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PANCAP CO-ORDINATING UNIT, CARIBBEAN COMMUNITY (CARICOM) SECRETARIAT

NATIONAL STRATEGIC PLAN (NSP) FOR HIV/AIDS IN ANTIGUA AND BARBUDA (2012-2016)

MINISTRY OF HEALTH, SOCIAL TRANSFORMATION AND CONSUMER AFFAIRS

ST. JOHN'S, ANTIGUA AND BARBUDA

December 2011

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ACRONYMS

ABC	Abstinence, Be faithful, Condom use	**MoH**	Ministry of Health
AIDS	Acquired Immune Deficiency Syndrome	**MSJMC**	Mount St. John's Medical Centre
APM	AIDS Programme Manager	**MSM**	Men who have Sex with Men
APPA	Antigua Planned Parenthood Association	**NAAC**	National AIDS Advisory Commission
ART	Antiretroviral Treatment	**NAP**	National AIDS Programme
ARV	Antiretroviral drugs	**NGO**	Non Governmental Organization
BSS	Behavioural Surveillance Survey	**NCTP**	National Care and Treatment Plan
CAREC	Caribbean Epidemiology Centre	**NSF**	National Strategic Frame work
CCH	Caribbean Cooperation in Health	**OECS**	Organization of Eastern Caribbean States
CCM	Country Coordinating Mechanism	**OVC**	Orphans and Vulnerable Children
CHAA	Caribbean HIV/AIDS Alliance	**PANCAP**	Pan Caribbean Partnership on HIV/AIDS
CHRC	Caribbean Health Research Council	**PAHO**	Pan American Health Organization
CIDA	Canadian International Development Agency	**PEPFAR**	[US] President's Emergency Plan For AIDS Relief
CMO	Chief Medical Officer	**PLHIV**	People Living with HIV
CRN+	Caribbean Regional Network of PLHA	**PLWHA**	People Living with HIV and AIDS
CRSF	Caribbean Regional Strategic Framework	**PMTCT**	Prevention of Mother-to-Child Transmission of HIV
DFID	[UK] Dept. for International Development	**STI**	Sexually Transmitted Infections
DGA	Division of Gender Affairs	**TB**	Tuberculosis
FBO	Faith-based Organisation	**UN**	United Nations
FSW	Female Sex Worker	**UNGASS**	UN General Assembly Special Session on HIV and AIDS
HFLE	Health and Family Life Education	**UNICEF**	UN Nations Children's Fund
HIV	Human Immunodeficiency Virus	**UNIFEM**	UN Development Fund for Women
3H	Health, Hope and HIV Network	**VCT**	Voluntary Counselling and Testing
HSP	Health Sector Plan	**WB**	The World Bank
ITECH	International Training & Education Centre for Health	**WHO**	World Health Organization
KABP	Knowledge, Attitudes, Beliefs and Practices Surveys on HIV/AIDS (Antigua and Barbuda) July, 2011		
MARP	Most-at-risk Population		
MBS	Medical Benefits Scheme		
M&E	Monitoring and Evaluation		
MTCT	Mother-to-Child Transmission of HIV		
MDG	Millennium Development Goals		

EXECUTIVE SUMMARY

During the plan period (2012 - 2016) Antigua and Barbuda will remain committed to its mission of substantially reducing the spread and impact of HIV through sustainable systems of universal access to HIV prevention, treatment, care, and support. The new priority areas identified are:

- Priority area 1: Promote an enabling environment that fosters universal access to HIV prevention, treatment, care and support.
- Priority area 2: An expanded and coordinated multi-sectoral response to the HIV epidemic
- Priority area 3: Prevention of HIV transmission
- Priority area 4: Treatment, care and support
- Priority area 5: Institutional Systems Development.
- Priority area 6: Barbuda Development Programme

The nation will scale up access to services through strategies designed to achieve the following goals:

- By 2016, to reduce the estimated number of new HIV infections by 33% of last three year average.
- By 2016, to reduce mortality due to HIV by 33% of last three year average.
- By 2016, to achieve 100% confidential referrals of all requesting PLHAs to relevant national social support agencies

Statistical data and information are collected individually or jointly by the Clinical Care Coordinator, the AIDS Secretariat and the Health Information Division of the Ministry of Health. The pronounced need for an effective monitoring and evaluation (M&E) system armed with the baseline data is addressed. A functioning M&E system is required to evaluate this NSP and to ensure that mid-term evaluations and annual corrections and projections are evidence-based.

The NSP, in its first two priority areas allocates effort and resources to the establishment of a governance framework with the potential to provide policy leadership to the multi-sectoral efforts to ensure universal access to HIV and AIDS services. It is premised on the understanding that additional resources may not be readily available from the Government which is presently battling an economic crisis that has lessened its annual revenue over the last three years by thirty percent. Concurrently transfers from international and regional organizations are projected to decrease dramatically over the next three years.

The plan reflects the re-allocation of major resources to the prevention of HIV transmission. It is constructed firmly around the understanding that the main cause of HIV transmission is unprotected sex regardless when, where, under what circumstances or between whom it is consummated. Its main programmatic focus is on the reduction of unprotected sex. It recognizes abstinence as a solution but offers little support that abstinence promotion can have negative impact on transmission rates.

The NSP reflects the objective of the Ministry of Health to assume programmatic responsibility for treatment and care of people living with HIV and AIDS in the general primary and secondary health care sites and proposes the gradually relinquishing of the intermediary role of the AIDS Secretariat in the provision of such treatment. The role of the Clinical Care Coordinator and appointed team of specialists is critical in making this transfer. The need for cross-training of public and private health workers and staff of NGOs providing HIV and AIDS services is recognized and provided for.

Similarly the NSP recognizes that the AIDS Secretariat is not staffed with the trained personnel capable of leading a campaign for the reduction of stigma and discrimination (S&D) and will instead focus on mitigating such – S&D - through organizational changes and service provision that embrace privacy and confidentiality as their main attribute. The objective is to offer all residents improved confidential access to services. The AIDS Secretariat will however continue to offer critical support to the stakeholder interest groups (MSM, SW, 3H, groups of PLHIV) and human rights groups in their attempts to reduce stigma and discrimination against persons living with HIV and AIDS.

Interventions for the reduction of the economic and social vulnerability of PLHA and their families will be sought in the extensive social safety network existing in the country. The AIDS Secretariat will continue facilitating the access of requesting PLHAs to the network through confidential and private referral systems, while lessening its direct contributions.

The NSP seeks to serve the population of Barbuda as a vulnerable group because of its small size, the existing intimacy of the small population and the relatively high teenage birth rates – an indication of the levels of unprotected sex among young people.

The NSP is accompanied by an Action Plan with associated costs which details the programmatic approach to achieve policy and operational goals.

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ANTIGUA AND BARBUDA NATIONAL STRATEGIC PLAN FOR HIV/AIDS (NSP) - 2012-2016

INTRODUCTION

The national response to the HIV epidemic in Antigua and Barbuda has been led by the Ministry of Health (MoH) since the first diagnosis of HIV in 1985 through a now defunct National AIDS Committee and subsequently through the AIDS Secretariat established in 1996. The National AIDS Programme (NAP) had initial emphasis on effecting behaviour change through information, education and communication strategies. It has evolved to include equal emphasis on treatment and care and provision of support. A total of nine hundred and six (906) such persons have been diagnosed (June 2011) since 1981. It is estimated [2011] that there are one hundred and seventy-five (175) children and adults living with AIDS.

During the last decade, successes of the programme include the introduction and expansion of voluntary, counselling and testing (VCT) services, access to antiretroviral (ARV) treatment and PEP, and a mother-to-child transmission (PMTCP) programme. Behaviour change communication (BCC) interventions have also been intensified. The collaboration of NGOs dedicated to serving people living with HIV, sex workers, men who have sex with men, and youth has been secured.

Still the number of new HIV infections has averaged fifty-two (52) annually during the last three years. Twenty (20) new cases have been diagnosed by June 2011 and the disease continues to be a major development challenge. The plan is written during the period when PANCAP meets in its 10^{TH} Annual General Meeting under the theme ‘‘Enhancing Country Ownership and Sustainability’. Contractions in Government revenue have considerably lessened its ability to commit additional resources to the NAP. At the same time the availability of financial resources from the international community continues to decline. These facts are taken into account when designing and costing the NSP.

The national response however has not been guided by a strategic plan since 2005. Direction for the period 2008 -2010 was defined in the Business Plan of the MoH that sought ‘to promote the prevention and management of communicable diseases through the development of appropriate programs and collaborative mechanisms’. The most recent Behaviour Surveillance Survey was conducted in 2007 but a KABP was conducted in July 2011. The programme is still challenged by the absence of a strong national coordinating mechanism designed to ensure multi-sectoral partnership and leadership, although a committee to prepare the application for Global Funds funds has been established.

This NSP 2012-2016 is envisaged as 'the bedrock of scaling up towards Universal Access'. It builds 'on past achievements and best practice and addresses the programmatic and information gaps'. It identifies strategic areas for intervention and programming. It is accompanied by an action plan and associated cost projections. The intent of the NSP is to provide strategic direction to the Government of Antigua and Barbuda, the Ministry of Health, the AIDS Secretariat and all stakeholders in enhancing the effectiveness and efficiency of the national programme response to HIV and AIDS.

2. METHODOLOGY

Kingdome Consultants Inc., working under the supervision of the Chief Medical Officer, Ministry of Health and in consultation with the Country Coordinating Mechanism (CCM), the Clinical Care Coordinator and the AIDS Secretariat led a consultative approach to the development of this National Strategic Plan (2012 – 2016)

The NSP and attendant Action Plan were developed with full reference to:

- International policy guidelines, notably the MDG pertaining to HIV and AIDS, universal access and the "Three Ones" principle
- The Caribbean Cooperation in Health lll and the PANCAP Caribbean Regional Strategic Framework on HIV and AIDS (2008 – 2012)
- National Health Policy and HIV and AIDS Policy and Programmes.

A multi-sectoral participation was guaranteed through direct interface with the existing CCM; individual meetings with relevant members of civil society both in Antigua and in Barbuda; the review of 2011 public consultations on the NAP and desk research of reports, internet sites and correspondence.

Two validation workshops were staged. The first validated the situational analysis and made recommendations for inclusion in the NSP; the second to review and validate the draft NSP. Participation in these workshops came from representatives of young people, people living with HIV (PLWH), men who have sex with men (MSM), sex workers (SWs), faith-based organizations (FBOs), Non-Governmental Organizations (NGOs), private-sector and a limited number of other government sectors.

3. SITUATIONAL ANALYSIS

3.1. Country description

The nation of Antigua and Barbuda comprises the islands of Antigua (17°06′N 61°47′W), Barbuda and the uninhabited Redonda. It is at the centre of the Eastern Caribbean's Leeward Islands group. The country is 440sq. km. in area with Antigua occupying 64% (282 sq. km.) of the land mass and containing ninety-eight percent (98%) of the population. The remaining two percent of the population (approx 1500 persons) live on the island of Barbuda, located twenty-seven miles north of Antigua. Light aircraft and ferry services connect both islands.

3.2. Population

A Census of Population and Housing was conducted during May 2011. Results have not yet been published. The descriptions below are taken from the mid-year population projections of the 2001 Census, as are the figures in various tables.

Table 1 PROJECTED TOTAL POPULATION BY SELECTED AGE GROUPS FOR 2008-2010

	2008			2009			2010		
AGE GROUP	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Total	**41,095**	**46,411**	**87,506**	**41,861**	**47,277**	**89,138**	**42,861**	**48,159**	**90,801**
15-24	6,711	7,388	14,099	6,836	7,525	14,362	6,964	7,666	14,630
% 15-24	16.3	15.9	16.1	15.9	15.6	15.8	16.2	15.9	16.1
%25-49	38.9	37.6	40.1	38.9	37.6	40.1	38.9	37.65	40.1
%15-49	55.2	53.5	56.2	54.8	53.2	55.9	55.1	53.6	56.2

It is estimated that approximately ninety percent (90%) of the population is of African descent. The other racial groups in the population include persons of mixed race (3.7%), white (2.4%) and small pockets of Chinese, Syrian, Lebanese, Indian and Portuguese. There is a visible increase (2011) in persons of Chinese descent. There is a relatively large immigrant segment – estimated at eighteen percent of current population estimates - from the other CARICOM countries, mainly Dominican Republic, Jamaica, Guyana, Montserrat and the Commonwealth of Dominica. The census projections for 2010 show (See Table 1):

- A resident mid-year population of ninety thousand, eight hundred and one (90,801) persons – forty two thousand eight hundred and sixty one (42,861/47%) males and forty eight thousand one hundred and fifty nine (48,159) females: a male to female ratio of 1:1.12

- Sixteen-point-one percent (16.1%)of the population is between the age range fifteen to twenty-four (15-24) years; forty-point-one percent (40.1%) is in the twenty-five and forty-nine (25-49) age range, making fifty-six-point-two percent (56.2%) of the population between fifteen and forty-nine (15-49) years of age.
- The literacy rate (not shown) is approximately ninety-nine percent (99%) and the Poverty Assessment of 2005 estimates 1.04% of the population as indigent.

3.3. Health profile

3.3.1. Health care delivery systems

The delivery of health care in Antigua and Barbuda is achieved through the following Government institutions and services[1]:

- Mount St. John Medical Center – a one hundred and eighty-eight (188) bed care facility providing general and specialty services that include internal medicine, general surgery, orthopaedics, ENT, pathology, radiology, nephrology, oncology, ophthalmology, paediatrics and obstetrics and gynaecology.
- Clarevue Psychiatric Hospital, with an in-patient capacity of one hundred and twenty (120) beds
- Fiennes Institute, a long term geriatric facility with a capacity of sixty eight (68)
- Hannah Thomas Hospital, an eight (8) bed facility located on the island of Barbuda.
- The country is subdivided into six medical districts. A network of seven (7) community clinics classified as health centres (one of these is physically located within the compound of the Hannah Thomas Hospital in Barbuda). There are seventeen (17) sub-centres.

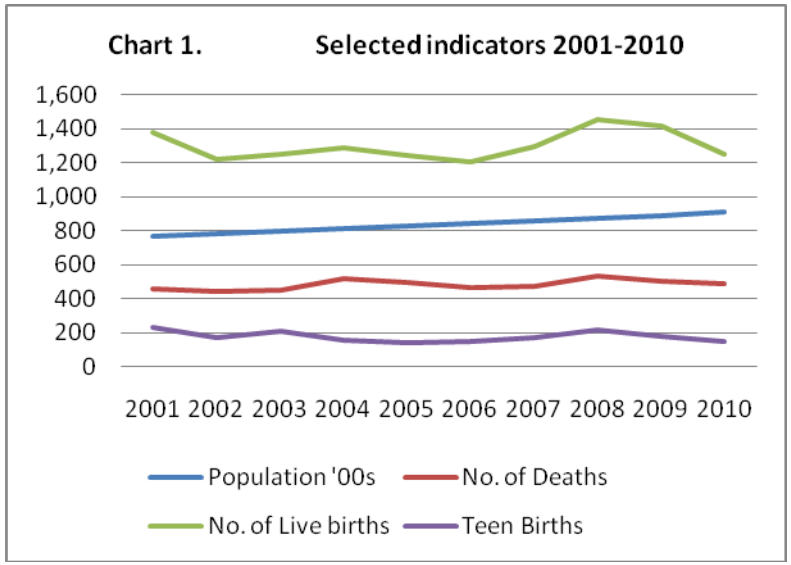
In addition there are a number of private facilities (to include the Adelin Medical Centre, Medical Associates, The Belmont Clinic) offering medical services and the Crossroads Centre, a thirty-five (35) bed, residential treatment centre for drug and alcohol addiction serving patients from developed countries (85%) and from the Caribbean region (15%).

3.3.2. Health Profile (excluding HIV/AIDS)

Chart 1 shows some of the main indicators of the health status of Antigua and Barbuda listed below:

[1] National Business Plan for Health, Ministry of Health of Antigua & Barbuda 2008-2010

- Life expectancy at birth in 2006 was seventy-six-point-one-four (76.14) years - females was seventy-eight-point four-seven (78.47) years and males seventy-three-point-six-two (73.62) years.
- The crude birth rate per 1000 population is averaged at fifteen-point-six-seven (15.67) for years 2002 to 2004 and decreased to fourteen-point-seven-one (14.71) in 2005.
- The Fertility rates were 61.6, 62.6, 58.6 and 55.1 births per 1000 females ages 15 to 49 for the period 2002 to 2005.
- Immunization coverage of ninety-eight percent (98%) against the diseases covered by the expanded programme in immunization.
- The infant mortality rate decreased from twenty two (22.0) per 1000 live births in 2004 to sixteen (16.0) in 2005.
- There were four maternal deaths for the period 2001 – 2005.
- The five (5) leading causes of death in 2004 were malignant neoplasms, heart disease, diabetes mellitus, cardio vascular disease, and hypertensive heart disease. In 2004 five hundred and sixteen (516) deaths – [269/males & 247/females] - were recorded.



3.4. Economic profile

The nation's economy is largely service driven. Per capita GDP is estimated at approximately thirty-five thousand Eastern Caribbean dollars (EC$34,691), the highest for the OECS counties. Tourism and tourism-related economic activities are responsible for eighty-five percent (85%) of all foreign exchange earnings and account for over two-thirds of gross domestic product GDP[2]. The majority of visitors come from Europe (46%) and the USA (29%). Both the cruise and yachting sectors are vibrant. Crews of visiting boats are identified as important clients in the sex trade.

A poverty survey in 2006 revealed that the poverty level is the lowest in the OECS at twelve percent (12%) compared to the regional twenty-nine percent (29%) average. 'Approximately three-point-seven percent (3.7%) of the population was living below the

[2] Government of Antigua Prospectus 2011 http://ab.gov.ag/gov_v4//pdf/GoAB%20RGSM%20Prospectus-%20July%202011.pdf

indigent line of EC$6.78 per day (US$2.51) and an additional fourteen-point-six percent (14.6%) was classified as poor and living on less than EC$18.90 per day (US$7)'[3].

In 2008, Antigua and Barbuda ranked fifty-ninth of one hundred and seventy-seven countries (59th of 177) on the United Nations Human Development Index[4] but was not included in the 2010 Human Development Index seemingly due to a lack of internationally verifiable data.[5]

During 2010 there was approximately a four percent decline (4.1%) decline in real GDP compared to a seven percent (7.1%) decline in 2009[6]. Unemployment has increased significantly in the last five years and is estimated at between ten to fifteen percent (10 – 15%).

3.5. Communication and Media

Antigua and Barbuda is served by at least seventeen radio stations, the vast majority (14) of which broadcast in the FM band; two (2) cable networks and one (1) broadcast TV station[7]. There are two newspapers - a daily (except Sunday) and a weekly. A national ICT Survey revealed that[8]:

- Access to radios and televisions is almost ubiquitous. Eighty two percent (82%) of respondents has radios; ninety seven percent (97%) has a television, approximately seventy two percent of whom has cable television.
- Seventy eight percent (78%) has one or more mobile phones. Only twelve percent (12%) of households do not have access to a mobile unit.
- Forty seven percent (47%) of households own a computer; sixty percent (60%) of respondents had used one during the past twelve (12) months.
- Thirty six percent (36%) has Internet access at their household.
- Sixty-five thousand (65,000) Internet users as of Jun/09, (74.0% penetration); Facebook users on June 30/11, 33.0% penetration rate[9].

[3] Kairi Consultants Ltd: Conditions and Household Budget Survey (2005–06)
[4] http://hdr.undp.org/en/statistics/
[5] UNDP: UNDP Releases 2010 Human Development Index
[6] http://www.ab.gov.ag/gov_v4/pdf/budget_speech_2011.pdf
[7] http://www.telecom.gov.ag/radio_stations_in_antigua.htm
[8] Antigua and Barbuda National ICT Household 2008 Surveyhttp://ab.gov.ag/gov_v4/pdf/statistics_reports/Antigua_Barbuda_Household_ICT_Survey_2008.pdf

Respondent in the sample population of a recent KABP study[10] when asked to give the places or persons that provide the most amount of information on HIV/AIDS identified local television (71%), followed by radio (62%), the newspaper (41%) and the internet (40%); a pattern that is consistent across both sexes. Posters and pamphlets were identified by approximately 3% of respondents.

'Friends and colleagues' (6%) was identified as the main source of HIV information from people; 'doctors' and 'teachers/lecturers' (5% each). 'Social workers', 'priests/pastors' and 'nurses' were identified as source by less that 2% (for each category), Government seminars even lower (~1%).

Only twenty-nine percent (29%) of respondents were aware that an AIDS hotline existed in Antigua and Barbuda – forty-six percent (46%) was unsure and twenty-five percent (25%) was unaware of its existence. Utilization of this hotline was reported by only six percent (6%). The highest percentage of persons (14%) who reported use of the HIV/AIDS hotline was from the age group fifteen to nineteen (15-19) years. There were three main reasons cited for using the HIV/AIDS hotline. Forty-one percent (41%) used it to obtain 'General Advise', twenty six percent (26%) to get Information on what HIV/AIDS is and twenty-one percent (21%) to find out about getting tested for HIV/AIDS.

3.6. Social and economic entitlements

Antigua and Barbuda's Social Safety Net system comprises a network of programmes with the well placed intent of improving the means available for economic advancement. It includes the School Uniform Grant; the School Meals Programme, the Home Improvement Grant; the Poverty Alleviation Grant; the GRACE Programme; Job Training initiatives; the Senior Citizens Utility Subsidy Programme and the Peoples Benefit Programme.

- **Ministry of Social Transformation** provides assistance to many groups including special and dedicated care to more than one hundred (100) elderly, disabled and shut-in individuals through the Government Residential Assistance and Care programme

[99] http://www.internetworldstats.com/carib.htm

[10] HEALTH ECONOMICS UNIT (HEU), Centre for Health Economics, UWI: FINAL REPORT: Knowledge, Attitudes, Beliefs and Practices (KAPB) Surveys on HIV/AIDS in four OECS Member States (Antigua and Barbuda) July, 2011. A total of one thousand two hundred and eight (1,208) persons formed the basis of the analysis for Antigua and Barbuda. Of these, approximately 57% of the respondents were female and 43% were male. The largest age group in the sample was the 25-29 year olds (18%) followed by the age groups 30 – 34 years and 35 to 39 years respectively.

for the Elderly and Eligible (GRACE). Other interventions include support to over one hundred and thirty (130) foster children and parents, financial assistance to fire victims and counseling and probation services that target the youth.

- **The Board of Guardians** provides support to the most vulnerable in society. Its clients include the elderly, mentally challenged, visually impaired, and other groups of individuals who receive stipends every fortnight to help cover the costs of their basic necessities. It provides support to households and families by way of the Home Improvement Grant, which is a two thousand, five hundred dollars ($2,500) grant to assist with essential home repairs. A funeral grant is provided to families who need financial support to cover the costs of final arrangements.

- **The Citizens' Welfare Division** gives effect to the Convention on the Rights of the Child by formulating a Child Care and Protection Policy. The Government remains focused on the provision of legal and institutional protection for children, particularly those who are vulnerable and at-risk and the elderly within our society.

- **The School Uniform Programme** in 2010 issued a total of ~eighty thousand (80,206) uniform vouchers to ~ thirty-five thousand (35,203) children.

- **The National School Meals Programme** provides a hot, nutritious meal to children in the 18 participating schools. A total of approximately three hundred and fifteen thousand meals were served in 2010 (up to November).

- **The Medical Benefit Scheme (MBS**) is financed by a mandatory salary deduction of all employed persons. The contribution is matched by a similar percentage (3.5%) from their employers. All persons who contribute to the MBS, persons in age groups 0-16 yrs and those incapable of work by virtue of age who are affected by chronic conditions such as cancer, hypertension, diabetes, sickle cell disease, cardiovascular diseases, mental illness, asthma, glaucoma and leprosy are entitled to received required medication, free of cost to them. HIV/AIDS medications are not on the schedule of the Scheme.

- **The Social Security Scheme** is financed by a mandatory (3%) salary deduction of all employed persons. The contribution is matched by a five (5%) percentage contribution from their employers. The Scheme provides benefits to insured persons and their beneficiaries when there is a loss or reduction of earnings as a result of sickness, pregnancy, invalidity, retirement and death.

4. HIV AND AIDS IN ANTIGUA AND BARBUDA

4.1. Epidemiology

The first case of HIV in Antigua and Barbuda was diagnosed in 1985. The numbers of persons diagnosed has steadily increased annually over the last twenty-five (25) years to a cumulative total of nine hundred and six (906) in June 2011 - with a male to female ratio of 1:1 up to 2004. (See Table 2). Subsequently, that ratio has changed to 1:1.4 with the number of new positive tests among females outnumbering the number among males. During this period (January 2004 -June 2011), four hundred and forty-four persons (213/males & 231/females) have tested positive.

Forty two percent (42%) of the respondents (KABP July 2011) admitted knowing someone infected with HIV – mainly relative or friend - while fifty percent (50%) said that they did not.

TABLE 2 # PERSONS BY YEAR, SEX AND STATUS TESTED HIV+

	ADULT		CHILDREN				Cumulative
YEAR	Male	Female	Male	Female	Unknown	TOTAL	Total
1985-87	3	2	0	0	0	5	**5**
1988-90	17	15	0	0	0	32	**37**
1991-93	46	11	2	4	0	63	**100**
1994-96	33	35	3	3	0	74	**174**
1997-99	47	45	2	3	0	97	**271**
2000	38	28	1	0	0	67	**338**
2001	21	11	0	0	0	32	**370**
2002	23	15	0	0	0	38	**408**
2003	22	14	1	1	1	39	**447**
2004	20	21	0	0	3	44	**491**
2005	27	31	0	0	4	62	**553**
2006	27	34	0	1	1	63	**616**
2007	30	34	1	1	0	66	**682**
2008	40	45	0	1	2	88	**770**
2009	25	21	0	0	0	46	**816**
2010	32	37	0	1	0	70	**886**
2011 (June)	12	8	0	0	0	20	**906**
TOTAL	**463**	**407**	**10**	**15**	**11**	**906**	

Source: Statistics Division – Ministry of Health

4.1.1. Distribution by year, sex and status

It has been established that the major mode of HIV transmission is through heterosexual contact. The epidemic is concentrated in the twenty to forty-four (20-44) years age group where sixty-seven percent (67%) of infections occur. (See Table 3). Twenty-two percent (22%) occur in the over forty-five year (>45) age group and seven percent (7%) in the under nineteen age (>19) group.

The main factor driving the epidemic is unprotected sex occurring in and through sex tourism, commercial and transactional sex, and because of gender inequality.

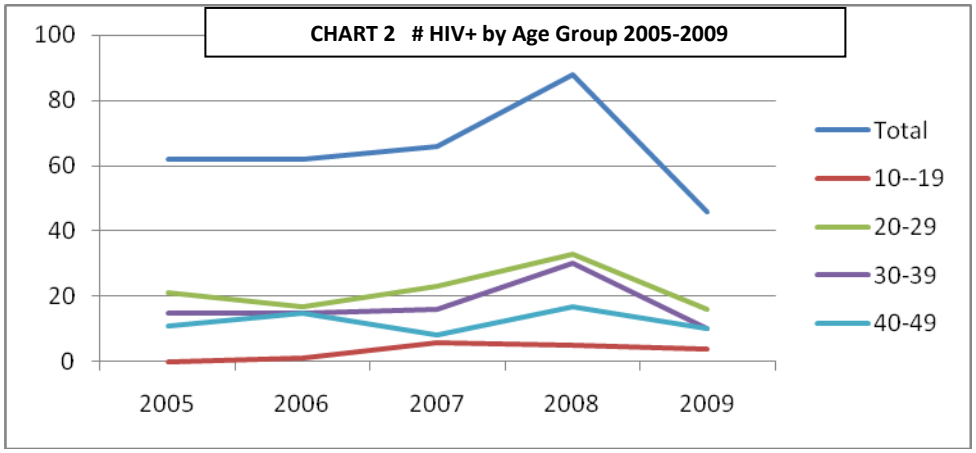
Five (5) cases of vertical transmission have been recorded since 2005. Information on other forms of transmission is not detailed.

It is noted in Chart 2 that in 2008, the number of HIV patients peaked at eighty-eight (88) with all cohorts except for the (10-19) showing increases over the years before. The number of infections in all age cohorts has reflected the downward trajectory of the total.

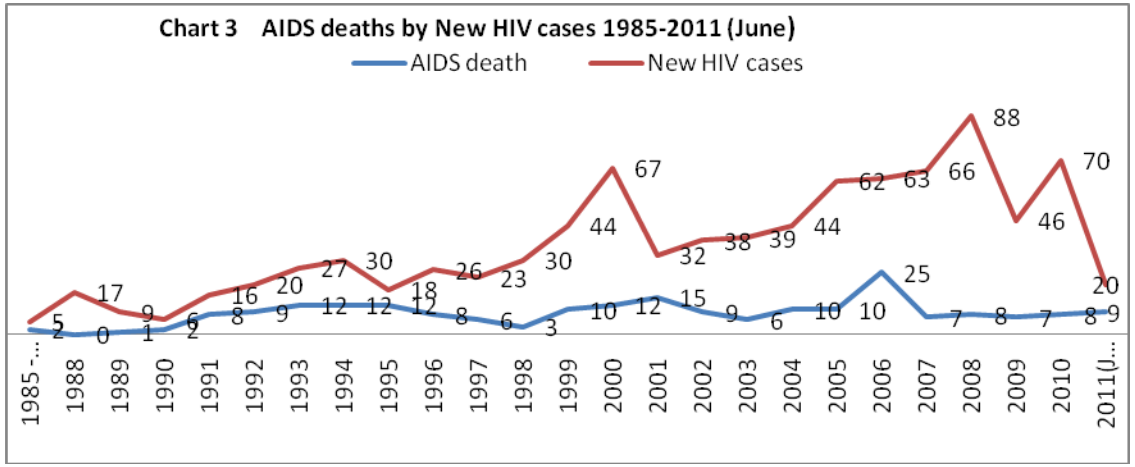
TABLE 3 HIV+ PERSONS BY YEAR AND BY AGE RANGE (2005 – 2010)

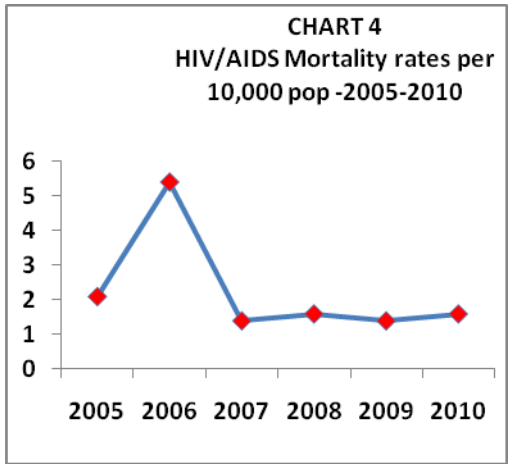
	2005			2006			2007			2008			2009		2010		TOTAL
AGE	M	F	N/S	M	F	N/S	M	F	N/S	M	F	N/S	M	F	M	F	
0 -- 4	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	2	5
5 -- 9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	2
10 -- 14	0	0	0	0	1	0	2	1	0	0	0	0	0	0	0	0	4
15 -- 19	0	0	0	0	0	0	0	3	0	1	4	0	2	2	1	3	16
20 -- 24	3	6	0	0	9	0	2	9	0	6	9	0	1	5	6	4	60
25 -- 29	5	6	1	4	4	0	3	9	0	9	9	0	6	4	3	4	67
30 -- 34	2	5	0	0	10	0	6	6	0	4	8	0	1	4	6	6	58
35 -- 39	5	3	0	2	3	0	3	1	0	7	10	1	4	1	1	3	44
40 -- 44	3	4	0	8	3	0	2	2	0	7	1	1	2	2	3	2	40
45 -- 49	3	1	0	4	0	0	2	2	0	4	4	0	4	2	3	3	32
50 -- 54	3	3	0	1	0	0	6	2	0	1	0	0	3	1	5	8	33
55 -- 59	1	0	0	2	3	0	2	0	0	1	0	0	1	0	2	1	13
60+	1	0	0	2	2	0	1	0	0	0	0	0	1	0	1	2	10
Not Stated	1	1	3	1	0	1	1	0	0	0	0	0	0	0	0	0	8
TOTAL	27	31	4	27	34	1	31	35	0	40	46	2	25	21	33	39	392

Source: Statistics Division – Ministry of Health



The total number of HIV/AIDS related deaths to June 2011 is two hundred and eighty (280), thirty-nine (39) in the last five years at an average of seven-point-five (7.5) deaths per annum - representing a marked decrease since 2005 when twenty-five (25) deaths occurred. (See Charts 3 and 4). The mortality rate over the period is approximately one per ten thousand. Thirty-four (34) persons were hospitalized with advanced HIV infection in 2008 and thirty-one (31) persons in 2009.





Source: Statistics Division – Ministry of Health

There is an unscientific temptation to relate the peak of twenty-five (25) AIDS related deaths in 2006 to the peak of sixty seven (67) HIV diagnoses in 2000 as shown in Chart 3 above. ART notwithstanding, there is a suggestion that a similar peak in deaths should be expected in about 2014 in reaction to the eighty-eight (88) HIV diagnoses of 2008. Again, there is no epidemiological basis for this prediction.

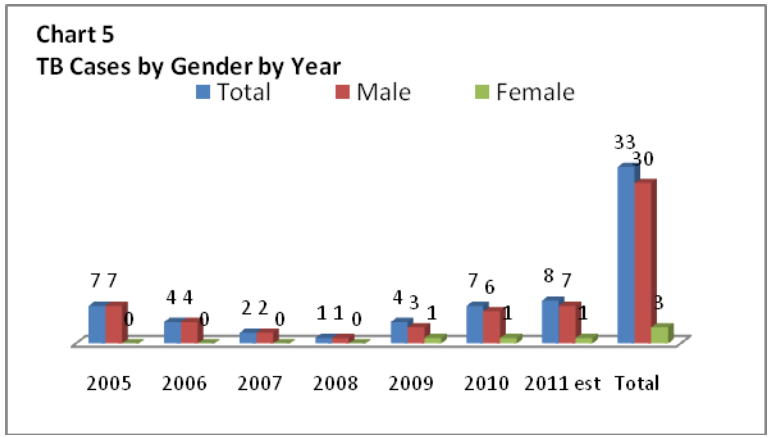
4.1.2. HIV and TB

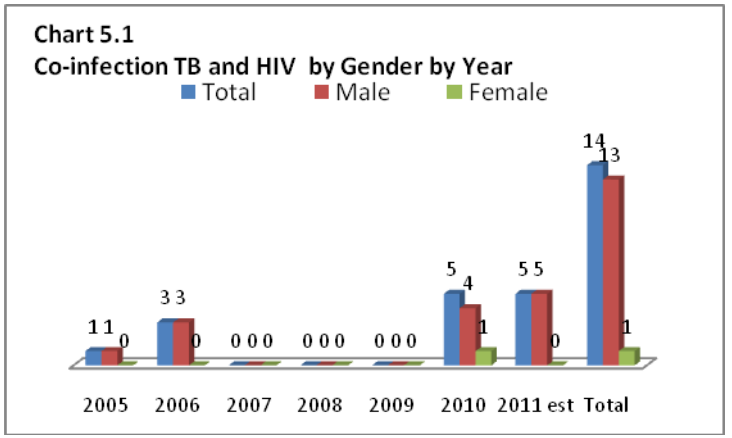
Without treatment and prophylaxis, people living with HIV have a 20–30 times higher lifetime risk of developing active tuberculosis, compared with people without HIV[11]. Charts 5 and 5.1 reflect the issue of the re-emergence of TB in Antigua and Barbuda and the level of co-infection - TB and HIV. They show the reemergence of TB after a decline from 2005 (7 cases) to 2008 (1 cases) to eight (8) cases in 2011 (to date). A total of thirty three cases of TB has been recorded since 2005, ninety percent of which is male.

[11] UNAIDS World AIDS DAY Report 2011

The number of co-infection cases reflect a similar pattern to the number of TB cases where there were three cases in 2006, no cases for the following three years and then five cases in 2010 and 2011 (to date) respectively. In 2010 seventy five percent (75%) of all new TB cases were co-infected, in 2011 (to date) sixty three percent (63%). A total of fourteen (14) cases of co-infection has been recorded since 2005, thirteen of which are male. There has been a total of six deaths of co-infected persons since 2005, two (2) in 2006 and one each year since 2008. All have been male.

Sexual Transmitted Diseases (STI) awareness in a sample population 'was high with 90% of the respondents being familiar with these diseases (KABP July 2011). Despite a high awareness however, thirty-seven (37%) of the respondents were unable to correctly identify the symptoms of STIs. Approximately nine percent (~9%) of the sample of respondents reported having an STI in the last 12 months. Most of these individuals sought advice and assistance from a Medical Facility'[12].





4.2. Vulnerable and Most-at-Risk-Populations

The youth population is identified as vulnerable. The MARPs associated with HIV are those groups traditionally identified in regional and international studies – commercial sex workers, men who have sex with men (MSM) and drug abusers.

[12] HEALTH ECONOMICS UNIT (HEU), UWI: FINAL REPORT: Knowledge, Attitudes, Beliefs and Practices (KABP) Surveys on HIV/AIDS in four OECS Member States (Antigua and Barbuda) July, 2011

Respondents in the KABP Study (2011) identify persons involved with multiple sex partners (33%), homosexuals (22%) and prostitutes (sex workers) (16%) to be most at risk. Those least likely to contract the virus were identified as those who abstained or had one faithful spouse. However, twenty percent (20%) of the respondents also indicated that "Anyone" was most likely to contract HIV/AIDS.[13]

Partnering patterns among those who were sexually active (90%; 85% in the last twelve months) show that seventy percent (70%) was involved sexually with their regular partner; twenty percent (20%) was involved with non-regular partners and two percent (2%) with sex workers. The degree of multiple partnering was found only among male respondents. While both male and female respondents had one regular partner on average, male respondents had an average of more than two (2) non-regular partners[14].

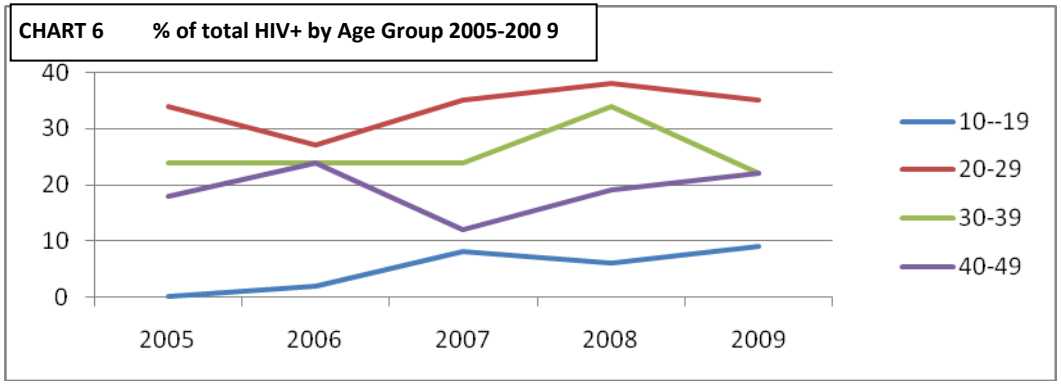
Ten percent (10%) of the respondents said that they had experienced sexual molestation (14% female versus 5% male). Interestingly, more males than females indicated that they did have forced sexual experiences over the past 12 months (3% versus 2%).

Populations made 'at risk' through 'non-behavioral economic, social or environmental factors'[15] are addressed here - to include the prison population and migrants.

4.2.1. Youth

CAREC, noting in 2004 that 'it is overwhelming young people who are getting infected' predicted that 'the data for the past 5 years point towards a worsening of the AIDS epidemic in Antigua and Barbuda[16]. Since 2004, there has been an annual increase in the number of HIV cases until 2008 when a dramatic decrease took place, continuing into 2011. Of interest however that is the percentage contribution from the

CHART 6 % of total HIV+ by Age Group 2005-200 9



[13] Ibid KABP Study
[14] Ibid
[15] PEPFAR Caribbean Regional HIV and AIDS Partnership Framework 2009 – 2013
[16] CAREC Status and Trends Analysis of the Caribbean HIV/AIDS Epidemic 1982-2002, 2004] quoted in Des Cohen: Strengthening The Response to HIV/AIDS in Antigua & Barbuda: http://www.the-philosopher.co.uk/hivdev/wordpapers/hiv-aids-antigua-barbuda.pdf

age groups ten to nineteen (10-19) and forty to forty-nine (40-49) is on the rise when compared to the contributions of other age groups and with the overall number of HIV cases. See Chart 6. There are implications here for HIV prevention programming.

CAREC[18] also pointed to 'evidence relating to youth which supports the proposition of early sexual activity and widespread risky sexual activity, often fuelled by alcohol and soft drugs, within a youth culture that is subject to many external influences that make this group hard to reach through formal programmes'. Table 4 compares the results of three studies – done in 2003 and 2009.

Table 4 Sexual Behaviours Results for students (%) 2003, 2009

	2003[1]			2009[2]		
	Total	Male	Female	Total	Male	Female
Ever had sexual intercourse	34.1	51.9	22.2	36.9	49.2	23.7
Used a condom at most recent intercourse	53.3	59.8	49.6	68.2	67.2	68.6
Age of first intercourse (years) <10	20.6	23.2	16.8	n.a		
11-12	42.8	54.8	23.5			
13-15	28.9	19.3	44.7			
16 and over	7.6	2.7	15.3			
Among students who had sex - % who had 'first time' sexual intercourse before 14 yrs	~71	~84	~55	76.3	82.8	61.5

[1]Source: Caribbean Youth Health Survey, reported in Halcon et al (2003) - Antigua & Barbuda, Bahamas, Barbados, BVI, Dominica, Grenada, Guyana, Jamaica St Lucia

[2] Source: Global School-based Student Health Survey 2009[17]

Results should be seen as indicative only as the studies had different population groups, one was national and the other regional. There is temptation anyhow to suggest that over the period 2003-2009, there is an increase in the percentage of youth who have had sexual intercourse; an increase in the percentage of youth which have had sexual intercourse before their fourteenth birthday; and importantly, a significant increase in the numbers of youth (~15%) who have used a condom at the most recent sex episode. (53.3% vs. 68.2%).

The KABP (2011)[19] paints a different picture. The average age of first sexual experience among respondents was sixteen (16) years. The average age for females stood at seventeen (17), while for males it fell to fifteen (15). The younger age groups across both sexes also tended to be sexually active at an earlier age than the more senior respondents (13 years of age for young males and 16 for younger females).

There is a high concentration of media messages addressed to youth in Antigua and Barbuda urging 'know your status/Get tested', mutually monogamous partnerships and condom use.

[17] Global School-based Student Health Survey: http://www.who.int/chp/gshs/Antigua_2009_FS.pdf

[18] Ibid

[19] HEALTH ECONOMICS UNIT (HEU),Centre for Health Economics, UWI: FINAL REPORT: Knowledge, Attitudes, Beliefs and Practices (KABP) Surveys on HIV/AIDS in four OECS Member States (Antigua and Barbuda) July, 2011

4.2.2. Sex Workers (SWs)

Sex workers are simply defined as 'individuals who are paid money in exchange for sex'[20]. Occasional raids of brothels by the police and the subsequent deportations of illegal residents or operatives indicate that along with nationals, migrants from other CARICOM countries are involved in the sex trade. There are sex workers living in the small Barbuda (1500) population and there is movement by sex workers from Antigua to Barbuda on weekends and festive occasions.

Estimates of the size of the sex worker population in Antigua and Barbuda vary considerably among observers from five hundred (500) to one thousand, five hundred (1500)[21]. Sex workers are found in three well established brothels, a red-light district that harbours street walkers, bars/restaurants, 'tenement yards' located around the city and home-based operations where women 'sell sex from the building or house where they live'. They may also have other occupations (maids, cleaners, shop and office attendants, waitresses etc.).

An HIV tracking study[22] evaluating condom use among Spanish-speaking sex workers (18-45 years) reveals that risk aversion among them is relatively high. Seventy-one percent report consistent condom use and forty-nine percent 'had a condom with them at the time of the survey'. The 2011 KABP reveals that relatively small percentage (2%) of respondents had sexual interactions with commercial sex workers in the past 12 months. Of this group, seventy-one percent (71%) used a condom on the last occasion[23].

The overwhelming majority of Hispanic sex workers understood that they were 'at risk for HIV if I do not use condoms' and felt 'confident asking clients to use a condom'[24]. There is little reason to believe that the knowledge and behaviour of English-speaking sex workers are markedly different – especially taking into account that English is the standard broadcast language of all public education and awareness messages about HIV and AIDS.

[20] A study undertaken by Family Health International (FHI) – August 2002 found at http://www.fhi.org/NR/rdonlyres/ekp62fa3kznvmsn4pqktuhrlkzgtuqwc57zx4piahrkhy36wm3jvmsbleve4f5pgtx6n7etyfpzmje/AAMappingofSWsFinal5Feb03.pdf

[21] The PSI TRac Study in Antigua had a sample size of 322 Spanish Speaking Sex Workers 18-45 years. (See Footnote 15) below

[22] Population Services International: Antigua (2010): HIV/AIDS TRaC Study Evaluating Condom Use Among Spanish Speaking Sex Workers 18-45 years. Round 2

[23] HEALTH ECONOMICS UNIT (HEU), Centre for Health Economics, UWI: FINAL REPORT: Knowledge, Attitudes, Beliefs and Practices (KAPB) Surveys on HIV/AIDS in four OECS Member States (Antigua and Barbuda) July, 2011

[24] Mean responses of 3.95 and 3.98 respectively on a scale of 1-4 (1-Strongly Disagree to 4-Strongly Agree)

4.2.3. Men who have Sex with Men (MSM)

There are no definitive studies on the size of the MSM population in Antigua & Barbuda but recent newspaper reports, quoting a local representative of the Caribbean Vulnerable Communities Coalition (CVCC)[25] suggest that 'the community that is identifiable, numbers about two hundred (200)[26] although estimates from local stakeholder groups puts this number closer to twelve hundred (1200)[27] . Laws that criminalize sodomy or buggery still exist but there is no evidence that they have been enforced in recent history.

Men who have sex with men (MSM) represent approximately 10% of HIV transmission in the Caribbean with rates varying from country to country – estimated low of five percent (5%) to a high of thirty-three percent (33%). CVC research[28] suggests that 'gay, bisexual and other MSM are not accessing healthcare for a range of reasons, including experiences of discrimination, judgmental and moralistic attitudes, outright hostility of healthcare providers, concerns about privacy and confidentiality, shame, lack of healthcare services specific to MSM needs and lack of money to pay for alternative private-sector health care'.

The KABP (July 2011) reveals that four percent (4%) of male respondents had male sexual partners – fifty percent (~50%) of whom had such within the last six (6) months fell in the twenty-five to thirty-nine (25-39) year age group. Sixty-five percent (65%) of all the males who said that they had sex with a male partner reported condom use the last time they had sex; fourteen percent (14%) indicate no use.

Approximately twenty-one percent (~21%) of women stated that they did have anal sex in the past six (6) months. The rate of condom use was not reported.

4.2.4. Drug Users

The use of alcohol and illegal drugs is considered a behaviour that may be associated with influencing the risk for HIV. The 2008 Global State Report researchers have reported a link between non-injecting drug use and sexual HIV transmission in several Caribbean countries…with high HIV prevalence estimates among crack-cocaine-smoking populations[29].

[25] Approximately twenty (20) Caribbean organisations representing the lesbian, gay, bisexual, and transgender (LGBT) communities
[26] Local MSM Community Watching Buggery Law Test Case: http://www.antiguaobserver.com/?p=65027
[27] Communication from Director (Ag) AIDS Secretariat
[28] Caribbean Vulnerable Communities Coalition: A multi-country study on Access to Healthcare 2009
[29] Ibid

A recent report by the Inter-American Drug Abuse Control Commission (CICAD)[30] has found that alcohol and marijuana are the drugs of choice in Antigua and Barbuda. Among students it was found that approximately seventy one (71.1) percent of students admitted to alcohol use in their lifetime compared to a regional average of sixty-eight-point-nine (68.9) percent. However, only forty-nine (49.2) percent said they had used alcohol in the past year. [31] Thirty-one (31) percent of males and four (4) percent of females (ages 15-24) had used marijuana within thirty (30) days of the 2005-2006 BSS Survey[32] interviews. Both genders report low use (>1%) of crack and cocaine. There are no reports of injecting drug use.

Thirty-nine percent (39%) of those interviewed [KABP July 2011] consumed alcohol less than once a week, while thirty-six percent (36%) of the respondents never drank alcohol. Another eight percent (8%) of the persons said that they did this either every day or at least once a day. This was the general pattern of the responses for both males and females and across the different age groups. .

4.2.5. Immigrants

The concept of 'immigrants' as opposed to 'migrant workers' may be more applicable in the Antigua and Barbuda situation where those migrating to the country 'come to live'. It is estimated that approximately thirty percent[33] of the resident population is not native. The last wave of immigration started in the mid-eighties with nationals from other Caribbean countries seeking to fill the vacancies in the rapidly expanding service industries – tourism and financial services in particular. The worsening economy has left many female immigrants unemployed or underemployed. Anecdotally, it is suggested that many – like nationals - are filling income gaps through transactional or commercial sex, increasing their vulnerability to HIV and other STIs.

The national health policies mandate that all residents have equal access to health care and treatment services. However alleged instances of anti-immigrant discrimination by some health providers have been discussed on public media, although not specific to HIV/AIDS services. PANCAP is presently executing a project 'Improving Access of Migrant Populations to HIV Services in the Caribbean' that will enhance both accessibility and the quality of HIV prevention, care, and treatment services for migrant populations.[34]

[30] OAS Inter-American Drug Abuse Control Commission: ANTIGUA AND BARBUDA EVALUATION OF PROGRESS IN DRUG CONTROL 2007-2009
[31] http://www.antiguaobserver.com/?p=64721
[32] Behavioural Surveillance Surveys (BSS) in Six Countries of the Eastern Caribbean States 2005-2006
[33] The 2001 census suggests 18%
[34] Executed by the German Technical Cooperation Agency (GIZ) working in partnership with the PANCAP Coordinating Unit (PCU), that will focus on five pilot countries including Antigua and Barbuda

4.2.6. Prison population

The male prison population has 'frequent movement in and out of the general population'. The KABP (July 2011) reveals that three percent (3%) of those surveyed had been imprisoned.

Recent studies in the OECS[35] show that 'HIV prevalence among male prison inmates was three times higher than the estimated OECS population prevalence'. In Antigua and Barbuda[36] the prevalence rate (2009) was three percent (3.0%) in the prison population. The study did not focus on the risk of HIV infection in prisons although there are indications for the contents of any Condom Policy bearing in mind the United Nations General Assembly Special Session on HIV/AIDS in June 2001 stated that 'the vulnerable must be given priority in the response to HIV/AIDS'. Inmates, with little or no control of their environment, are by definition vulnerable and those who are HIV positive are at risk of stigmatization.[37]

4.2.7. Persons engaged in transactional sex

The KABP (July 2011) reports that only an extremely small percentage of respondents (0.6%) report ever been involved in transactional sex (giving or receiving gifts or drugs) with non-tourists. Two percent (2%) of respondents indicates that it had paid/received gifts for sex from non-tourists. (0.4% in the last thirty days).

4.2.8. Barbuda Programme

The Barbuda population is small (1500), characterized by intimate heterosexual relationships that result in high birth rates. Since 2008, the AIDS Secretariat has established an HIV Outreach Programme in Barbuda that has resulted in:

- 2008: Two visits resulting in 96 persons tested – all negative. Three condom outlets established. Two education sessions staged
- 2009: Two visits - each staging HIV Awareness sessions, free and confidential HIV test. World AIDS Day activities that included three HIV Awareness sessions, an HIV Provider Initiated Counselling and Testing (PICT) Workshop (20 participants), free HIV Counselling and Testing and a march through the streets of Codrington.

[35] EV Boisson; C Trotman: HIV sero-prevalence among male prison inmates in the six countries of the organization of eastern Caribbean States in the Caribbean, West Indian Medical Journal vol.58 no.2 Mona Mar. 2009 http://caribbean.scielo.org/scielo.php?script=sci_arttext&pid=S0043-31442009000200006&lng=en&nrm=iso

[36] Ibid - A third of the 163 inmates…refused to participate…limiting the ability to generalize the results to the whole prison population

[37] Lines R.: HIV infection and Human rights in prison. In Møller L, Stöver H, Jürgens R, Gatherer A. and Nikogosian H. eds. WHO Regional Office for Europe. Health in prisons. A WHO guide to the essentials in prison health; 2007: 61–70.

- 2010: Three HIV Awareness sessions, free and confidential HIV test (80 persons tested) and World AIDS Day activities similar to 2009 where an additional 78 persons tested.
- 2011 (to date): HIV Outreach continued; Pre-regional HIV Testing Day 2011 in May, Two education sessions - 78 persons tested. A visit is scheduled for WORLD AIDS Day in December.

The situational analysis associated with this NSP process however revealed a gap in the transfer of information between focal persons in Barbuda and the Barbuda Council and a lack of bureaucratic involvement in the HIV response. The Church position calls for abstinence although admitting that its message is possibly 'falling on deaf ears'. The condom uptake is mainly through females attending Child Care clinics but the supply is insufficient and there are occasions when the clinic is unable to meet the demand. There is a sex trade in Barbuda – there are resident operatives and sex workers from Antigua who travel there on weekends and festive occasions.

There is a lack of confidence in the confidentiality of the small health system and a concomitant fear of stigmatization in the small population.

4.3. Stigma and Discrimination

The KABP[38] study revealed that in the sample population there was:

- a consistent trend in the willingness to care for both male and female relatives with HIV (between 67% and 70%).
- a willingness to attend schools with students with HIV (86%) and support for an HIV positive teacher to continue on the job was also significant (80%).
- a willingness to work along with a co-worker who was HIV positive (80%). The tolerance level in each case was significantly higher among women.

The study indicated however that there was less willingness to engage in activities that entailed closer or more direct interaction with a PLHIV, such as purchasing food items directly from a shopkeeper who was HIV positive (30%). This was further reflected in a mere fifty-eight percent (58%) of respondents who were willing to share a meal with a PLHIV.

Acts of discrimination, abuse or denial of access to services or social events on the basis of one's HIV status were identified by between ten percent (10%) and sixteen percent (16%) respectively of the respondents. In spite of the small percentage of persons

[38] HEALTH ECONOMICS UNIT (HEU), UWI: FINAL REPORT: Knowledge, Attitudes, Beliefs and Practices (KABP) Surveys on HIV/AIDS in four OECS Member States (Antigua and Barbuda) July, 2011

reporting these acts, just over one half of the respondents were nevertheless inclined to keep secret any family member who was HIV positive. This tendency was driven largely by 'Shame and Fear' of being ostracized or discriminated against.[39]

5. FINANCE

The NAP is financed from two main sources of funds – the Antigua and Barbuda Government and the OECS Global Fund Project. Table 5 shows the annual allocations 2008 – 2010 and the corresponding amounts expended. In total, just over one million US dollars (US$1,091,238) have been expended by both organizations on the NAP in Antigua and Barbuda.

Table 5 DOMESTIC & INTERNATIONAL AIDS SPENDING BY CATEGORIES & FUNDING SOURCE US$

	GOVERNMENT		OECS GLOBAL FUND PROJECT		TOTAL	
Year	ALLOCATED	EXPENDED	ALLOCATED	EXPENDED	ALLOCATED	EXPENDED
2008	287,603	260,213	163,081	131,501	450,684	391,714
2009	260,649	259,259	133,212	133,212	393,861	392,471
2010	254,352	141,347	165,706	165,706	420,058	307,053
2011(Est)	318,530	n.a	6,852	6,852	325,382	n.a

Source: AIDS Secretariat, Ministry of Health, Social Transformation and Consumer Affairs

Government funds are applied to wages and salaries and allowances; office supplies and audio-visual material, testing equipment, and training workshops. Global Fund funds have been applied to the employment of five PLWHAs in national public education programme; payment for ARV medications; treatment for opportunistic infections and specialized medical services; payment for nutritional supplements and replacement formula in the PMCT programmes; rent for AIDS Secretariat offices, and training and workshops.

The NAP is supported by PEPFAR[40] with its overarching purpose 'to reduce HIV and AIDS incidence and prevalence in the Caribbean region, build the capacity of national governments to develop and maintain sustainable, comprehensive and effective national HIV and AIDS programs and strengthen the effectiveness of regional coordinating agencies to provide quality, cost-effective goods and services to bolster national HIV and AIDS programs.' PEPFAR was designed to support the realization of the CRSF (2008-2012) through technical assistance contributions to the improvement or scale up of services and systems for institutional strengthening and human capacity development. The identified areas for interventions include HIV Prevention, Strategic Information and Laboratory Strengthening.

[39] Ibid

[40] A Collaborative Effort Of The United States' President's Emergency Plan For AIDS Relief (PEPFAR) To Support The Caribbean Regional Strategic Framework On HIV and AIDS (2008 – 2012)

6. IMPACT OF PROGRAMMES

In addition to the epidemiological changes noted in the document, a number of important advances have been noted. These are discussed below.

6.1. Integration of HIV/AIDS Services

There are current programmatic efforts in the Ministry of Health to integrate HIV/AIDS services into the primary and secondary care system. There is public support for such efforts. Seventy six percent (76%) and seventy-four percent (74%) of the KABP[41] respondents respectively expressed their willingness to share both medical personnel and facilities with PLHIV. An additional seventy-seven percent (77%) was in favor of PLHIV accessing their HIV medication at these facilities, while seventy-three percent (73%) was in support of PLHIV testing being done at their PHC facilities. Fewer respondents (65%) were however in favour of the children of PLHIV being treated at the same clinic as their children. Male respondents, as well as those in the younger age groups were less accommodating to PLHIV accessing PHC services[42] (KABP July 2011).

Almost all of the respondents (97%) said that they knew of a site where they can get treatment and care for HIV/AIDS. The majority of the respondents (78%) said that if they had an option, they would seek "Private Care" with only twelve percent (12%) opting for 'Public care'. 'Confidentiality' (36%) and 'knowing someone who worked there' (15%) were the main reasons why respondents shunned care in the public sector

6.2. Knowledge of HIV/AIDS

Knowledge of HIV/AIDS was found to be extremely high in Antigua and Barbuda with ninety-nine percent (99%) of respondents having heard of both HIV and AIDS. This high awareness was consistently recorded across key demographic variables, age and sex of respondent. A significant seventy-two percent (72%) of the respondents saw the epidemic as either very serious or reaching crisis stage in the country. Women were more inclined to see the situation as a serious one than their male counterparts. Roughly seventy-six percent (76%) of the respondents identified HIV as different from AIDS[43].

[41] HEALTH ECONOMICS UNIT (HEU), UWI: FINAL REPORT: Knowledge, Attitudes, Beliefs and Practices (KABP) Surveys on HIV/AIDS in four OECS Member States (Antigua and Barbuda) July, 2011
[42] Ibid
[43] Ibid

The findings however point to some persisting misconceptions on this issue, as reflected one third (33%) of respondents who expressed the view that the virus can be contracted by kissing a PLHIV. Having food or drink prepared by an HIV positive person, using the same toilet facilities or being coughed or sneezed on by a PLHIV were also among the persistent myths related to ways of contracting the virus. Eleven percent of the sample felt that there was a cure for HIV/AIDS. For twenty-seven percent (27%) of this group Antiretroviral (ARVs) were identified as the cure. Prayers and Bush/Folk Medicine were also mentioned by seventeen percent (17%) and seven percent (7%) respectively of this group.

Awareness of the key modes of transmission of the virus was generally high with sexual intercourse, followed by blood transfusion, injecting drugs and Mother to Child Transmission (MTCT) being the most mentioned. There was also generally high level of awareness of the ways to avoid contracting HIV/AIDS. Consistent condom use, commitment to one faithful partner and abstinence were among the more frequently mentioned methods.

A majority (72%) of respondents said that in its normal course of life it either had no chance or little chance of contracting HIV. A further nine percent (9%) thought that it either had a good chance or moderate chance of contracting HIV. Eighteen percent (18%) of the respondents either were unsure of this or gave no response. More males than females thought that they had a good chance or moderate chance (10% versus 8%). For males, the twenty-five to thirty-nine (25-39) year olds (13%) was most likely to answer this way, while for females, the twenty to twenty-four (20-24) year olds (9%) were most likely to do the same.

6.3. Sexual Behaviour

Ninety percent of the respondents (KABP July2011) had engaged in some form of sexual intercourse (oral, vaginal or anal penetrative sex) with more males than females doing so (92% versus 89%). Those in the 25-39 years age group for both sexes were most likely to have had sex (males: 99% and 98%: females).

The majority of persons (97%), who did have sex in the past 12 months said that they did not knowingly have unprotected sexual intercourse with an HIV positive person however point-four percent (0.4%) - all females between 15-39 years of age - stated that they did have such a sexual encounter.

6.4. Behaviour Change

Fifty nine percent (59%) of respondents in the KABP (July 2011) reported behavior change as a result of receiving information about HIV/AIDS; twenty-eight percent (28%) said they did not while six percent (6%) stated that they were not sexually active. The

remaining seven percent (7%) of the sample population either did not know if they had done so or gave no response. Further investigation revealed that when disaggregated by age, those in the twenty-five to thirty-nine (25-39) age group were more likely to alter their sexual behavior than persons in the other age groups. This trend is consistent for both males and females.

Respondents, who reported behavior change as a result of hearing about HIV/AIDS, identified the number of sexual partners and condom use as the main areas in which this change occurred. Forty four percent (44%) stated that they only had one sexual partner now; sixteen percent (16%) indicated that they abstained from sex – twenty-percent (20%) among females and twelve percent (12%) among males; forty-three percent (43%) reported always using condoms during sex; and nineteen percent (19%) stating that they use condoms more often. Consistent condom use was highest in the youngest age groups for both males and females.

6.5. Condom Use and Access

6.5.1. Condom Use

Consistent condom use was identified by respondents in the KABP (July 2011) as the main way of avoiding the contracting of HIV/AIDS. Awareness of the male condom was very high (99%), while eighty-four percent (84%) of the respondents had either used it in the past, or was present users. Approximately half of both males and females stated that they used a condom every time (males: 47% and females: 48%). Percentage usage was highest among the fifteen-to-nineteen (15-19) year olds.

Fewer respondents knew of the female condom however, with a mere forty-six (46%) admitting to have seen it but not use it, and a further twenty-nine percent (29%) heard of it but never saw it. The likelihood of use was also low with just eleven-point-five percent (11.5%) expressing an interest in doing so. The KABP also revealed:

- Condom use with regular partners was relatively low with thirty-eight (38%) of respondents indicating the use of condoms at their last sexual encounter. It was higher among the younger respondents with regular partners. The low perception of risk associated with being in a faithful monogamous relationship was given in fifty-nine percent (59%) of the cases as the reason for not using a condom. Of those who had sex with his/her regular partners over the past year, forty-seven percent (47%) indicated that it used a condom every time while forty-three (43%) indicated that it did so either almost every time or sometimes. The remaining ten percent (10%) stated that it never used a condom, was unsure or did not give a response.
- Condom use with non-regular partners, while higher, was still relatively low, with 65% of the respondents indicating that they were used. Approximately twenty-eight percent (~28%) of the respondents who did not use condoms with their non-regular

sexual partners did so on the premise that they considered the relationship as a faithful, monogamous one and so one that is perceived as low risk.

- Thirty- two percent (32%) did not think condoms were necessary. Fourteen percent (14%) of this group also cited a dislike for condoms as their reason for not using them, while in eleven percent (11%) of the cases the unavailability of a condom was given as the reason for not using one.

6.5.2. Access to Condoms

Condoms are available free of cost at government Health Centres, CHAA and the AIDS Secretariat. They are sold at pharmacies, supermarkets, places of entertainment, the Antigua Planned Parenthood Association and through PSI/SFH. Standard drug kits for managing STI are provided by the MoH. Condoms are also distributed free of cost at national events and festivities such as Carnival, Sailing Week etc.

The KABP shows that the majority of the respondents (95%) knew either a place or person from where they could obtain condoms. 'Pharmacy' was the dominant response, followed by 'Supermarket', 'Shop' and 'Clinic'. Notably, seven percent (7%) of the respondents identified the 'Bar' and/or 'Guest House/Hotel' as a place where they could obtain a condom. Additionally, ninety one percent (91%) of the sample reported that it would take less than one hour to obtain a condom from a source which is close to their homes or places of work.

6.6. PMTCT

Knowledge of MTCT is relatively high. Eighty-six percent (86%) of respondents in the KABP (July 2011) indicated that a pregnant woman infected with HIV can pass the virus to an unborn child, eight percent (8%) said no, while six percent (6%) were either unsure or gave no response. This was the general pattern for both the male and female responses. Seventy three percent (73%) of the sample confirmed that HIV can be transmitted to a newborn baby through breastfeeding was while ten percent (10%) indicated that this was not possible.

Table 6 # HIV+ Women Receiving ARV Drugs - PMTCT Programme Ante-Natal Clinic MSJMC 2008-2010

	2008	2009	2010
No. of patients seen at Antenatal Clinics	1310	1119	974
No. tested before Antenatal Clinics attendance	879	818	791
No. of patients pre-test counseled for HIV	234	171	123
No. of patients tested for HIV	233	171	121
No. of patients testing positive for HIV	2	0	0
No. of patients on ARV	2	2	1

Source: AIDS Secretariat, Min. Health, Social Transformation and Consumer Affairs

The PMTCT programme initiated in 1999 in the antenatal clinic at the Holberton Hospital, has achieved interventions with ninety-nine percent (99%) of pregnant women during the last three years (2008 – 2010). It has provided them and their partners HIV testing and if there is need, antiretroviral drugs at no costs. HIV-positive mothers are given the option of a Caesarian Section delivery. They are also offered free infants formula and discouraged from breast-feeding. See Table 6.

6.7. Anti-Retroviral Treatment

ARVs for HIV+ patients are currently obtained through the Organization of the Eastern Caribbean Pharmacy Procurement Service (OECS PPS), a cooperative purchasing arrangement using Global Fund monies, and distributed through a single point of service at MSJMC.

- In 2008, there were one hundred and five persons with advanced HIV, who started taking ART. Fifty-six (56) clients completely adhere to their medication. [44] Currently, one hundred and twenty three (123) patients are receiving ARVs. The number of people who died, stopped treatment or was lost to follow up in 2008 is forty-nine (49).
- In 2009, there were one hundred and twenty-six (126) adults and children with advanced HIV under treatment. The number of adults and children with HIV who received and continued ARV's is ninety eight. The number of people who died, stopped treatment or was lost to follow up is twenty eight (28).
- In 2011 (July), there were one hundred and seventy-five (175) persons living with AIDS who were under treatment.

6.8. Voluntary Counseling and Testing

VCT services are available free of cost at all community health centres, the AIDS Secretariat, Antigua Planned Parenthood, and the laboratory of the public hospital in Antigua and Barbuda. HIV testing is provided at private medical offices and private laboratories also. Nurses in the public health centres have been trained to provide voluntary counselling and testing.

(KABP Study, July 2011) reflects that almost all of the respondents (97%) said that they could name a specific place where HIV testing is done in their community. This was the general consensus across the different age groups for both sexes. In addition:

[44] Report from the Clinical Care Coordinator's Office 2010

- Approximately sixty-five percent (65%) of the respondents had ever done an HIV test in the past. Females were much more likely to have been tested than males (72% versus 55%). Of those who took the test, forty-five percent (45%) did so because it was mandatory. In twenty-seven percent (27%) of the cases the tests were required for medical purposes.
- Respondents tended to favor private care over public care when in need of testing services (78% versus 12%).
- Pre-test counseling was received by thirty-eight percent (38%) of respondents who said that they had done an HIV test. On the other hand, 59% was not counseled. In a similar manner, a higher percentage of persons did not receive post-test counseling as opposed to those who were counseled.

6.9. Laboratory Services

There is one public health laboratory (a department of the Mount St. John's Medical Centre (MSJMC), the only public hospital in Antigua) and four private laboratories. All donated blood units received in 2008 and 2009 were screened for HIV. Table 7 refers.

However, 'a significant forty percent (40%) of the sample also mentioned giving blood as a possible way of contracting the virus, while 18% identified having a blood test. This needs to be noted, as it speaks to a possible area of concern as it relates to perceived safety of the blood banks and may be reflected in a general reluctance in wanting to donate blood.'[45]

Table 7 # OF BLOOD UNITS COLLECTED AND SCREENED – 2008 - 2010

	2008		2009		2010	
SOURCES OF REFERRAL	**Blood screened**	**HIV +**	**Blood screened**	**HIV +**	**Blood screened**	**HIV +**
Blood donors	912	0	907	1	1914	4
Fb STI patients	71	0	11	3	150	6
Antenatal clients	275	0	276	3	651	3
Insurance clients	1354	0	1308	17	9	1
Total	2612	0	2502	24	2724	14

Source: MSJMC Laboratory quarterly report, Min. of Health, Social Transformation and Consumer Affairs

6.10. Findings On Programming Response

The monitoring and evaluation systems in the NAP are weak. However, although the plans and programmes have not been formally evaluated, stakeholders at recent consultations identified successful interventions and programmes, inter alia:

- Important advances in care, support and treatment

[45] HEALTH ECONOMICS UNIT (HEU), UWI: FINAL REPORT: Knowledge, Attitudes, Beliefs and Practices (KABP) Surveys on HIV/AIDS in four OECS Member States (Antigua and Barbuda) July, 2011

- Improved dissemination of education and information on HIV and AIDS
- Improved access to prevention services
- Strengthening of supportive health systems including an effort to develop a tracking system
- Deeper involvement of stakeholders in decision making and programming.

THE NATIONAL STRATEGIC PLAN (NSP) DETAILS

7. PLANNING PARAMETERS AND STRUCTURE

VISION

A nation united in its efforts to upscale its response to HIV and AIDS through the sustainable execution of information, education and prevention programmes and the provision of accessible and affordable treatment, care and support services.

MISSION

To substantially reduce the spread and impact of HIV in Antigua and Barbuda through sustainable systems of universal access to HIV prevention, treatment, care, and support.

GOALS

- By 2016, to reduce the estimated number of new HIV infections by 33% of last three year average[46].
- By 2016, to reduce mortality due to HIV by 33% of last three year average[47].
- By 2016, to achieve 100% confidential referrals of all requesting PLHAs to appropriate national socio-economic support agencies.

8. GUIDING PRINICIPLES

8.1. Commitment To Regional And International Commitments, Goals And Principles

- International

Antigua and Barbuda is signatory to and compliant with the major international and regional protocols and agreements dictating a national response to the HIV and AIDS epidemic. There is policy recognition of the renewed UNGASS Declaration of Commitment on HIV/AIDS that labeled the epidemic as 'a global emergency and one of the most formidable challenges to human life and dignity' and further that HIV/AIDS is a national developmental issue that requires the integration of HIV and AIDS policy and programmes into national development plans.

[46] New infections for 2009=46; 2010 = 70 and we assume 40 for 2011 (20 up to June 2011). The latter figure will be revised when 2011 final figures are available. Sum of new infections over the last three years = 156; Average is 52 - minus 33% which is 17 = 34 cases

[47] (Same as above – average 8 minus 33% which is 3) = 5 deaths

The Government subscribes fully to the Millennium Development Goal of 'fighting disease epidemics such as AIDS' and its specific objectives of 'have halted by 2015 and begun to reverse the spread of HIV/AIDS; and 'achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it'.

The NSP is designed within recognition of the UNGAS call on 'every country to set in 2006 [and beyond] ambitious AIDS targets that reflect the urgent need to massively scale up HIV prevention, treatment, care and support and move as close as possible to the goal of universal access.' It accepts the "Three Ones" principles[48] as the appropriate organizational framework for scaling up access to services. It complies with the Global Fund concepts of country ownership and performance-based funding through the establishment of a national coordinating mechanism for the sourcing and management of Global Fund grant funds.

- Regional

Government is firmly committed to the Caribbean Cooperation in Health (CCH lll) as established by the Heads of Government/CARICOM Secretariat and the implementation of the regional health framework for HIV and AIDS through the joint regional actions of PANCAP. As such, this NSP mirrors closely the health framework established in the PANCAP Caribbean Regional Strategic Framework on HIV and AIDS (2008 – 2012). The goals of the CRSF are adapted, as are its six priority areas with associated strategic objectives and expected national results

Government shares the vision enunciated by the PANCAP Model Condom Policy of protecting 'the rights of all sexually active people in the Caribbean by creating an environment which enables them to acquire condom related information and skills, and access and use condoms as an option to prevent the transmission of STIs, including HIV and undesirable pregnancies.

8.2. Implementation of National Policy

The HIV & AIDS response is guided by the following national policies:

- **The Antigua and Barbuda National Health Policy (1994)** which commits the Government to 'health for all' through the primary care approach; recognizes 'sexuality' as a determinant of healthy lifestyles and promotes the basic principles for

[48] One agreed AIDS action framework that provides the basis for coordinating the work of all partners; One national AIDS coordinating authority, with a broad-based multi-sectoral mandate; One agreed country-level monitoring and evaluation system.

universal access, namely that services have to be equitable, accessible, affordable, comprehensive and sustainable over the long term.

- The **National AIDS Programme Policy (**1997) which recognizes HIV as 'a threat to the public's health and well being'; confirms Government's commitment 'to work collaboratively and in a sustained manner with all sectors – nationally, regionally and globally, to reduce the threat and impact of this infection in public health, and assigns responsibility to the Ministry of Health – as priority – for facilitation and promotion of 'those information, education and management services which are known to reduce their (sexually transmitted diseases) incidence and prevalence'.

- **HIV/AIDS in the Workplace Policy** which supports 'an HIV infected employee in a positive and non-discriminatory manner by establishing rules relating to employment, retention, termination and confidentiality.

- **National Policy on Health and Family Life Education (HFLE)** which approves 'age-appropriate instruction on 'human sexuality' and aims to ensure that 'children and youth will be empowered to make life-enhancing choices and carry them into adulthood'.

National HIV/AIDS related policies need to be updated, monitored and evaluated in light of new directions at the global and regional levels and the relatively long periods since they have been initiated.

8.3. Universal Access

The basic principles of 'universal access' direct the design and implementation of health services programmes. The principle, reinforced by regional and international HIV and AIDS policy, is the bedrock of the national health policy and the national AIDS programme policy mandating the continuous scaling up of access to health care through the provision of services that are 'equitable, accessible, affordable, comprehensive and sustainable over the long term'.

8.4. Multi-Sectoral Approach

The successful implementation of the strategies of this plan requires multi-sectoral cooperation and collaboration. MoH is identified however as the lead implementation agency with the responsibilities for the operationalization of actions plans. In instances where the achievements of targets are external to MoH control, its primary responsibility is negotiating and lobbying for national policy

decisions that direct HIV and AIDS response actions in other Ministries, civil society and the private sector. The AIDS Secretariat will offer technical support to relevant agencies requesting such and will promote joint programme execution, where applicable.

8.5. Gender

The leadership of the NSP recognizes fully the need to mainstreaming gender thinking throughout the HIV and AIDS response, in both policy and programme. The plan mandates the AIDS Secretariat to lobby and negotiate with the Division of Gender Affairs (DGA) the inclusion of relevant HIV and AIDS data and information in its gender advocacy programmes. DGA leadership ensures gender sensitivity in behavioral change messages, enhancing their effectiveness. The skills for improving the negotiating skills of women about sex, condom use, domestic violence and other similar issues are located in the DGA. The issue of the 'feminization' of the epidemic in Antigua and Barbuda will be explored.

The Ministry of Health will continue to ensure the reduction of the risk of HIV transmission to newborns and concomitantly offer treatment, care and support services to mothers.

9. PRIORITY AREAS FOR ACTION (2012 – 2016)

The priority areas identified in this NSP are consistent with those identified in the Caribbean Regional Strategic Framework (2006 – 2012) with the exception that a priority area 'Institutional Systems Development' is proposed to incorporate capacity development needed to maintain existing services and implementing new ones, institutional systems development particularly for 'monitoring and evaluation' development, and supplies management. The resulting six priority areas, which form the core of the Antigua and Barbuda NSP (2012-2016) are as follows:

- Priority area 1: Promote an enabling environment that fosters universal access to HIV prevention, treatment, care and support.
- Priority area 2: An expanded and coordinated multi-sectoral response to the HIV epidemic
- Priority area 3: Prevention of HIV transmission
- Priority area 4: Treatment, care and support
- Priority area 5: Institutional Systems Development.
- Priority area 6: Barbuda Programme Development

9.1. PRIORITY AREA 1: Promote an enabling environment that fosters universal access to HIV prevention, treatment, care and support.

The existing delivery of HIV and AIDS health services at the MSJMC, the office of the Clinical Care Coordinator and at all health centres provides an equitable distribution of accessible services to the various main population centres of the nation. Practical application of 'universal access' principles has been challenged by cost recovery efforts in the health sector.

The provision of accessible care to HIV and AIDS patients is also challenged by the prevailing stigma and discrimination (S&D) against MSMs, and against persons who have contracted HIV. The plan recognizes the two aspects of S&D as connected but yet separate issues. There are no specific indicators to suggest that the removal of S&D against MSMs would improve their preparedness to access HIV and AIDS services beyond the rates established for the general population. Programme focus on the mitigation of S&D associated with HIV and AIDS is planned for it is recognized that the both attitudes deter people from getting tested, from accessing treatment and care or disclosing their status to partners.

The plan promotes the further inclusion of HIV and AIDS services in existing general health services and the requirement of adequately prepared health workers to manage their expanded roles. The imperative of providing continuous sensitization and training of all health workers is addressed.

9.2. PRIORITY AREA 2: An expanded and coordinated multi-sectoral response to the HIV epidemic

The plan seeks to deepen the influence of the multi-sectoral approach by lobbying Cabinet for the establishment of the National AIDS Advisory Commission and enhancing the outreach programmes of the AIDS Secretariat particularly in the workplaces of the tourism and construction sectors.

The multi-sectoral approach also mandates the inclusion of representatives of vulnerable groups in the policy making, programme design and implementation, and monitoring and evaluation actions of the Ministry of Health and the AIDS Secretariat.

9.3. PRIORITY AREA 3: Prevention of HIV transmission

The prevention of new HIV infections is the primary goal of the national HIV response. The plan recognizes that the main mode of transmission of HIV in Antigua and Barbuda is through unprotected sex, whether this unprotected sex occurs between heterosexual couples, between commercial sex workers and their clients, between men who have sex with men, among youth, between those involved in transactional sex or other circumstances.

The plan therefore promotes the acceptance and implementation of the PANCAP Condom Policy; its associated programmes ensuring condom access to the entire population; and information and educational programmes promoting safer sex – the reduction in the numbers of sexual partners and correct and consistent use of male or female condoms.

Community based provision of Voluntary Counselling and Testing services and programmes aimed at the prevention of sexually transmitted infections will be intensified. A standardized database for the capture of HIV testing data needs to be established so as to enable the analysis of the impact of standard media messages urging regular testing, for there is evidence in other studies that negative results may reinforce risk behaviours. This evidence is based on the assumption that persons who need to test regularly are those who continue to be engaged in risk behaviours.

The prevention of mother to child transmission services and post exposure prophylaxis will be continued. Blood safety will be maintained.

Behaviour change through information and education programmes remains the major focus of HIV prevention efforts. Work will be intensified in the school system through expansion of HFLE programmes; and in workplaces – particularly those of the tourism and construction sectors. The design of messages will be reviewed in effort to improve their relevance and potential to change or at least modify traditional and cultural sexual beliefs and behaviours. The use of the mass electronic media and printed materials will be continued. Supply management efforts will be improved to ensure the continuous availability of commodities and IEC materials at all appropriate sites and for distribution at recreational and other crowd/group activities.

The role of stakeholders in community education and empowerment in either leading or supporting behaviour change efforts is promoted in this plan.

9.4. PRIORITY AREA 4: Treatment, Care And Support

Significant gains have been made over the last five years in providing diagnostic services, HIV voluntary counselling and testing services, access to antiretroviral medications and PEP, specialized clinical service and psycho-social and physical support - generally through collaborative efforts with the NGO community. The NSP focuses on the enhancement of these services with efforts to ensure their sustainability and to fill existing gaps.

The NSP specifically addresses:

- The need to improve the percentage of HIV positive patients accessing ARV. Approximately twenty percent (20%) of children and adults with HIV have either stopped treatment or was lost to follow up (2009).
- The strengthening of the clinical care team led by the Clinical Care Coordinator with focus also on the treatment of STIs and Opportunistic Infections (OI).
- Actions to counter existing stigma and discrimination as a barrier to accessing regular care by improving partnerships with private physicians to enable the treatment of PLWHA in private settings. Physicians will also be encouraged to fully report HIV and AIDS statistics encountered in their practice.
- Wider distribution of protocols to health workers on post-exposure prophylaxis and its availability for the prevention of HIV transmission through accidentally exposure.
- The linkages between STI and TB programmes and the NAP will be strengthened with the aim of ensuring that all HIV positive persons are screened for these diseases and that treatment services are available if positively diagnosed.

The improvement of systems for drugs and commodity procurement and distribution will be addressed under the 'Institutional Systems Development' priority area; as are the requirements for human resources development to meet the demands of new and expanded services in both the clinical and administrative areas as the integration of HIV and AIDS response services into the general health system is deepened.

NGOs and FBOs will be encouraged to provide support to HIV related orphans and vulnerable children, and to dependents of PLHIV and deceased HIV positive persons. A monitored confidential referral system will be established between them, the national social safety network and the AIDS Secretariat.

9.5. PRIORITY AREA 5: Institutional Systems Development

The NAP has become more complex over the last decade as new strategies, treatment and care regimes and support mechanisms are introduced. There is priority need to scale up the institutional capacity of the AIDS Secretariat and stakeholders in the Government sectors and civil society to:

- Fully integrate HIV and AIDS services into the general health services
- Implement an information system for monitoring and evaluation of the NSP and its programme components
- Conduct local research and collate and disseminate relevant research results from Caribbean countries
- Improve capacity to negotiate for financing

9.6. PRIORITY AREA 6: Barbuda Programme Development

The AIDS Secretariat is active in Barbuda through its visits promoting behaviour change strategies and VCT but there seems to be a disconnect between the NAP and the political leadership (Chairman of Council and the Health Committee) which is not fully knowledgeable or informed of the status of the HIV epidemic in the island or the activities of the AIDS Secretariat.

Strategies under this priority area promote institutional development and improvement of information flows along with the enhancement of existing programme activities.

10. PRIORITY AREAS and Strategic Objectives

The following Tables (8-13) detail the strategic approach to the implementation and evaluation of the objectives of the priority areas.

Table 8	STRATEGIC OBJECTIVE	EXPECTED NATIONAL RESULTS	INDICATORS
PRIORITY 1: **AN ENABLING ENVIRONMENT THAT FOSTERS UNIVERSAL ACCESS TO HIV AND AIDS PREVENTION, TREATMENT, CARE, AND SUPPORT SERVICES;**	**1.1: To develop policies, programmes, and legislation that promote human rights, including gender equality, and reduce socio-cultural barriers in order to achieve universal access.**	▪ Legislation that addresses issues related to the legal, ethical, and human rights of those infected with, or affected by HIV. ▪ National AIDS policy and delivery systems that ensure all residents have access to HIV services reviewed, enhanced and implemented ▪ NGOs providing HIV and AIDS services are supported to implement best practice guidelines. ▪ Confidentiality for clients strengthened through national policies on privacy and confidentiality. ▪ Participation of vulnerable groups in the response to HIV Increased.	• **Increased utilization of HIV prevention services to include VCT, PMTCT & Condom uptake** • **Increased utilization of HIV and AIDS treatment, care and support services**
	1.2: To mitigate the stigma and discrimination associated with HIV and AIDS	▪ Integration of HIV and AIDS services into the general health system ▪ Confidential access to available services enhanced and promoted ▪ The advocacy of national opinion leaders for the human rights of persons living with HIV and AIDS secured ▪ Support the stakeholders in the human rights movement (3H; Associations of MSM, SWS, PLHA). ▪ Promotion to Cabinet for the endorsement of the draft amended HIV in the Workplace Policy [Also 1.3]	
	1.3: To reduce the economic and social vulnerability of households	▪ Policies and interventions introduced into social safety network to further reduce the social and economic impact of HIV on PLHIV households. ▪ Confidential referral systems and networks of social agencies and organisations to facilitate access for PLHIV and others in need to social support programmes enhanced.	▪ **Confidential referrals of all requesting PLHAs to appropriate national socio-economic support agencies**

Table 9	STRATEGIC OBJECTIVE	EXPECTED NATIONAL RESULTS	INDICATORS
PRIORITY AREA 2: AN EXPANDED AND COORDINATED INTER-SECTORAL RESPONSE TO THE HIV/AIDS EPIDEMIC	**2.1: To enhance the ownership of national HIV programmes and the responsibility for driving the response to the epidemic.**	• National HIV programmes organised in keeping with the U.N. "Three One's" principle. • National financial contributions to HIV programmes increased. • HIV responses included in all relevant sectoral development plans with the aim of achieving a sustainable national response.	• **Levels of improvement in all elements of 'Universal Access** • **NAP structured on the "Three Ones" principle** • **HIV policies, programmes, & services integrated in Education, Health and Labour sectors.**
	2.2 To strengthen the multi-sectoral response to HIV, including involvement of key government ministries, NGOs, CBOs, FBOs, PLHIV networks, the private sector, trade unions, & vulnerable groups.	• National multi-sectoral AIDS Commission revitalized as a central coordinating mechanism. • Capacity developed within each sector to effectively participate in the national response and to develop and integrate HIV policies, programmes, and services within their sector. [See 5.2] • Support groups and networks of PLWHA and most-at-risk populations empowered to be effective advocates, partners and leaders. [See 5.2]	• **Levels of representation and participation of various stakeholders in the national response.**
	2.3: To mitigate the impact of HIV on youth	• Participation in well-designed and gender-sensitive health and family life skills and HIV/STI prevention education programmes made compulsory for all primary, secondary, and tertiary level students... • Access to youth-friendly health and social services promoted.	• **Reduction in HIV transmission in the <24 years cohort**
	2.4: To scale up the HIV response in the work place	• National public and private sector organisations introduce comprehensive workplace policies and programmes. • Communication programmes to raise awareness and improve prevention throughout the tourism and construction sectors developed and implemented (see Priority Area 3).	• **HIV Policy in the Workplace is accepted and implemented**
	2.5: To improve management of tuberculosis (TB), opportunistic infections (OIs), and sexually transmitted infections (STIs)	• Cross-infections of HIV and TB, OIs and STIs eliminated • Update and implementation of existing protocols for treatment of tuberculosis (TB), opportunistic infections (OIs), and sexually transmitted infections (STIs)	• **Elimination of the incidence of TB and STI and a reduction in the rates of cross-infection with HIV**

Table 10	STRATEGIC OBJECTIVE	EXPECTED NATIONAL RESULTS	INDICATORS
PRIORITY AREA 3 PREVENTION OF HIV TRANSMISSION	**3.1: To prevent sexual transmission of HIV.**	•Condom policies and promotion advocating improved and expanded acceptability and accessibility implemented. •Condom negotiation and condom use skills strengthened. •Healthy and responsible sexual behaviour, attitudes, and practices promoted and increased through innovative behaviour change communication strategies. •Universal access to HIV testing and counseling services to include provider-initiated (rapid) testing strengthened.	**Number of new HIV cases ≤ thirty four (34) in 2016**
	3.2: To reduce vulnerability to sexual transmission of HIV.	•Capacity to design and implement behaviour change communication addressing social vulnerability enhanced. •Research on the social determinants and vulnerability to HIV sourced and disseminated.	
	3.3 To establish comprehensive, gender-sensitive and targeted prevention programmes for children (9-14 years old) and youth (15-29 years old).	•Access to accurate, gender-sensitive information and skills on adolescence, sexuality and their HIV/STI vulnerability ensured for young people particularly within school settings. •Exciting behaviour change IEC programmes addressing youth developed & implemented. •Comprehensive condom programmes for youths developed, addressing the accessibility and availability of condoms as well as condom negotiation skills. •Youth-led HIV behaviour change communication prevention programmes developed. •Peer education programmes for school and community-based youth strengthened. •Access for out of school youth to HIV prevention and other services ensured. . •CSOs supported to reach youths with programmes to reduce HIV vulnerability	
	3.4: To achieve universal access to targeted prevention interventions among MARPS most-at-risk (MSM, SW, drug users and prisoners, and immigrant populations)	•Targeted behaviour change communication interventions to increase safer sexual practices among most-at-risk populations developed and implemented. •Improved health seeking behaviour including early HIV/STI diagnosis & treatment promoted. •Access to HIV testing and counseling ensured and promoted. •Peer education programmes for MARPs (especially SW and MSM) strengthened. •HIV/STI policies and prevention services are implemented in the prison system. •Barriers to access to HIV preventive services by immigrant population removed	
	3.5: To enhance prevention of mother-to-child transmission of HIV services to all pregnant women & their families.	•Service delivery capacity of prevention of mother-to-child transmission programmes in primary care facilities strengthened. •PMTCT Plus programmes provided. •Positive prevention promoted for PLWHIV at PMTCT sites	
	3.6: To strengthen prevention efforts among PLHIV, as part of comprehensive care	• Advocacy for abstinence for PLHIV intensified •Advocacy for increased safer sex practices among PLHIV intensified. • Advocacy for disclosure of HIV status by PLHIV to their sexual partners strengthened.	
	3.7: To reduce vulnerability to HIV through early identification & treatment of other STIs.	•Increased access and utilization of STI services •HIV testing and counseling offered to all persons attending STI clinics	
	3.8: To reduce vulnerability to HIV transmission through accidental exposure	• Infection control programmes enhanced • Access to post-exposure prophylaxis (PEP) for workers accidentally exposed in health care settings ensured.	

TABLE 11	STRATEGIC OBJECTIVE	EXPECTED NATIONAL RESULTS	INDICATORS
PRIORITY AREA 4TREATMENT, CARE, AND SUPPORT	**4.1: To increase access and adherence to treatment, care, and support services for persons living with HIV.**	• Universal access to antiretroviral (ARV) treatment • Universal access to health services for tuberculosis (TB), opportunistic infections (OIs), and sexually transmitted infections (STIs) • Increased adherence to treatment • Increased access to support through national social safety net	**Mortality due to HIV ≤ five (5) annually by 2016**
	4.3 To improve access to nutritional and psychosocial services for persons living with HIV	• The collaboration and cooperation of civil society secured in providing support and care services • Referral systems to social support services and poverty alleviation interventions strengthened [See 1.3]	**Number (#) confidential referral systems operational and # referrals made**

TABLE 12	STRATEGIC OBJECTIVE	EXPECTED NATIONAL RESULTS	INDICATORS
PRIORITY AREA 5 INSTITUTIONAL SYSTEMS DEVELOPMENT	**5.1: To develop appropriate evidence-based policies, practices, and interventions**	• National policy-making, programme design, and planning approaches informed by an information system that monitors and evaluates the international, regional and national HIV response • Research results, lessons learned, and databases on HIV from Caribbean countries and other regions compiled and disseminated at the national level and used in HIV response. ▪ Information sharing between primary, secondary and national levels improved. ▪ An expanded and effective network of people living with HIV/AIDS, advocating for improved care and support, and contributing to national policy implementation;	**Level of integration of HIV services into primary health care services.**

	5.2: Capacity development to provide comprehensive and integrated HIV/AIDS services	▪ A cadre of appropriately trained personnel able to implement policies and manage programmes towards universal access ▪ A cadre of appropriately trained personnel able to provide HIV and AIDS services within the general health system • Surveillance, monitoring, and evaluation and management information systems capacity strengthened. • Laboratory services for screening, diagnosis, clinical staging, and monitoring treatment outcomes enhanced in the public sector. • Effective supplies management of strategic public health supplies including HIV medicines, diagnostics, and other commodities operational.	**# training and education programmes staged and # persons trained** **National HIV monitoring & evaluation plan operational** **Improvements in Laboratory services** **Reduction in outages of HIV drugs & commodities**

TABLE 13	**STRATEGIC OBJECTIVE**	**EXPECTED NATIONAL RESULTS**	**INDICATORS**
PRIORITY AREA 6 **BARBUDA PROGRAMME DEVELOPMENT**	**6.1 To strengthen the inter-governmental and multi-sectoral response to HIV in Barbuda**	• Political commitment to and leadership of the HIV response • Resources support to the HIV response	**The status of the HIV epidemic in Barbuda halted and reversed.**
	6.2: To prevent sexual transmission of HIV.	•Healthy and responsible sexual behaviour, attitudes, and practices promoted and increased through island-relevant behaviour change communication strategies. •Access to HIV testing and counseling services to include provider-initiated (rapid) testing strengthened. •Comprehensive condom programmes for male and female, adults and youths developed, addressing the accessibility and availability of condoms as well as condom negotiation skills.	

11. FINANCE

11.1. Tentative costs of the NSP 2012 - 2016 (EC$) are shown below in Table14.

TABLE 14 GOVERNMENT FINANCIAL CONTRIBUTIONS TO HIVAIDS RESPONSE (2012 BUDGETED AND PROJECTED (2013-16) EC$							
Category	**2012**	**Major changes 2012 - 2016**	**2013**	**2014**	**2015**	**2016**	**Plan Period**
Salaries & allowances	876,832	Increase in professional staff at AS	950,000	980,000	1,009,400	1,040,000	**4,856,232**
Grants to individuals	60,000	Support to diminish by 10% per annum after year 2	60,000	54,000	48600	38,880	**261,480**
Office supplies	10,000	5% annual increase	10,500	11,025	11,576	12,155	**55,256**
Maintenance	3,000	5% annual increase	3,200	3,500	3,500	4,000	**17,200**
Conference	5,000	Increase in conference attendances	10,000	10,000	12,000	12,000	**49,000**
Committee Boards	1,500	Advisory Commission established	150,000	150,000	160,000	160,000	**621,500**
Commodity supplies	10,200	100% increase targeted for condom procurement	50,000	50,000	50,000	50,000	**210,200**
IEC materials	3,000	Increase in IEC design and placement	90,000	90,000	100,000	100,000	**383,000**
Test equipment	60,000	20% increase in VCT and PMTCT over period	90,000	100,000	100,000	120,000	**470,000**
Research, Books etc	2,000	10% increase annually	25,000	25,000	7,500	7,500	**34,500**
Training	5,100	Increase in number of training programmes	70,000	60,000	50,000	50,000	**235,100**
Barbuda	5,000	Increased number of visits and supplies	40,000	40,000	40,000	30,000	**155,000**
TOTAL EC$	**1,041,632**		**1,526,200**	**1,551,025**	**1,610,076**	**1,619,535**	**7,348,468**

The estimated Government contribution to the total cost of the NSP 2012-2016 is crudely estimated to be approximately seven-point-three-five (7.35) million EC dollars or two-point-seven (2.7) million US dollars. The estimate is based on the budget proposals for 2012 and takes into account:

- Costs are included for the operation of the National Advisory AIDS Commission to include fees to members and the employment of an Executive Secretary. Adjustments in 2012 budget will have to be made to support the Commission.
- An increase in management staff in 2012 at the AIDS Secretariat – a senior technical officer reporting to the APM with responsibility for implementation of the plan and the monitoring and evaluation system
- Increases in medical supplies, IEC materials and test equipment as scaling up of access is pursued
- Major increases in training and conferencing as capacity building takes place
- The prevalence of PLWHA is expected to increase but support will be sought through social safety net
- Participation in BSS in 2014

An application to Global Fund through the OECS Secretariat to provide support costs for ARVs, VCT, HIV prevention, Prophylaxis, laboratory, Stigma & Discrimination programmes, improved surveillance and contact tracing will not be considered by the funding agency until 2014. The Ministry of Health and AIDS Secretariat will require an additional three hundred and fifty thousand dollars (EC$350,000/130,000US$) sourced from Antigua and Barbuda Government through special warrants or from external funding agencies, regional and international. The prospect of local private sector funding is weak but efforts will be made to secure such.

Additional costs are projected for:

- Behaviour Surveys or KABPs and applied research as directed by gaps discovered in the NAP,
- Capacity building efforts that take place regionally or internationally, and
- Special mass media campaigns that may be identified.

Table 15 below shows possible sources of funding and technical assistance. The NAAC is expected to lead the resource mobilization efforts.

TABLE 15	POSSIBLE SOURCES OF FUNDING AND TECHNICAL ASSISTANCE	
DONOR/PARTNER NAME	**TARGET AREAS IN HIV/AIDS**	**PROJECT FUNDING**
GLOBAL FUND	VCT, ARV, Youth, MARP	YES
PEPFAR	HIV Prevention, Strategic Information and Laboratory Strengthening.	Technical Assistance Regional/National training
DFID	BCC, campaigns, other	YES
CIDA	TBD	YES
UNIFEM	"Teen Talk" project	YES
UNICEF	Caribbean Youth Summit; Regional Children's Workshop; other symposia for youth	Regional support
PAHO/CAREC	Various prevention, care, support and treatment; MARP, BSS	Regional and national support
PANCAP/CCNAPC	M&E; organization; regional assistance; institutional support; M&E support	Technical Assistance
ITECH/JHPIEGO/CHART	ARV, VCT, counseling and other HIV/AIDS related	Technical Assistance Regional training
CRN+	Advocacy and leadership for human rights and positive prevention	Technical Assistance Regional training
INTERNATIONAL AIDS ALLIANCE	Work with MSM, CSW, Taxi drivers etc. MARP issues—prevention, VCT, care, support	National support - Technical Assistance
CHRC	Work on M&E of the NAP and within the NAS/MOH health system	Regional institution - Technical assistance in research methods and information systems.

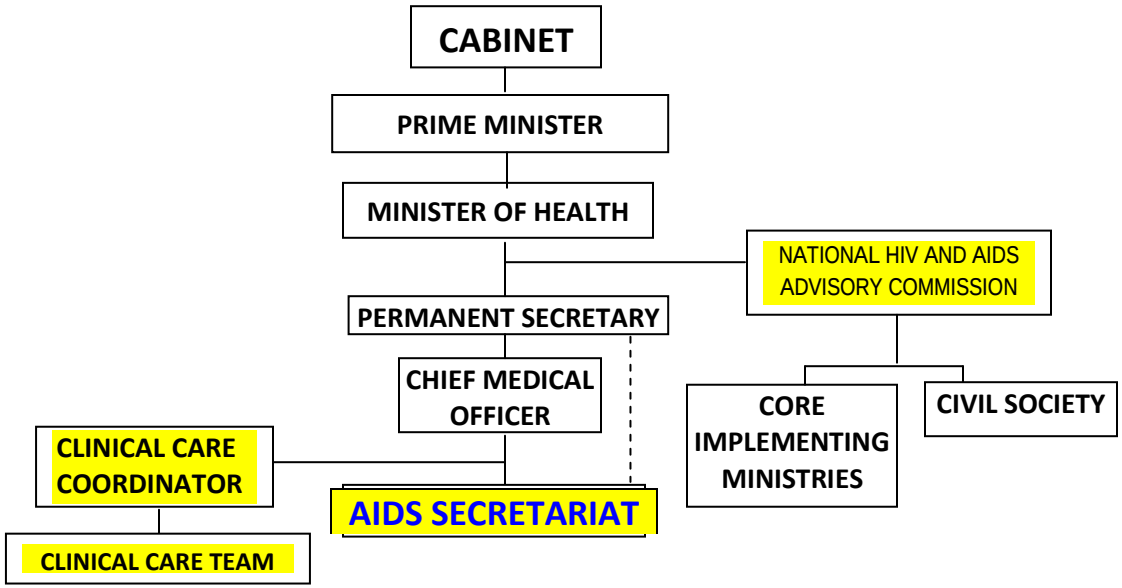
12. PROGRAMME ORGANIZATION AND MANAGEMENT

The proposed organization chart is shown in Chart 7. The National HIV and AIDS Advisory Commission is a multi-sectoral body with representation of various government sectors and civil society whose role is to ensure that the NAP accomplishes its objectives as outlined in the NSP. It advises on overall policy direction, lobbies and negotiates with Cabinet and Government Ministries for

national implementation and forges multi-sectoral collaboration between core implementing Ministries and stakeholders in civil society.

The Ministries of Health, Education, Youth Affairs and Sports, Labour, Legal Affairs, Social Transformation, Gender Affairs and Tourism are identified as the core implementing Ministries for the National HIV/AIDS Response. Membership from Civil Society will be sources from FBOs, representatives of PLWHA, Youth, NGOs, the Media and the EPI Unit. A competent full-time Executive Secretary with excellent communication skills (written and oral) is the only employee of the Commission.

CHART 7



The Clinical Care Team includes specialists in Obstetrics and Gynaecology; Paediatrics, Internal Medicine in addition to representatives from Pharmacy, Nutrition, Nurse/Counselors and Social Work. A Patient Advocate is also included in the membership.

The management staff at the AIDS Secretariat will be strengthened to include a Manager responsible for leading the implementation of the NSP and the monitoring and evaluation system that will be established. The AIDS Programme Manager will take direct responsibility for the capacity development activities.

13. LESSONS LEARNED

The preparation of this NSP forced the understanding that 'HIV/AIDS is a complex problem, with many levels of causation, from individual high risk behaviors to social and economic high risk situations'[49]. Efforts to combat the disease in Antigua and Barbuda must take place on at least three levels of causation[50]:

- **Structural** - include laws, policies and standard operating procedures. Mechanisms for change at the structural level include constitutional and legal reform, civil and human rights activism, legislative lobbying and voting
- **Environmental -** to include living, resources, social pressures and opportunities. Processes for change at the environmental level range from community organization and legal action to the provision of services
- **Individual -** factors relate to how the environment is experienced and acted upon by individuals and may include, amongst others…low perception of risk. Change at the individual level is most often achieved through education, counseling, reward and punishment, and the provision of information.

Intense literature review, media monitoring and consultations with stakeholders and others have highlighted the following lessons:

- HIV and AIDS will be a permanent feature of national socio-economic planning for the foreseeable future. The HIV response must therefore be national in scope, multi-sectoral, strategically planned, adequately funded and astutely managed. Active political leadership and Government involvement is crucial.
- The critical goal of the AIDS response is 'prevention of the transmission of HIV' and this determines the core function of the AIDS Secretariat. Other areas of the response including treatment, care and support would be better served if integrated into the existing national health and social systems.
- Collaboration between individuals, teams and organizations in the implementation and monitoring of the progress of the NSP will reinforce the effectiveness of the multi-sectoral framework in combating HIV and AIDS.
- Capacity building of health care workers in sound public health principles and integrated health services delivery is essential to the sustainability of HIV prevention and treatment.

[49] M. Ricardo Calderón M.R, Series Editor: The HIV/AIDS Prevention and Control SYNOPSIS Series, Regional Accomplishments and Lessons Learned; AIDSCAP/Family Health International 1997
[50] Ibid

- The vertical HIV and AIDS programme is presenting confidentiality challenges of its own. Providers have become known and association with them and their services have lead to the loss or perception of loss of privacy expected by clients.
- The NSP is implemented through a series of programmatic interventions. The prioritization of actions may be influenced by the activities in other sectors, other programmes and national circumstances. Decisions however should be evidence-based. The importance of timely and accurate information should be emphasized.
- BCC messages are effective when their design is based on a deep understanding of the socio-cultural, psychological and economic circumstances of the target populations. The information conveyed must be relevant and technically sound. Media spots must be of high quality and professionally produced.
- Socio-cultural challenges are best led by active stakeholders poised to benefit from the recommended changes. The denial of human rights to any individual through stigma and discrimination or other means remains abhorrent to the AIDS framework and its negative impact on HIV prevention programmes is clearly understood. The AIDS Secretariat is neither designed nor resourced to function as a human rights organization.

ACKNOWLEDGEMENTS

Consultants of Kingdome Consultants Inc. acknowledge the contributions made by many in the Ministries and Divisions of Government and Civil Society Organizations to the preparation of this strategic plan.

We thank specifically the Chief Medical Officer, Dr. Rhonda Sealy Thomas; Clinical Care Coordinator, Dr. Prince Ramsey; the staff of the AIDS Secretariat led by Ms. Delcora Williams, AIDS Programme Manager; Dr. Martha Alonso of the Health Statistics Division and members of the Steering Committee including Ms. Alexandrina Wong who gave of their time and knowledge in influencing the strategic directions established in this NSP.

We are grateful to all stakeholders who attended the consultations and the persons and organizations we interviewed in both Antigua and Barbuda for their willingness to be a part of the consultative process.

We recognize that it is the same spirit of cooperation that will support and further the implementation of the identified strategies.

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December 2011