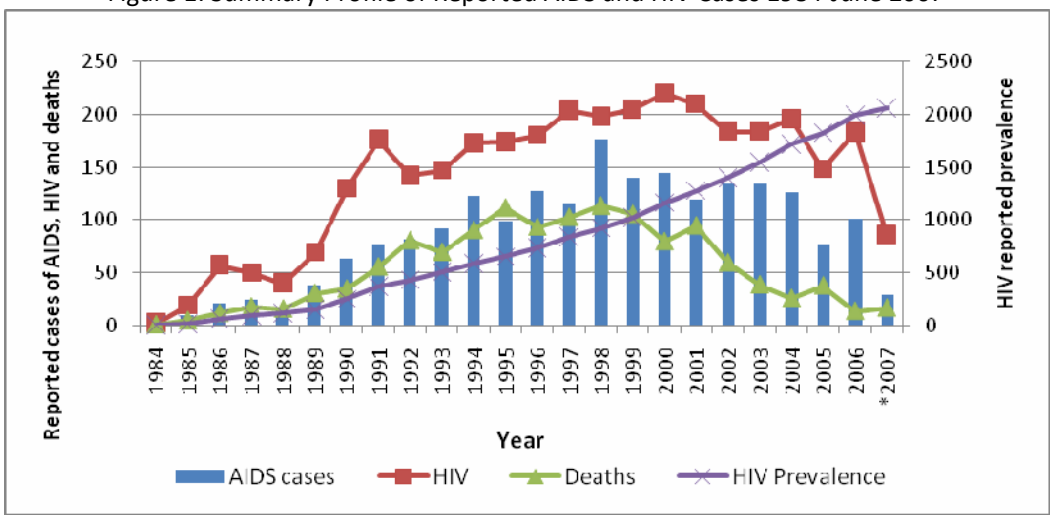
This report was prepared in collaboration with stakeholders from government, private and civil society organisation including development partners. Stakeholders were consulted at various stages of the report preparation process particularly during data collection, actual report development and review.

Status of the epidemic

The Barbados epidemic has evolved over the past quarter of a century from being mainly concentrated in and driven by sexual networks of men who have sex with men (1984 to early 1990s) to rapidly increasing incidence in self-reported heterosexual males and in females of child bearing age (feminization of the epidemic). The major mode of transmission is through heterosexual contact. Approximately 89% of the reported cases of HIV occur within the sexually active age group 15 to 49 years. One in every three cases is female. Current figures on reported cases show that females of child bearing age represented 50% of new AIDS cases in 2006. The challenge has been in characterizing the nature of the epidemic, and accurately documenting the changing trends that result from changes in transmission dynamics.

The number of annual AIDS cases declined by 46% with a concomitant reduction of 85% in the number of deaths between 2001 and 2006. The increase in HIV prevalence highlights the decline in AIDS deaths (See Figure 1).

Figure 1: Summary Profile of Reported AIDS and HIV Cases 1984-June 2007



* 2007 data covers the period January to June 2007 only.

There has been a dramatic decline in AIDS case-specific mortality since 1995 among men and women from a high of 50% in 1995 to 2% in 2006. . Until 2004, the highest proportion of AIDS diagnosis was in the 30 to 39 years age group. Since then the 40 to 49 years age group represented the greatest proportions of AIDS diagnosis. The median age of people living with HIV and AIDS has risen from 35 years in 2001 to 39 in 2006.

Policy and programmatic response

The Government of Barbados continues to be committed to giving the highest priority to the fight against HIV and AIDS as epitomised by the establishment of the National HIV/AIDS Commission (NHAC) under the Prime Minister's Office. Within the public sector, the eighteen (18) key line ministries are required to submit annual costed HIV/AIDS Work Plans for which funding is received as part of the annual budgetary process. Only, half of these ministries have HIV/AIDS Core Groups. The programmatic response to HIV is characterised by the successful engagement of stakeholders; the brokering a model partnership with Trade Unions; and the development of a comprehensive campaign to mobilise private sector and civil society partners into tangible and meaningful action.

The NHAC has prepared a comprehensive policy on the national multisectoral response to the epidemic which recognises the contribution of the various sectors in the National AIDS Programme. At the time of report preparation, the policy document is awaiting Cabinet approval. This is further supported by the Ministry of Health which has developed policies and guidelines for prevention, treatment and care such as the PMTCT policy.

Table 1: Overview of UNGASS Indicator Data

National Commitment & Action
1) Amount of national funds disbursed by governments in low and middle income countries **See Table 4**
2) National Composite Policy Index **Indicates steady progress between 2005 and 2007, however during the period civil society engagement has shown significant.**
National Programmes:
3) Percentage of donated blood units screened for HIV in a quality-assured manner **100% (QEH Records, 2007)**
4) Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy **100% children receiving ART in 2006 and 2007 (QEH Records, 2007)** **Over 80% adults receiving ART in 2006 and 2007 (QEH Records, 2007)**
5) Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to- child transmission **Indicates increase in PMTCT coverage with figures rising from 84.6% in 2006 to 95.2% in 2007 (PMTCT Records, 2007)**
6) Percentage estimated HIV-positive incident TB cases that received treatment for TB and HIV **100% (In 2006 and 2007, there were 2 TB cases with HIV-Co-infections, MH 2007)**
7) Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results **98.5% (MH , 2006)**
8) Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results **85.1% MSM in 2007 (NHAC, 2007) and 73.3% FSW in 2006 (MH, 2007); data collected from special studies**
9) Percentage of most-at-risk populations reached with HIV prevention programmes **N/A (Data not available)**
10) Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child **N/A (indicator not reported on; OVC not a major population)**
11) Percentage of schools that provided life-skills based HIV education within the last academic year **40.7% (Ministry of Education, 2007)**

Knowledge, Sexual Behaviour and Orphans' school attendance

12) Current school attendance among orphans and among non-orphans aged 10-14
    1:1 (Ministry of Education, 2007) (Indicator of limited use to Barbados)
13) % of young women and men aged 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
    NA (Data not available; survey not conducted due to financial and logistical challenges, DYA 2007)
14) % of MARPS who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission
    36.7% FSW (MH, 2007)(Data not available for MSM in format requested by UNGASS, NHAC 207)
15) % of young women and men aged 15-24 who have had sexual intercourse before the age of 15
    NA (Data not available; survey not conducted due to financial and logistical challenges, DYA 2007)
16) % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12
    NA (Data not available; survey not conducted due to financial and logistical challenges, MLC 2007)
17) % of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse
    NA (Data not available; survey not conducted due to financial and logistical challenges, MLC, 2007)
18) % of female and male sex workers reporting the use of a condom with their most recent client
    80.0% FSW (MH 2007)
19) % of men reporting the use of a condom the last time they had anal sex with a male partner
    64.5% (Preliminary figure available; data being analysed, NHAC 2007)
20) % of injecting drug users reporting the use of a condom the last time they had sexual intercourse
    N/A (Data not available, not a major pop)
21) % of injecting drug users reporting the use of sterile injecting equipment the last time they injected
    N/A (Data not available; not a major pop)

Impact

22) % of young people aged 15 – 24 who are HIV infected
    N/A (Data not available, no population based sero-prevalence survey has been conducted)
23) % of MARPS who are HIV infected
    N/A (Data not available, no population based sero-prevalence survey has been conducted)
24) % of adults and children with HIV known to be on treatment still alive 12 months after initiation of ART
    93.5% adults (MH 2007)
25) % of infants born to HIV-infected mothers who are infected
    To be modelled by UNAIDS using data in country progress report

II. Overview of the AIDS Epidemic

There is a growing recognition that HIV is not just a serious health issue in Barbados but a major potential developmental catastrophe that threatens to reverse the social and economic achievements of the past half-century. The prevalence of HIV/AIDS in the adult population is posing a serious challenge to the society's resources to provide treatment and care for persons who are infected as well as prevent future infections.

Evolution of the HIV/AIDS Epidemic 1984 to 2006 – Trends and Dynamics

The first case of AIDS case was reported in 1984. Since the early 1990s AIDS has been the leading cause of death in the age group 15-49 years and the data indicates that men and women have been equally affected since 2005, except in the age group 15-29 years. In 2001 it has been estimated (using both SPECTRUM and AIDSProj with AIDS case surveillance data and antenatal sentinel surveillance data[1)], that 1.9% (approx 4,000 adults) of the adult population were living with HIV in 2001. Further updates using larger data sets provided an estimate of 1.5% (approximately 3,600 adults[2]). There were an estimated 210 orphans due to AIDS deaths in 2000 and this was estimated at 244 in 2006 (using Spectrum).

1. Nature of the epidemic

The Barbados epidemic has evolved over the past quarter of a century from being mainly concentrated and driven by sexual networks of men who have sex with men (1984 to early 1990s) to rapidly increasing incidence in self-reported heterosexual males and in females of child bearing age (that is, the feminization of the epidemic). The major mode of transmission is through heterosexual contact. Approximately 89% of the reported cases of HIV occur within the sexually active age group 15 to 49 years. One in every three cases is female. The challenge has been in characterizing the nature of the epidemic, and accurately documenting the changing trends that result from changes in transmission dynamics.

Internationally, tuberculosis has re-emerged as a major public health threat particularly due to HIV. However, there has not been a corresponding increase in the incidence rate of tuberculosis in Barbados although the incidence rate of HIV has not declined significantly.

The key populations at higher risk are the youth, men having sex with men (MSM) and sex-workers (SW). Recent sexual practice surveys indicate that the epidemic may be spreading through the general population due to risky sexual practices. The survey data also indicates that self reported risky practices within the perceived key populations at higher risk have decreased during the last five years of the programme (MSM and sex workers studies). Hence, sub-epidemics presenting different patterns of transmission dynamics and resulting incidence over time, are likely to happen.

[1] Antenatal services users are the only sentinel population that has been monitored since the early 90s with high screening levels.

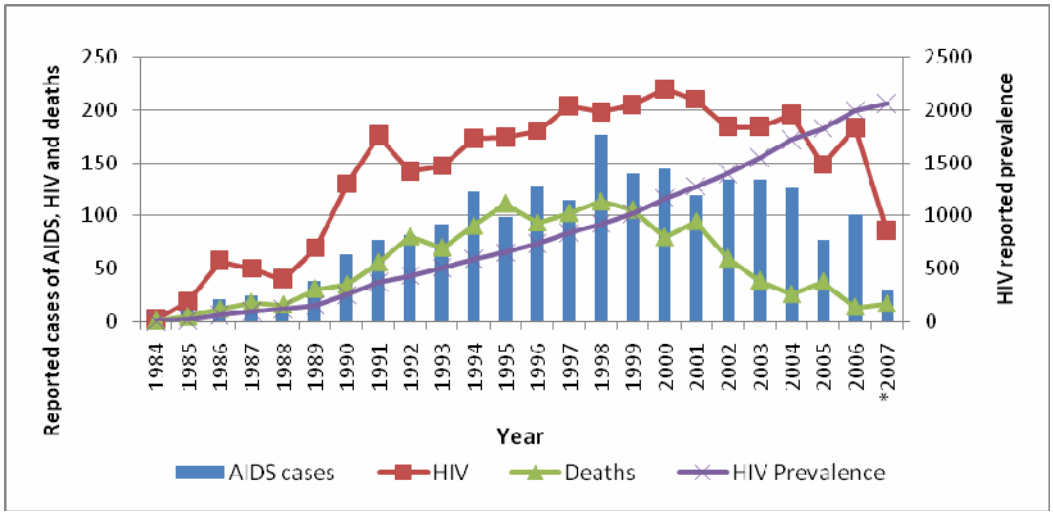
[2] New models taking into account the improved survival of patients on HAART are needed. Models that use antenatal HIV prevalence and back calculation through AIDS case reporting are no longer reliable in projecting all aspects of the epidemic with significant HAART coverage. Hence, more data of HIV stages, resistance, sexual networks, etc., using appropriate models are required.

Current trends linked to behavioural survey findings point to a mixed epidemic of increasing generalization with concentrations of HIV prevalence in selected key populations at higher risk. The general perception based on interviews and anecdotal evidence is that the most at risk groups are men having sex with men (MSM), sex workers (SW), prisoners, informal sex workers (who report as part of the general population) and the youth. However, the validation of this assumption is hindered by weak surveillance systems which prevent identification and classification of these groups. The total prevalence levels in the country and among key populations at higher risk are still unknown.

2. Reported Cases and Age Distribution

The first reported case of AIDS in Barbados was in December 1984. Since then the cumulative total of reported cases has risen from 762 in 1996 to 2060 by June 2007 (Figure 1). Statistics from the Ministry of Health (MH) show that, as of June 2006, a total of 3,381 cases of HIV and 1,314 AIDS-related deaths had been reported. Between 2001 and 2006, the number of annual AIDS cases declined by 46% with a concomitant reduction of 85% in the number of deaths.

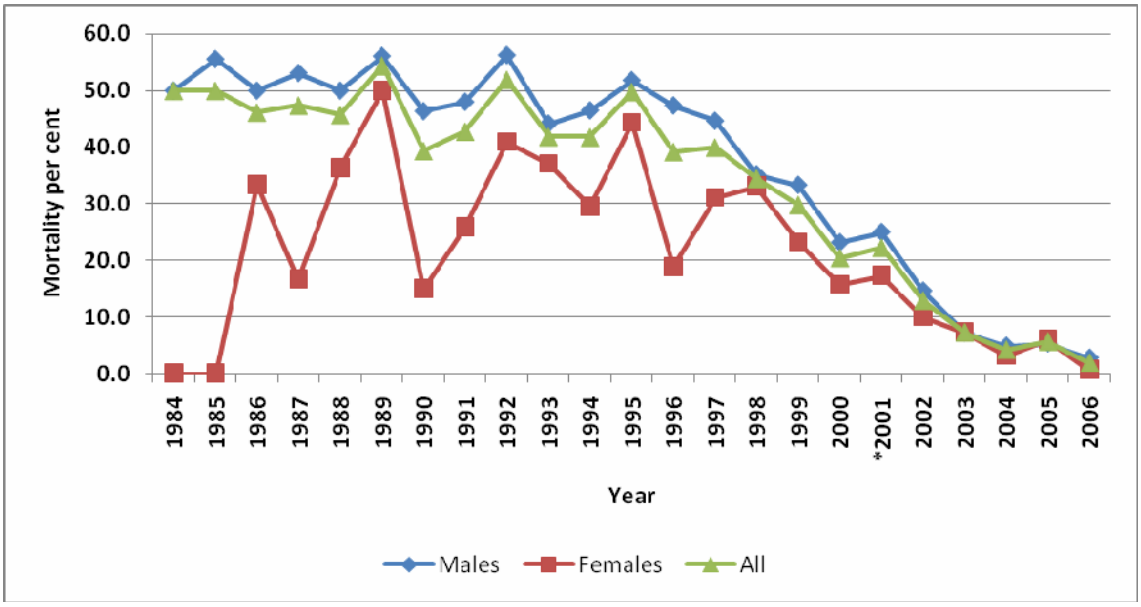
Figure 1: Summary Profile of reported AIDS and HIV cases 1984 to June 2007



* The data for 2007 are for January to June.

The increase in HIV prevalence (shown in Figure 1) highlights the decline in AIDS deaths. There has been a dramatic decline in AIDS case-specific mortality since 1995 among men and women, as shown in Figure 2, from a high of 50% in 1995 to 2% in 2006.

Figure 2: AIDS case-specific mortality 1984-2006



Recent estimates demonstrate that incidence rates have not declined significantly moving from 0.14% in 2002 to 0.12% in 2007.

In 2006, over 75 percent of reported HIV infections occurred within the 15 to 49 age group. Until 2004, the highest proportion of AIDS diagnoses was in the 30 to 39 age group. Since then the 40 to 49 age group has represented the greatest proportion of AIDS diagnosis. The median age of people living with HIV has risen from 35 years in 2001 to 39 in 2006.

Table 2: Distribution of HIV cases 2004-2007

Year	0 - 4 yrs		5 - 14 yrs		15 - 49 yrs		50 and over		Unknown		Total
	Number	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	*Number*	*Percent*	
2004	5	2.6	3	1.5	152	77.6	28	14.2	8	4.1	196
2005	0	0.0	0	0.0	128	87.7	15	10.3	3	2.0	146
2006	1	0.5	0	0.0	140	76.5	33	18.0	9	4.9	183
2007[3]	2	2.3	1	1.2	70	81.4	13	15.1	0	0.0	86

Table 2 shows that children between the ages 5 and 14 years represent fewest number of infections and cases of AIDS; it is clear that this is the window period that children can be taught to protect themselves from HIV infection before they become sexually active.

[3]Data for 2007 are available for the first 6 months of 2007, that is, up to the end of June 2007

3. Gender Distribution

In 2000 about one in every three cases of HIV was a female. In 2006, the male to female ratio of HIV cases was 1:1 whereas men accounted for almost 60% of reported AIDS cases (see Figures 3 and 4).

HIV prevalence among pregnant women, measured by HIV infection among women attending ANC at government polyclinics, has decreased from 1.1% in 1999 to 0.47% in 2005. It was slightly higher in 2006 at 0.67% but is now recorded as 0.26% up to the end of November 2007. The data in Table 3 were specifically collected from all 8 government polyclinics' ANC booking register books.

Table 3: HIV among pregnant women

	2005		**2006**		**2007***	
Age (years)	*Tested*	*HIV+*	*Tested*	*HIV+*	*Tested*	*HIV+*
15-19	350	0	359	1	370	1
20-24	503	4	479	4	455	2
25+	865	4	947	7	733	1
Total	1718	8	1785	12	1558	4
HIV+ per cent		0.47		0.67		0.26

* The data for 2007 are for January to November.

In the past 3 years since 2004, reliable antenatal data required for modelling has not been available in the public domain or comprehensively collected under any HIV surveillance system thus creating delays in updating national prevalence estimates.

Figures 3 and 4 show the increment of HIV and AIDS cases among the female population, particularly in the group of 15-49 years of age.

Figure 3: HIV cases reported by year of diagnosis and gender, 1984-2006

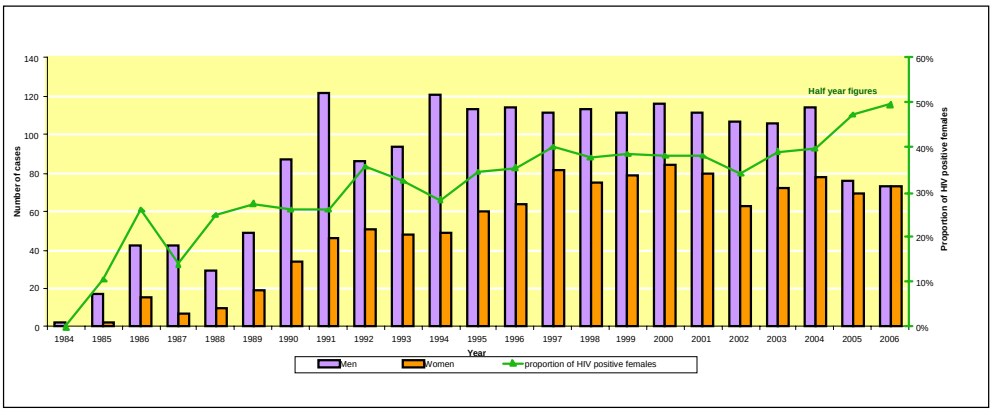
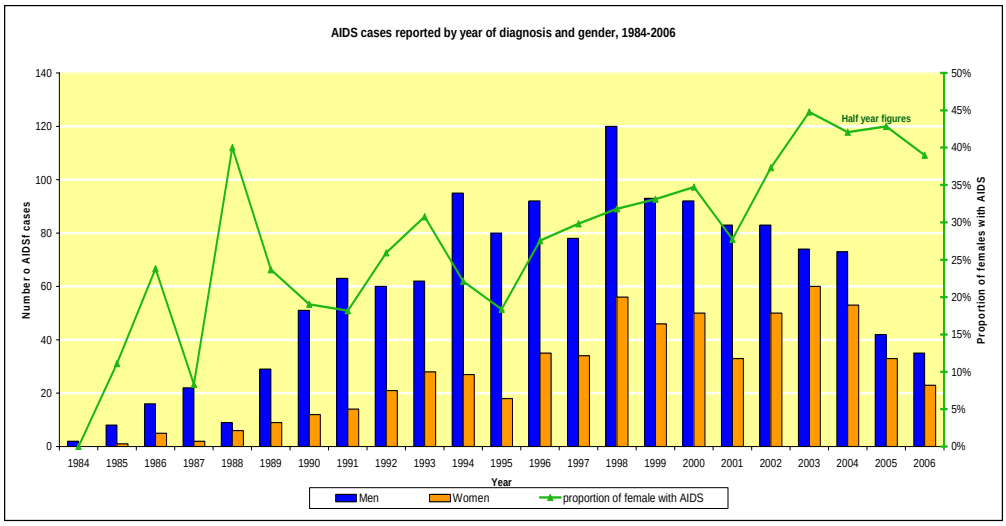


Figure 4: AIDS cases reported by year of diagnosis and gender, 1984-2006



4. Challenges to the national response

One of the programme's challenges is the disconnect between knowledge levels and sexual practices. As Table 4 indicates, knowledge levels among young people are quite high and have shown an upward progression over the 2001-2005 period. This speaks to a substantial measure of success enjoyed by the Information, Education and Communication (IEC) programme. However, the data in the Table taken from three Knowledge, Attitudes, Beliefs and Sexual Practices surveys conducted by the Division of Youth Affairs, also demonstrate that there has been a noticeable failure by the youth to translate knowledge into positive behaviours. This data provides a convincing argument for the restructuring existing IEC programme to encapsulate targeted Behaviour Change Communication (BCC), if the HIV prevention programme is to have a significant impact on behaviour change.

Table 4: Data on knowledge-behaviour gap

VARIABLES	YEAR		
	2001	**2003/2004**	**2005/2006**
Knowledge - Prevention	*15-29 years*	*10-18 years*	*15-24 years*
• Abstinence	17.1%	82.1%	92.7%
• Be Faithful	30.6%	77.8%	92.3 %
• Condom use	46.9%	87.3%	93.7 %
Behaviour			
• Have Multiple Partners	48.9% (male partners) 43.7% (female partners)	36 persons %?	80 persons %?
• Consistent Condom Use	17.1	< 3%	Data not recorded
• Number of persons involved with multiple partners	118 out of 735 (16.1%)	36 out 347 (10.4%)	80 out of 273 (29.0%)

Source: Report on the National KABP Survey on HIV/AIDS Dec 2001 (Division of Youth Affairs, 2001)
Report on the Secondary School Behavioural Surveillance Survey 2003-2004 (Division of Youth Affairs, 2004)
Report on the National Youth KABP Survey on HIV/AIDS 2005-2006 (Division of Youth Affairs, 2006)

The effectiveness of the National AIDS Programme is further challenged by the existence of stigma and discrimination which restricts programme efforts to reach vulnerable groups such as youth, MSM, prisoners and persons living with HIV. Factors such as country size, intricate family and social networks and societal conservatism often colour negative perceptions of government services, affecting individual willingness to access these services and contributing to instances of self stigma and enacted stigma (Adomakoh et al., 2003). These factors also limit programme effectiveness, the willingness of key populations at higher risk to become involved in programmes specifically designed to meet their needs and the implementation of innovative approaches to HIV.

Engagement in the Voluntary Counselling and Testing programme in the communities and polyclinics has reaped moderate success, representing one quarter of all tests done island wide (MH statistics, 2005 and 2006). Formation of partnerships with community organisations and other civil society groups could possibly provide the vehicle for extending programme coverage beyond the general population to key populations at higher risk as well as increasing access and referrals to the treatment and care programme.

Perhaps the biggest challenge facing the national multisectoral expanded response is the dearth of strong surveillance, monitoring and evaluation systems to capture essential data to chart policy and programme direction, for instance, lack of data on key populations at higher risk. This is further compounded by poorly defined information flows, unclear institutional roles, and financial and human resource challenges which preclude effective system strengthening (See Sections VI and VIII for further details).

Finally, despite the multisectoral character of the National AIDS Programme, there is still room for:

- strengthening existing relationships,
- greater incorporation of private sector and civil society into the NAP through the creation of more vibrant roles and
- enhancing institutional capacity particularly at the ministry and civil society levels which will include additional manpower.

III. National Response to the AIDS Epidemic

A. National Commitment and Action

The Government of Barbados continues to be committed to giving the highest priority to the fight against HIV and AIDS. The establishment of the National HIV/AIDS Commission (NHAC) in 2001 under the Prime Minister's Office is one of the signs of this commitment. Within the Public Sector, there are 18 key line Government Ministries with 50% having an HIV/AIDS core group and each Ministry having an annual Work Plan for which they receive financing as part of the annual budgetary process. The Government's financial commitments for HIV/AIDS are shown in Table A1.

Table A1: Government financial commitment for HIV/AIDS

	Financial Year (April – March)					
NAP	**2001-2002**	**2002-2003**	**2003 -2004**	**2004 - 2005**	**2005 - 2006**	**2006-2007**
Prevention	120,680	643,948	883,909	900,884	1,502,451	1,125,145
Care & Support	1,873,030	1,611,835	1,348,699	1,729,860	1,515,498	1,713,864
Treatment	3,469,801	2,696,603	2,968,490	4,194,801	5,890,027	6,521,192
Management	1,358,971	191,7892	2,463,564	2,668,092	3,821,253	3,656,248
Total BDS	6,822,482	6,870,278	7,664,662	9,493,638	12,729,228	13,016,449

Source: NHAC accounts

The NHAC has successfully engaged a range of stakeholders; brokered a model partnership with the Trade Unions; and redoubled its efforts to mobilize the private sector and civil society into tangible and meaningful action.

Indicator 1: Domestic and international AIDS spending by categories and financing sources

A National AIDS Spending Assessment (NASA) could not be undertaken to provide detailed resources and spending by programme categories due to capacity constraints, namely human and financial resources. A quick desk review shows that domestic public expenditure on AIDS in 2006 was BDS13, 800,145.33 (excluding funds from international sources; but inclusive of health, education, social development and other sectoral expenditure). The total amount of AIDS expenditures in 2006 (including international and private sources of funds) was $7,128,686.65.

Table A2: Major financial sources of money spent in 2006 on NAP activities

Name of donor	Amount spent in 2006 in US dollars	Start date of agreement	End date of agreement	Focus area of Support
World Bank Project	3,666,243.00 [4]	2001	2007	National AIDS Programme - Loan
AIDS Strategy Action Plan	111,000.00	2006	2007	Development of the National Strategic Framework 2007-2012
UNAIDS	30,000.00	2006	2007	Development of the National Strategic Framework 2007-2012
World Bank	24,000.00	2006	2007	Prevention
UNIFEM	8,220.00	2006	2007	Development of the National Strategic Framework 2007-2012 - Gender
Organizations and Individuals	55,893.98			

Source: NHAC Accounts

Indicator 2: ***National Composite Policy Index (Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation)***

This indicator assesses progress in the development and implementation of national HIV and AIDS policies. Relevant data is collected using a two-part questionnaire completed by government and civil society representatives respectively.

In the case of Barbados, Part A was completed by representatives of the National HIV/AIDS Commission and the Ministry of Health. With respect to Part B, only two (2) of the six agencies to whom the questionnaire was sent, completed and returned the questionnaire in a timely manner despite promises to do so. [5]

Based on the data collected in Part A, the Government of Barbados has made some progress in respect of policy development and implementation. Conversely, the submission of partially completed questionnaires and the non-response to Part B by four out of six civil society organisations may be indicative of:

- The absence of an enabling environment for civil society to function
- The complexity of the questionnaire and the lack of capacity among some civil society partners to respond to such a questionnaire
- The need to strengthen civil society involvement through targeted programme interventions (See Annex 2)

[4] This figure is included in the BDS $13, 800,145.33.
[5] A total of three (3) questionnaires were received two (2) from CARE and one (1) from UGLAAB.

B. Prevention

Indicator 3: Percentage of donated blood units screened for HIV in a quality assured manner

The Blood Safety Programme started in 1984. At present, there is one HIV blood screening laboratory at the Department of Pathology, Queen Elizabeth Hospital. Approximately 350 blood units are collected and screened every month as shown in Table B1. Only one blood donor was HIV positive among the blood donated and screened in the twenty three month period. The country needs between 5000 and 6000 blood units annually.

Table B1: Number of blood units collected and screened in 2006 and 2007.

Year	**Blood units**	
	Screened	***HIV+***
2006	4138	0
2007 (Jan. – Nov.)	3882	1

The laboratory follows documented World Health Organisation standard operating procedures for HIV screening and participates in three external quality assurance schemes (shown in Annex 3.1):

- The United States of America Department of Health and Human Services, Centers for Disease Control and Prevention for HIV-1 antibody
- Pan American Health Organization (PAHO) Caribbean Epidemiology Centre (CAREC/PAHO/WHO) for HIV-1& HIV-2
- International Consortium for Blood Safety (ICBS), São Paulo, Brazil, for syphilis, HIV, HTLV, HCV and HBsAg

Indicator 5: Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission

Antenatal (ANC) Voluntary Counselling and Testing (VCT) for HIV was initiated in Barbados in 1991 and rolled out to all Polyclinics. PMTCT programme was initiated in Barbados 1995 with the availability of ARVs. Since 2002 HAART are used and treatment is free to all Barbadian citizens

In 2004, 89.7% of all pregnant women in Barbados were tested for HIV. The PMTCT programme has effectively reduced the vertical transmission of HIV from 30% to less than 2% with the introduction of HAART. The programme's success can be attributed to: good access to care, the good health service infrastructure and the country's population size. In spite of the apparent success, the programme has challenges with the information system (documentation and reporting) and some of the pregnant women who refuse to be tested. Barbados can achieve PMTCT Universal Access targets as testing uptake nears 100%.

Table B2 shows the number of women who were HIV positive in 2006 and 2007 and were enrolled in the PMTCT programme.

Table B2: PMTCT uptake 2006 & 2007

Pregnant Women	M&E reported data	
	2006	*2007*
On ARV	33	20
HIV+	39	21
% on ARV	84.6%	95.2%
Source: Ministry of Health		

Indicator 9: Percentage of most-at-risk (female sex workers) populations reached with HIV prevention programmes

A study of male and female sex workers has just started. The preliminary baseline data do not provide information on level of prevention programme coverage among most-at-risk populations. This information is expected to be available from a follow-up survey of the survey subjects. Consequently, it is not possible to report on this indicator at this juncture.

C. Care, treatment and support

Indicator 4: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

Data for this indicator was obtained from the list of patients registered at the Ladymeade Reference Unit (agency responsible for the HAART programme) and from the Consultant Paediatrician from the Queen Elizabeth Hospital.

Table C1: ART Coverage [6]

Year	Children			Adults		
	Males	*Females*	***Total***	*Males*	*Females*	***Total***
2005	N/A	N/A	***N/A***	N/A	N/A	***N/A***
2006	N/A	N/A	***100.0%***	79.1%	92.2%	***84.5%***
2007	N/A	N/A	***100.0%***	79.6%	93.8%	***85.5%***

Source: Ministry of Health

Given the general unavailability of data as indicated by Table C1, it is not possible to fully report on this indicator. Despite the absence of data, there are some challenges with the country's ability to report on this indicator:

- there is no way of knowing whether registered patients are accessing ARV from another source

[6] In 2006 and 2007, there were sixteen (16) and seventeen (17) children respectively with advanced HIV who were receiving antiretroviral therapy. This represented 100.0% coverage for 2006 and 2007. Unfortunately, the data provided was not disaggregated by sex.

- the difficulty in screening deaths from the database means that these are sometimes overlooked resulting in the concomitant inflation of the denominator and deflation of the numerator.

Indicator 6: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

The current DOTS programme (modified DOTS in Barbados) is achieving the goal of bringing the spread of TB in Barbados under control. Implementation of this programme often places a strain on health care workers and drains public expenditure.
The DOTS programme benefited many patients by preventing loss of income in the most productive years of teens to middle age groups in a timely intervention in TB and TB/HIV co-infected patients. Table C2 gives figures of TB/HIV co-infection over the period 2004-2006.

Table C2: TB/HIV co-infection

Year	Male	Female	Total
2004	5	0	**5**
2005	1	1	**2**
2006	0	0	**0**
2007	0	2	**0**

Source: Ministry of Health

Indicator 10: Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child

The Government of Barbados provides all OVC with basic external support (that is, education, welfare). It should be noted that access to national social services is based on qualification for such services. This indicator, despite its international relevance, is one on which Barbados will not report.

In Barbados, the Welfare Department, Ministry of Social Transformation provides two categories of assistance. The first category, national assistance, is further subdivided into monetary grants and assistance-in-kind. The latter refers to the provision of clothing, food and utilities. Table C3 presents data on the number of HIV dependents (that is, children) who received national assistance from the Welfare Department in 2007.

The second category, educational assistance entails the provision of school fees, school uniforms and textbooks. This service is sometimes provided in conjunction with the Ministry of Education which, at the request of the Department, will grant waivers for school fees as well as the Textbook Loan Scheme. The Welfare Department, in providing educational assistance, does not differentiation between children affected or infected by HIV and other children to whom educational assistance is also provided.

Table C3: Number of Children Receiving National Assistance in 2007

Age Range	Male	Female	Total
0 - 1	1	0	**1**
2 - 3	0	0	**0**
4 – 5	2	1	**3**
6 - 7	3	9	**12**
8 – 9	5	3	**8**
10 – 11	6	7	**13**
12 – 13	6	5	**11**
14 - 15	3	5	**8**
Total	**27**	**30**	**57**

Source: Welfare Department

Indicator 11: Percentage of schools that provided life skills-based HIV education in the last academic year

Around the world, Life Skills-Based Education (LSBE) is being adopted as a means to empower young people in challenging situations. LSBE refers to an interactive process of teaching and learning which enables learners to acquire knowledge and to develop attitudes and skills which support the adoption of healthy behaviours.

From quality life skills-based education come children who have acquired skills in critical thinking, decision-making, communication, negotiation, conflict resolution, coping, and self-management which can be applied to specific contexts such as HIV prevention, hygiene practices, or conflict resolution.

This table shows that while all public secondary schools are teaching the life-skills syllabus, only a quarter of the public primary schools offer the set programme of study. It should be noted that there are a small number of private primary and secondary schools, three and eight respectively for which data is not available.

Table C4: Life skills training in schools

School level	%	Schools with at least 30 hours of LS training	Schools surveyed
Primary School	24.7	20	81
Secondary and High School	100.0	22	22
Total	**40.8**	**42**	**103**

Source: Ministry of Education

Although life skills are taught at all primary schools, roughly 25.0% of teachers adhere to the teaching of the HIV module in the prescribed manner. This explains the low coverage of the life-skills teaching in primary schools.

Indicator 12: Current school attendance among orphans and among non-orphans aged 10–14

The Government of Barbados is conscious of the value of education and this is actively promoted. Universal free primary and secondary education is available to all children therefore each child between the ages of 10 and 14 benefits from free public education. IA proactive approach to school attendance of all school-aged children through the School Attendance Unit within the Ministry of Education, Youth Affairs and Sports. The school attendance ratio for orphans to non-orphans is 1:1. Therefore the National AIDS Programme will not report on this indicator.

D. Knowledge and behaviour change

Indicator 7: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results

Given the country is unable to report on this indicator as required, a proxy indicator using data from the VCT programme will be presented instead. The VCT programme has a country-wide coverage within the eight polyclinics and in the community at large. However, HIV testing conducted through this medium represents only one-quarter of all tests done in the country.

In 2005, 98% of all the people tested for HIV received their results. More women than men accessed the services. For every 100 men who tested, there were over 140 women as shown in Table D1.

In 2006, 98.5% of the people tested received their results. The profile of persons being tested in 2006 echoes that of 2005 with more women accessing the services than men. For every 100 men there were 230 women as shown in Table D2.

In both instances, data were not available by age.

Table D1: VCT coverage in 2005

	Testing and counselling 2005								
	Polyclinics			*Community*			*Total*		
	Male	*Female*	***Total***	*Male*	*Female*	***Total***	*Male*	*Female*	***Total***
Pre-counselled and tested	850	1282	***2132***	963	1282	***2245***	1813	2564	***4377***
Received post-test counselling and results	833	1282	***2115***	921	1255	***2176***	1754	2537	***4291***
% tested and know results	98.0	100.0	***99.2***	95.6	97.9	***96.9***	96.7	98.9	***98.0***

Table D2: VCT coverage in 2006

	Testing and counselling 2006								
	Polyclinics			*Community*			*Total*		
	Male	*Female*	***Total***	*Male*	*Female*	***Total***	*Male*	*Female*	***Total***
Pre-counselled and tested	637	1353	***1990***	782	1912	***2694***	1419	3265	***4684***
Received post-test counselling and results	622	1345	***1967***	754	1893	***2647***	1376	3238	***4614***
% tested and know results	97.6	99.4	***98.8***	96.4	99.0	***98.3***	97.0	99.2	***98.5***

Indicator 8: Percentage of most-at-risk populations (female sex workers) that have received an HIV test in the last 12 months and who know their results

The data for this indicator were obtained from a baseline survey of the study of sex workers in Barbados. The study population consists of male and female sex workers who currently operate in Barbados within the boundaries in any of the five areas delineated in the Mapping exercise.

Several definitions have been proposed for 'sex worker', however, the definition used in this study is 'female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally and who may or may not consciously define those activities as income-generating' (UNAIDS, 2002).

The complexity of the legal and social context of sex work in Barbados precludes the effective use of probability sampling in the baseline study qualitative and quantitative components. The SW population in several areas could not be accurately estimated even by key informants who were well acquainted with the areas. Consequently, the snowball sampling technique was used.

The data presented in Table D3 on HIV testing among sex workers, are based on preliminary baseline survey of the study of sex workers, male and female, in Barbados. The results available, so far, relate to female sex workers only. The numbers are small and the results should be taken as indicative of possible coverage of HIV testing services among this group of most-at-risk population. Eighty percent of sex workers under the age of 25 years stated that they had had an HIV test and received the results of the test. The corresponding results for sex workers 25 years of age and over is 66.7%

Table D3: Female sex workers tested for HIV and know their results

Results Received	**Female HIV tested**		**Total**
	<25	*≥ 25*	
Yes	12	10	**22**
No	3	5	**8**
Total	**15**	**15**	**30**
%	***80.0***	***66.7***	***73.3***

MSM

Data on MSM was derived from the Men's Lifestyle Survey, a preliminary baseline study of men over the age of fifteen (15) years conducted from February 2006 to May 2007. A subset of MSM was sampled using snowball methodology. From this data as illustrated in Table D4, MSM were more likely to access HIV testing services than heterosexual males. This behaviour may due to the work of UGLAAB among this sub-population.

Table D4: HIV Testing Patterns among Heterosexual Males & MSM

Survey Items	Heterosexual	MSM	Total
Ever taken HIV Test	56.9	77.3	**60.8**
Find out the results	76.0	85.1	**78.3**
HIV test in the last 12 months	29.7	47.4	**33.7**

Indicator 13: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

A KABP survey was conducted in 2005. Regrettably, the attendant database was lost. The follow-up survey initially to be completed in late 2007 did not materialise due to pressing work assignments in the Division of Youth Affairs. It is, therefore, not possible to report on this indicator.

However, reports on the two KABP surveys (2001 and 2005) reveal that knowledge on individual survey items regarding transmission methods exceed 84.0%. Some instances exist where knowledge levels are lower than expected. For example in the 2005 survey, 75% agreed that HIV can not be transmitted by mosquito bites while data recorded on other knowledge items ranged from 85% and over.

The National AIDS Programme has some concern about the utility of this indicator. It is agreed that the importance of HIV-related knowledge cannot be discounted. However, it must be asked how useful and relevant it is to report on an indicator which:

- seeks to measure perfect knowledge, that is, seeking five (5) correct responses out of five (5); and
- facilitate global comparison but may have little or no relevance at the national level.

Failure to attain a perfect score may actually belie programme efforts.

Perhaps the strength of this indicator lies in its ability to flag misconceptions and knowledge gaps but this in itself is an exercise in futility if what is being measured is not indicative of the programme under scrutiny.

Indicator 14: Percentage of most-at-risk populations (sex workers) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

The data for this most-at-risk population came from a preliminary baseline survey of a behavioural study of male and female sex workers in Barbados. The data, so far, relate to female sex workers only.

Table D5 shows that less than 40% of the 30 sex workers responding to the questions gave correct responses to all the questions on ways of preventing the sexual transmission of HIV and rejection of misconceptions about HIV transmission

Table D5: Female sex workers' knowledge of prevention of sexual transmission of HIV

Age	**Female**		
	% correct	*Correct*	***Total***
<25	33.3	5	**15**
25+	40.0	6	**15**
Total	**36.7**	**11**	**30**

.

The results should be taken as merely indicative of the situation in this most-at-risk population because they are based on very small numbers.

Indicator 15: Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15

A KABP survey was conducted in 2005. Regrettably, the attendant database was lost. Therefore, no data is available for reporting on this indicator as required. Information extrapolated from the Report on the National Youth KABP Survey on HIV/AIDS 2005-2006 revealed that 19.6% or 97 out of 494 young people (15-24 years of age) reported having had sex before the age of 15.

Indicator 16: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

Data for this indicator is not available. The Workforce Impact Study (a KABP study) was not conducted due to financial and logistical challenges.

Indicator 17: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

Data for this indicator is not available. The Workforce Impact Study (a KABP study) was not conducted due to financial and logistical challenges.

Indicator 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client

The data for this indicator (shown in Table D6) come from preliminary baseline survey of a behavioural study of male and female sex workers in Barbados. The data, so far, relate to female sex workers only.

Table D6: Condom use by female sex workers

Age	Used a condom		Total
	Yes (%)	*Yes (#)*	
15-24	73.3	11	**15**
25+	86.7	13	**15**
Total	**80.0**	**24**	**30**

The indications are that a majority of sex workers may be consistently using condoms (73.3% sex workers under the age of 25 years and 86.7% for those aged 25 years and over). The results should be taken as merely indicative of the situation in this most-at-risk population because they are based on very small numbers and the survey sample was not selected randomly

MSM
Condom use in heterosexual males is low compared with MSM. Supportive male organizations therefore need to be empowered to address male education and BCC in much the same way as NGOs that are available to MSM have started (See Table D7).

TableD7: A Comparison of Condom use among Heterosexual males & MSM

Survey Items	Heterosexual	MSM
Always use condom with non regular partner	21.5%	41.9%
Never use condom	33.8%	3.0%
Condom use during last encounter with non regular partner	45.6%	64.5%

Indicator 19: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

See Section on MSM above.

Indicator 20: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

There is a small number of people in the country with drug addiction problems as evidenced by the existence of a 12-bed drug rehabilitation unit in the Psychiatric Hospital. This unit caters for men only. Women are housed in the general population of the Psychiatric Hospital. No data are available on condom use by injecting drug users to report on this indicator as required by UNGASS. There is, however, some information on drug use and sexual behaviour contained in a study conducted by the NCSA entitled '*The Relationship Between*

Drug Use and Risky Sexual Behaviour'. This study showed that there were 3.7% injecting drug users (10 people) among the 278 respondents. One hundred and seventy-three (173) drug users had had sex under the influence of drugs of whom twenty-two (22) reported practicing safe sex.

Indicator 21: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

Since no specific survey or study has been done on the intravenous drug users, the country is not in a position to report on use of sterile injecting equipment by drug users. However, studies on drug use and sexual behaviour reveal that IDU represent a small proportion of the population. For example, the 2005 NCSA study *'The Relationship Between Drug Use and Risky Sexual Behaviour'* reveal that 3.7% or 10 persons engaged in intravenous drug use.

E. Impact

Indicator 22: Percentage of young women and men aged 15–24 who are HIV infected

The Health Information System surveillance data could not provide the necessary components for this indicator. Barbados does not carry out periodic sentinel surveillance of women attending ANC services but relies on routine reports from the 8 government polyclinics. It was, therefore, decided to collect the data from the booking registers of ANC in all the 8 polyclinics. All women seen at the polyclinics for ANC services are tested for HIV. Table E1 shows the HIV situation among pregnant women accessing ANC services at the government polyclinics in 2005, 2006 and up to November 2007.

Table E1: HIV among antenatal clients from 2005 to November 2007 by age groups

	2005		**2006**		**2007**	
Age (years)	*Tested*	*HIV+*	*Tested*	*HIV+*	*Tested*	*HIV+*
15-19	350	0	359	1	370	1
20-24	503	4	479	4	455	2
15-24	853	4	838	5	825	3
HIV + percent						
15-19		0.00		0.28		0.27
20-24		0.80		0.84		0.44
15-24		0.47		0.60		0.36

The results indicate very low levels of HIV infection among pregnant women seen at ANC in government polyclinics, 6 per thousand in 2006 and less than 4 per thousand in 2007. These figures are believed to reflect the general situation among pregnant women since those who use private ANC services are unlikely to change the values because they are believed to be very few.

Indicator 23: Percentage of most-at-risk populations who are HIV infected

Barbados has not conducted any sero-prevalence studies so the country is therefore unable to report on this indicator.

Indicator 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Improvement in the survival of patients on ART has been discussed in reference with case-specific mortality. Over 90% of adults on antiretroviral therapy are surviving for more than a year. There are no survival differences between male and female patients (Tables E2 and E2).

Table E2: 12-month survival of patients on ART in 2006

2006									
	Male			**Female**			**Total**		
	Survivors	*Enrolled*	*% survival*	*Survivors*	*Enrolled*	*% survival*	*Survivors*	*Enrolled*	*% survival*
Children									
Adults	42	45	93.3	49	51	96.1	91	96	94.8
All									

TableE2: 12-month survival of patients on ART in 2007

2007									
	Male			**Female**			**Total**		
	Survivors	*Enrolled*	*% survival*	*Survivors*	*Enrolled*	*% survival*	*Survivors*	*Enrolled*	*% survival*
Children									
Adults	62	67	92.5	53	56	94.6	115	123	93.5
All									

Indicator 25: Percentage of infants born to HIV-infected mothers who are infected

There is nearly 100% antenatal care coverage in Barbados with similar figures recorded for HIV screening. For instance, screening rates ranged from 93% in 2000 to 83% in 2006.

The document "The HIV/AIDS Situation in Barbados, 1984 to 2006," revealed that antenatal prevalence rates among pregnant women are fluctuating, having declined from 1.1% in 2001 to 0.8% and 0.5% in 2005 and to rise again in 2006 to 1.5 %. Incidence of new cases in pregnant women declined from 0.7 % to 0.4 %.

According to Table E3, the proportion of HIV positive infants born to HIV positive mothers is extremely low with minimal variations occurring between 2004 and 2006. In 2006, of the thirty-eight (38) children born only one (1) was diagnosed HIV positive. These low figures attest to the success of the Prevention of Mother-to-Child Transmission (PMTCT) programme.

Table E3: Infants born to HIV-infected Mothers

2004		**2005**		**2006**	
Freq.	*%*	*Freq.*	*%*	*Freq.*	*%*
$^{2}/_{19}$	10.5%	$^{0}/_{16}$	0.0%	$^{1}/_{38}$	2.6

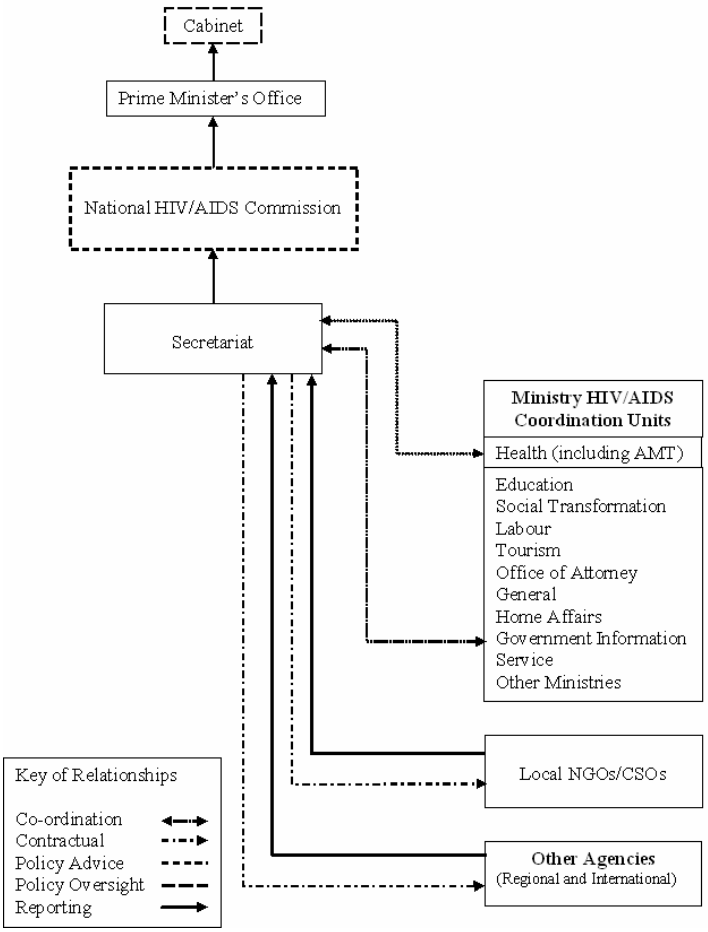
IV. Best Practices

Barbados has responded positively to the HIV epidemic particularly in the areas of coordination and treatment and care for people living with HIV in spite of a number of challenges (some of which are discussed in the next section). Small island countries with similar characteristics to Barbados may benefit from learning how Barbados has managed to make an all-inclusive involvement in the response to the epidemic by civil society, private and public sectors. The country would also like to share its approach to sustaining political commitment and providing treatment to people needing antiretroviral drugs.

Multisectoral coordination

In May 2001, the Prime Minister's Office assumed responsibility for the co-ordination of the national multisectoral response to HIV and AIDS and established the National HIV/AIDS Commission (NHAC) (Chart 1). The NHAC replaced the National Advisory Committee on AIDS under the Ministry of Health, which had previously managed the National AIDS Programme (NAP) from 1987-2001.

Chart 1 Management Structure for the Project



The NHAC was faced with the daunting task of harmonising the various micro-level responses. NHAC had to address the diversity of programming, agency territoriality, limited

knowledge and understanding of HIV and AIDS and a dearth of funds with which to implement programmes.

The successful harmonisation of partners within the NAP was achieved in a very systematic way by:

- Formation of a national partnership forum (HIV Coordinators and Focal Points) representing government, private sector and civil society including PLHIV
- Development of a tiered approach to national involvement of partners
- Sensitisation of in excess of 90% of government employees about HIV and related issues. Sensitisation was conducted through one-day workshops (that is, HIV 101, Stigma and Discrimination, Socio-economic impact). Other opportunities taken through media campaigns to address issues such as stigma and discrimination; distribution of promotional items with positive messages e.g. bookmarks, t-shirts etc.
- Initially working with eight (8) key line ministries to develop and strengthen their ministry-level AIDS Programmes through a series of workshops in M&E, document preparation etc and develop programme monitoring tools and an M&E plan with the gradual extension of the programme to all Ministries.
- Ongoing training in programme planning, implementation, monitoring and evaluation to build capacity to enable strategic partners to engage in programming activities.
- Monthly government, private and civil society HIV Coordinators' meetings which create a forum for idea and information sharing, programme planning and coordination, problem resolution and general NAP feedback.

The NHAC is established as a coordinating body; however, due to the limited capacity of some of its implementing partners it has on occasion assumed the role of an implementation agency. The Commission has embarked on an intensive mobilisation and capacity building campaign to involve and equip partners to participate in the NAP in a meaningful manner. With the implementation of the new NSP 2008-2013, it is hoped that the Commission will finally be able to divest itself of this role and focus more on its coordination and management functions which will in turn allow the NAP's strategic partners to assume a more prominent role as their capacity for implementation increases.

Political Commitment

The accomplishments and successes of the NAP are attributable to the commitment from the highest level of government as evidenced by the sustained personal commitment from the Prime Minister. While many of the day-to-day responsibilities were assigned to the Minister of State in the Prime Minister's Office, the Prime Minister remained active in ensuring that the response is strengthened and sustained.

The Government's commitment to the national response to HIV is demonstrated by its actions, namely:

- the location of the NHAC within the Prime Minister's Office,
- the development of a national strategic plan,
- the provision of executive powers within the Prime Minister's Office,
- the allocation of financial resources and

- the careful selection of a Special Envoy and technically skilled staff for the NHAC Secretariat.

Over the years, careful planning, programming and implementation of activities; the efficient organisational structure, the availability and prudent use of financial resources have contributed to the achievements and successes of the NAP. The unwavering and sustained political commitment of successive administrations, the leadership of the NACA and the NHAC, and the involvement of Government Ministries, PLHIV, the private sector and NGOs have been integral to the NAP and cannot be understated.

The Ministries and other partners work in a complementary, collaborative manner to implement activities in the NAP. The setting up of organisational structures with support from the NHAC has resulted in Ministries, partners and stakeholders becoming more active in implementing HIV/AIDS activities.

Treatment and care for PLHIV

Barbados decided early on in the epidemic that it would provide any needed comprehensive care to all its citizens living with HIV. The care the country provides through the public and private sectors covers: fight against stigma and prejudice, psycho-social support, provision of shelter and care and ART.

Diagnosis, Treatment and Care

Currently, Government provides the highly active anti-retroviral therapy (HAART) to individuals with comprehensive services that address the clients' medical, social and psychosocial needs. The Ladymeade Reference Unit (LRU), established in 2002 provides comprehensive management of PLHIV and covers the medical, as well as the psycho-social aspects of care. This is already resulting in HIV/AIDS infected persons living longer and experiencing a better quality of life. Since the establishment of the LRU, there has been an increase in patient load and a 42% reduction in AIDS-related deaths.

The GOB provides anti-retroviral (ARV) drugs free to all Barbadian residents who meet the clinical criteria for care and in accordance with sound public health policy. The GOB has advocated for and worked with drug manufacturers and suppliers of ARVs for a reduction in drug pricing for the Caribbean region including Barbados. Significant achievements in the area of care and treatment include:

- An improved and strengthened VCT programme in polyclinics;
- The provision of comprehensive clinical, laboratory and pharmacy services at the LRU by a multi-disciplinary team;
- The provision of ARV drugs free to all Barbadian residents who meet the clinical criteria for care;
- The reduction of mother to child HIV transmission has resulted from Government's policy to provide Zidovudine [AZT] to all pregnant women who were HIV positive.
- Increase in the survival of people on treatment for AIDS;
- A reduced demand for hospital services indicated by a decrease in hospital admissions and total hospital days;
- An increase in outpatient visits and a decline in deaths from AIDS-related causes.

Creating a Supportive Environment for PLHIV

In an effort to create a supportive environment for PLHIV, the Ministry of Health established the Elroy Phillips Centre in the mid-1990s. This facility provides shelter and care for ambulatory PLHIV in an environment free of prejudice and stigma. There is also a small Food Bank managed by the MH and operates through donations and volunteers. Construction of a new Food Bank and Personal Development Centre which will provide psycho-social support for PLHIV, a meeting area for peer support groups, counselling, skills building and educational activities, should be completed by March 2008. In 1993, the support group CARE (Comfort, Assist, Reach out, Educate) Barbados was established and serves as the major advocate for the PLHIV community.

In an effort to reduce the impact of stigma and discrimination, a number of activities have been developed to empower PLHIV and inform society. These include:

- the establishment of a Unit for investigating discrimination against PLHIV;
- the development of a discriminatory registry to record and investigate all forms of discrimination against PLHIV;
- orientation workshops to disseminate workplace policies on HIV/AIDS;
- national efforts to effect change in social norms related to stigma and discrimination. These include public debates, meetings and seminars on PLHIV empowerment, human rights, decriminalising homosexuality and prostitution and legal, ethical as well as socio-economic issues relevant to HIV/AIDS; and
- the development of a human rights mass media campaign under the theme “Embrace Tolerance, Protect Human Rights.”

V. Major Challenges and Remedial Actions

Despite the numerous achievements of the national program, the single greatest gap in the HIV/AIDS and STI program is the monitoring and evaluation (M&E) system which is not fully functional. Some data have not been collected, analyzed or shared, and on one occasion was lost (the entire dataset of the 2005 Youth KAPB survey). Many of the UNGASS indicators that should have been easily and routinely reported could not be reported because the data are either not available or they are not in a form that is usable for the computation of the indicators.

It is unclear whether the educational messages designed to reach particular target groups have been effective in motivating behavioural changes, as research and evaluation have not been systematically performed by some sectors. Traditionally, prevention programmes within the NAP have focused on IEC. With the realisation that this methodology is no longer adequate, efforts are currently being made to shift the focus to BCC. Through World Bank funding, a consultant was hired and a BCC Strategy developed. A fully costed one year action plan has been developed to implement the first year of the strategy and training of approximately thirty (30) partners was undertaken. The youth KABPs indicate the educational messages reach the target group in terms of raising knowledge levels but the transition to positive behaviour has not been as effective.

These data gaps not only prevent managers from being able to assess program performance, hindering their ability to make corrections, but prevent Barbados from knowing if HIV/AIDS investments have been effective and complicate the task of deciding what interventions in which to further invest. The lack of a comprehensive and fully operational monitoring and evaluation system is a major challenge to the national response to the epidemic.

Steps are, however, being taken to address this challenge. Under the National Strategic Plan for HIV and AIDS 2008-2013, the ability to track the progress of activities undertaken in the National AIDS Programme is critical. Responsibility for the implementation of this system lies with the NHAC, its Secretariat and its strategic partners in government, private sector and civil society. While the Commission has been successful with the coordination of a strong national multisectoral response based on the "Three Ones" Principles, there remains a pressing need to establish a fully operational and scaled up M&E of the NAP. In other words, the programme needs to move beyond the ad hoc reporting and sporadic conduct of basic M&E among a few partners to engagement in systematic and systemic M&E which permits sound evidence-based planning and decision-making.

Data reporting tools have been standardized and shared with partners. Once partners have been trained in M&E, reporting will transition to the standardized tools.

Accordingly, within the new M&E Framework there is clear delineation of the roles of strategic partners:

a. The National HIV/AIDS Commission (NHAC)

With respect to M&E, the members of the NHAC are mandated to provide:

- overall guidance and strategic direction to the NSP,
- facilitate active support of the M&E system among the sectors they represent and

- promote a culture of data usage for decision- and policy-making.

b. The NHAC Secretariat

The roles of the Secretariat staff in the implementation of the M&E System vary according to post held by each officer:

- The Director will promote the M&E System within all sectors; encourage the compulsory reporting of all organisations within the NAP and utilise information from the M&E System to guide the national response.
- The Assistant Director will coordinate the M&E component of the NAP including developing standardised reporting formats and M&E training plans, prepare M&E reports for dissemination to partners locally, regionally and internationally and in conjunction with other technical officers (Deputy Director, Behaviour Change Communication Specialist, other M&E staff and financial and administrative officers) will review and approve the M&E HIV Work Plans and budgets submitted by strategic partners.

c. Implementing Partners

The other partners in the NAP will:

- report data at agreed frequency to measure output level indicators.
- participate in training programmes organized by the NAP to build their data collection and reporting capacities,
- participate in the assessment of the implementation and review of the M&E plan,
- ensure adequate analysis of data collected at the organization/facility level to inform decision-making at that level and
- support the implementation of the various data collection activities.

VI. Support from the Country's Development Partners

Barbados, like other Small Island Developing States (SIDS) in the Caribbean, faces several challenges including relative poverty; an extremely narrow resource base; an unsustainable high external debt; and intra-regional mobility further exacerbated by the advent of the Caribbean Single Market and Economy. As the country searches for development partners' support it is committing its own resources to NAP. In 2001, the Prime Minister committed BDS$100 million over a five year period to the National AIDS Programme.

The World Bank classification of Barbados as a high income country, due to a high GDP per capita income of USD $11,465, poses significant challenges to the country's ability to fund and implement its National AIDS Programme. Categorisation as high income country has made it more difficult to raise resources in the international lending market. When loans have been available, they have proven impractical due to unfavourable lending conditions. Despite this, the country receives limited external funding for HIV and AIDS, minimal bi-lateral funding and multi-lateral support predominantly in the form of technical assistance. Table 5 shows the major sources of the money spent in 2006 on NAP activities. Support from development partners has primarily come from the World Bank through the GOB/IBRD HIV Prevention and Control Project (USD $15.1m and funding for the development of the National Strategic Plan).

The Inter-American Development Bank has argued that finding the necessary financial resources to fund effective prevention, care and treatment programmes are an immediate challenge for governments and donors.[7] Developmental efforts by SIDS like Barbados have been pursued within the constraints of limited financial resources including an overall decline in official development assistance (ODA). The health issue has been acknowledged as a major determinant of sustainable development, one which requires further action by the SIDS with much needed support from the international community if effective control of diseases such as HIV/AIDS is to be realised.

UNAIDS and UNIFEM have provided some financial and technical support to NAP. Other UN partners – UNIFEM, UNDP and WHO/PAHO are primarily providing technical assistance.

[7] Taken from Resource Requirements to Fight HIV/AIDS in Latin America and the Caribbean, IADB 2004

Table5: Major financial sources of money spent in 2006 on NAP activities

Name of donor	Amount spent in 2006 in US dollars	Start date of agreement	End date of agreement	Focus area of Support
World Bank Project	3,666,243.00	2001	2007	National AIDS Programme - Loan
AIDS Strategy Action Plan	111,000.00	2006	2007	Development of the National Strategic Framework 2007-2012
UNAIDS	30,000.00	2006	2007	Development of the National Strategic Framework 2007-2012
World Bank	24,000.00	2006	2007	Prevention
UNIFEM	8,220.00	2006	2007	Development of the National Strategic Framework 2007-2012 - Gender
Organizations and Individuals	55,893.98			

Source: NHAC Accounts

Apart from financial support from the limited number of developmental partners such as the World Bank, UNAIDS and a few others, Barbados has formed alliances with several regional and international agencies in the management and coordination of the NAP. (The list of regional and international partner is shown in Box-3.) NHAC is working with these partners to increase their contributions to the national effort particularly in connection with:

- Donor harmonisation especially in the areas of data collection and indicator monitoring
- Resource mobilisation assistance
- Technical assistance including South-South technical exchanges
- Capacity building which ensures knowledge transfer
- Technical exchanges

Box-3 Listing of Regional & International Partners

Regional Partners

- CCAS
- CCNAPC
- CDERA
- CFNI
- CHART
- **CHRC**
- **CRN+**
- IAA - Caribbean
- **PAHO/CAREC**
- **PANCAP**
- UWI / UWI HARP

International Partners

- **ASAP** [2]
- Brazil
- CDC
- CHAI
- Cicatelli Inc.
- CIDA
- COL
- COMSEC
- DfID/UK
- EU
- ILO/USDoL
- JHIPEGO
- London Lighthouse
- O/seas Universities
- PSI
- UNDP
- UNESCO
- UNFPA
- UNICEF
- **UNIFEM** [4]
- WHO
- **World Bank** [1]
- **UNAIDS** [3]

Note: Generally, very limited development assistance was provided by regional partners. For example, CAREC is assisting the Ministry of Health with the strengthening of their surveillance programme. For the international partners – the major ones are highlighted in bold font and numbers are used to designate order of importance.

VII. Monitoring and Evaluation Environment

Current M&E Status

In Barbados, HIV monitoring and evaluation is not governed by a comprehensive M&E system. At present, five ministries (MST, MES, MLS, MTI and MH) engage in M&E activities either internally or through arrangements with external service providers. In terms of M&E staffing allocations, NHAC has only one national M&E officer; the MH has a programme unit but no assigned M&E officers, and the Division of Youth Affairs and the Education Section of the MES each have a Research Officer.

Ministries and government departments submit detailed costed HIV/AIDS Work Plans with M&E components to the NHAC. At present, approximately ten (10) ministries and departments submit work plans to Commission. Of these, only five (5) use the standard format. In terms of reporting on programme results, 14 out of 16 ministries report representing a figure of 87.5%. Despite this, M&E is a sporadic rather than routine activity. This is due in part to lack of skills, resources (physical, financial and human) and bureaucratic barriers whereby government procedures restrict programme implementation thus precluding the need for programme M&E.

Challenges for a comprehensive M&E

The challenges to the development and sustainability of a comprehensive M&E system can be summed up in one word – **resources**. AIDS Programmes within government ministries and departments lack the human resources necessary to fulfil the M&E function. These human resource constraints include not only manpower but skills (technical resources) needed to execute M&E tasks effectively. Where these are available, funding is sometimes absent.

The dearth of logistical systems to facilitate M&E is another challenge. In this instance, the challenge lies not with their existence but with the fact that these tools (work and M&E plan formats) were not standardised and partners either did not know or were unsure about their usage. Other challenges to M&E and remedial actions are discussed in Chapter VI.

Remedial Actions

The NHAC has sought to address the challenges posed to the standardisation of M&E by developing:

- A national M&E framework with core indicators
  - to track the overall performance and impact of the NAP
  - to guide the collection, analysis, use and provision of information that enables tracking of progress made in response to HIV and enhance decision making
- a detailed operational M&E and budget covering the period 2008-2013 to guide the implementation of the M&E system
- an M&E communications and advocacy plan to aid the development of an enabling environment for M&E
- an M&E training plan

M&E Technical Assistance

Technical assistance is required to develop an M&E culture through equipping strategic partners with the skills and know-how to conduct M&E effectively and efficiently. The NHAC has therefore identified the need for training in the following areas:

- Basic Monitoring and Evaluation -
- Using Monitoring and Evaluation Tools
- Understanding Indicators & Data Sources
- Data for Decision-Making
- IT Training
- SPSS or Statistical Software
- Setting up an M&E Programme within an organisation

In terms of skills-building, further assistance is required with the identification of comprehensive overseas courses designed to equip partners with the skills and know-how to conduct M&E therefore initiating the process of building an internal cadre of M&E Specialists. Here the aim is to build M&E expertise through supplementing the generalist training programme.

Additional support is required with the development of a Management Information System for the NHAC to facilitate the management, updating and reporting within and beyond NAP requirements. This support entails the sourcing of qualified IT specialist(s) to develop, pilot and refine periodically the MIS system.

Annex 1. Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes	No
b) NAP	Yes	No
c) Others (please specify) MINISTRY OF HEALTH, MINISTRY OF EDUCATION	(Yes)	No

2) With inputs from

Ministries:

Education	(Yes)	No
Health	(Yes)	No
Labour	Yes	No
Foreign Affairs	Yes	No
Others (please specify)	Yes	No

Civil society organizations	(Yes)	No
People living with HIV	(Yes)	No
Private sector	Yes	No
United Nations organizations	Yes	No
Bilaterals	Yes	No
International NGOs	(Yes)	No
Others (please specify)	Yes	No

3)	Was the report discussed in a large forum?	(Yes)	No
4)	Are the survey results stored centrally?	Yes	(No)
5)	Are data available for public consultation?	(Yes)	No

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: NICOLE DRAKES, ASSISTANT DIRECTOR (AG.)

Date: 2008-01-11

Signature: Nicole V. Drakes

Please provide full contact information:

NATIONAL HIV/AIDS COMMISSION, PRIME MINISTER'S OFFICE

Address: 2ND FLOOR, WARRENS OFFICE COMPLEX, WARRENS, ST MICHAEL BB12001 BARBADOS

Email: ndrakes@hiv-aids.gov.bb

Telephone: 246 310-1000

ANNEX 2: National Composite Policy Index questionnaire

ANNEX 3.1: External Quality Assurance Laboratories

ICBS International Consortium for Blood Safety

Performance Evaluation by Parameter

External Quality Assessment Scheme – Caribbean Region

Panel OPS 0206 C

Queen Elizabeth Hospital

Barbados

Syphilis	HIV	HTLV	HCV	HBsAg
A	A	A	A	A

Qualification criteria:

"A" 100% correct results, no False-Positive and no False-Negative results.

"B[1]" False-Positive result was reported.

(< 5% of the total of determinations performed)

"B[2]" False-Positive result was reported.

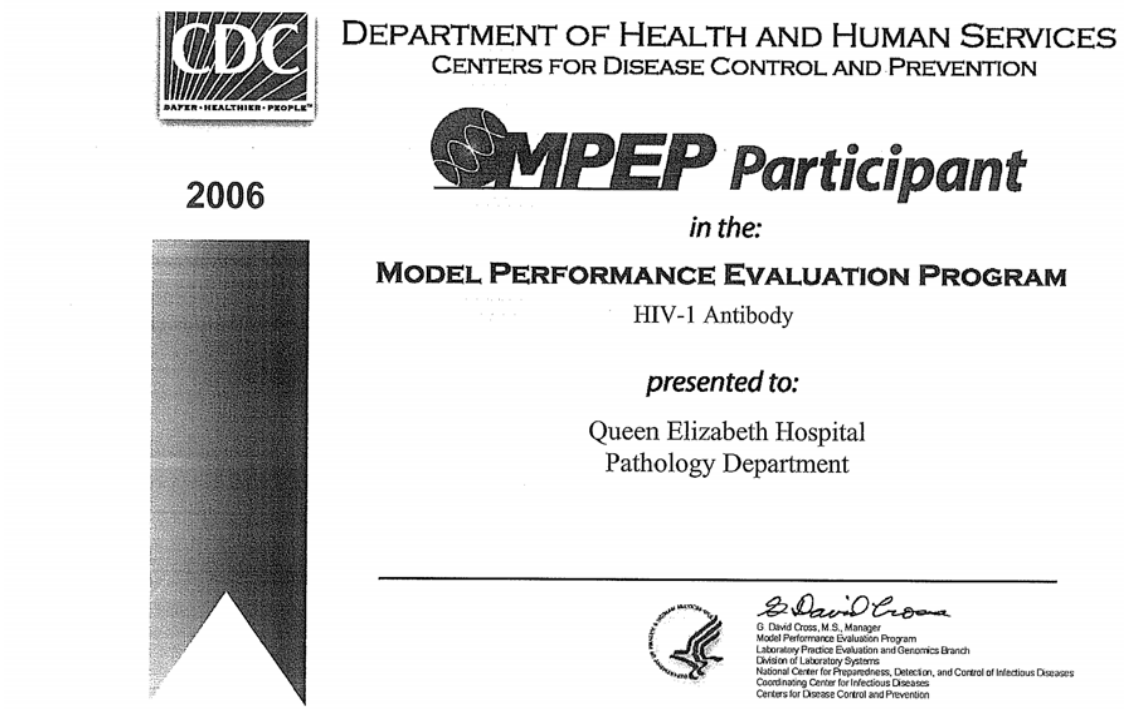
(> 5% of the total of determinations performed)

"C" False-Negative result was reported.

São Paulo, February 2007.

Dra. Márcia Otani

Fundação Pró-Sangue Hemocentro de São Paulo
e-mail: otanimarcia@uol.com.br Tel: 55 11 3061 5544 ext. 353 Fax: 55 11 3088 8317



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

2006

MPEP Participant

in the:

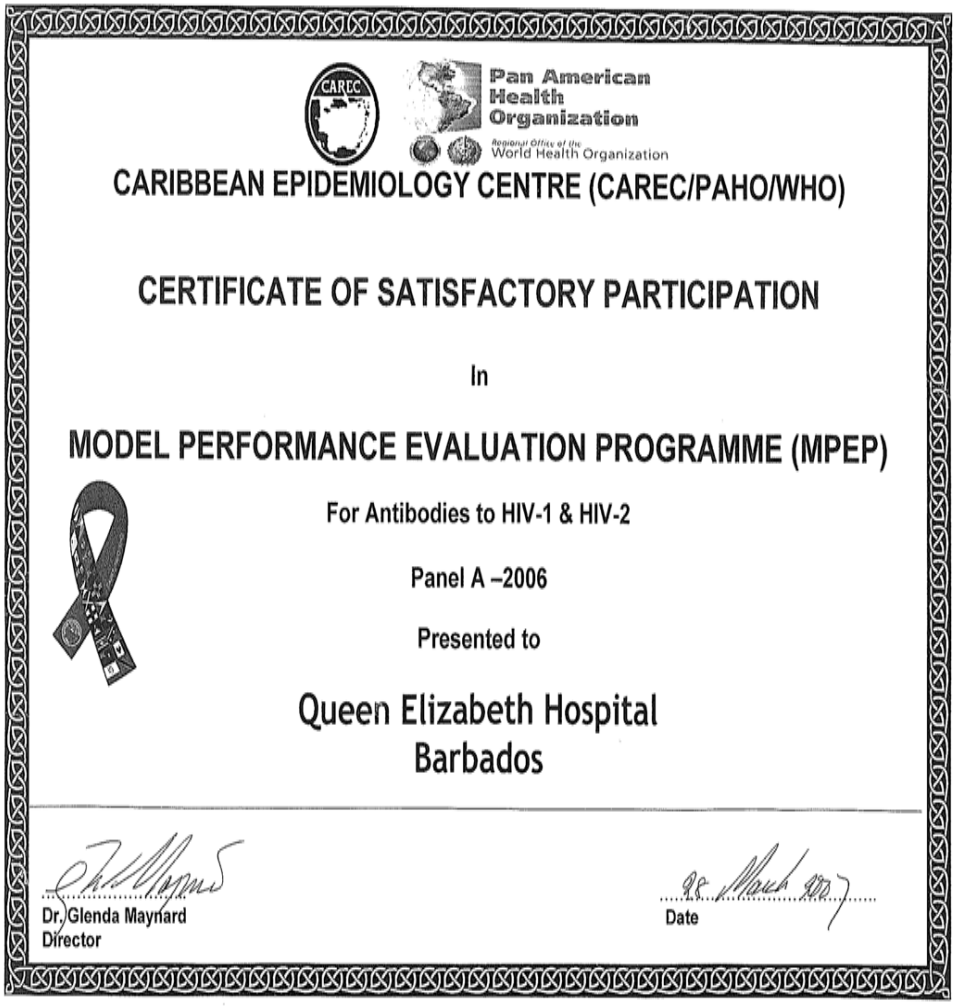
MODEL PERFORMANCE EVALUATION PROGRAM

HIV-1 Antibody

presented to:

Queen Elizabeth Hospital
Pathology Department

G. David Cross, M.S., Manager
Model Performance Evaluation Program
Laboratory Practice Evaluation and Genomics Branch
Division of Laboratory Systems
National Center for Preparedness, Detection, and Control of Infectious Diseases
Coordinating Center for Infectious Diseases
Centers for Disease Control and Prevention



Pan American Health Organization
Regional Office of the World Health Organization

CARIBBEAN EPIDEMIOLOGY CENTRE (CAREC/PAHO/WHO)

CERTIFICATE OF SATISFACTORY PARTICIPATION

In

MODEL PERFORMANCE EVALUATION PROGRAMME (MPEP)

For Antibodies to HIV-1 & HIV-2

Panel A –2006

Presented to

Queen Elizabeth Hospital
Barbados

Dr. Glenda Maynard
Director

28 March 2007
Date

Please email your complete UNGASS Country Progress Report **before 31 January 2008** to UNAIDS Evaluation

Department at: ungassindicators@unaids.org.

If the Country Response Information System (CRIS) is not used for submission of indicator data, please submit reports

by 15 January 2008 to allow time for the manual entry of data into the Global Response Information Database in

Geneva.

Printed copies may be posted to:

Dr. Paul De Lay, Director, Evaluation Department

UNAIDS 20 Avenue Appia

CH-1211 Geneva 27 Switzerland