GLOBAL AIDS RESPONSE PROGRESS REPORT

ANTIGUA and BARBUDA

Reporting period: January 2010-December 2011 Submission date: 31st March 2012.

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Preparation process for the new targets in the 2011 Political Declaration on AIDS country progress report:

1. Plan and conduct consultation with stakeholders on the 19th November, 2011.
2. Review and collate data for the period under review by the AIDS Secretariat MOH, HIV Epidemiologist and Health Information Division.
3. Report writing and editing was done by Health Information Division.

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- The Ministry of Education, Youth, Sport, Gender Affaires and Local Government
- The Ministry of Health, Social Transformation and Consumer Affairs
- Ministry of Legal Affairs and Justice
- Substance Abuse Division
- Health Information Division
- Civil Society organizations including:
- PLHIV Networks such as:
- Health, Hope and HIV (3HN)
- Antigua and Barbuda HIV AIDS Network
- CAREN HIV support group
- NGOs and faith-based Organizations

Information for the report was obtained from reviewing relevant documents, interviewing Stakeholders and convening a meeting with stakeholders at the Ministry of Health on the 19th November, 2011.

Acronyms

3HN	Health, Hope and HIV Network
ABHAN	Antigua and Barbuda HIV/AIDS Network
ART	Antiretroviral Therapy
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
CHAA	Caribbean HIV/AIDS Alliance
CMO	Chief Medical Officer
DFID	Department for International Development of the United Kingdom
FBO	Faith-based Organization
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HID	Health Information Division
HAART	HIV AIDS Antiretroviral Therapy
ILO	International Labour Organization
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
MSJMC	Mount St. John's Medical Centre
NAC	National AIDS Committee
NAP	National AIDS Programme
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
STI	Sexually Transmitted Infections
TB	Tuberculosis
GLOBAL AIDS RESPONSE PROGRESS REPORT	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nation Children's Fund

VCT	Voluntary Counselling and Testing

Status at a glance

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 1992. The National AIDS Programme (NAP) had initial emphasis on effecting behavioural change through information, education and communication strategies.

It has evolved to include equal emphasis on treatment and care and provision of support and is the coordinating body for all HIV and AIDS efforts and serves as the focal point for the collection and dissemination of data on HIV and AIDS.

A total of one hundred and three (103) persons have been diagnosed during the period January 2010 to December, 2011. There were two hundred and sixteen (216) children and adults living with AIDS at the end of 2011. Treatment remain centralized where Care and treatment is administered by a Clinical Care Coordinator.

During the last decade, successes of the programme include the introduction and expansion of voluntary, counselling and testing (VCT) services, free access to Antiretroviral (ARV) treatment and Post Exposure prophylaxis (PEP), and a Prevention of mother-to-child transmission (PMTCT) 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.

Despite increasing levels of knowledge with regards to mode of HIV transmission, the national statistics suggest that sexual behaviours have not changed significantly. What has changed over the period under review is the demographic of the disease in which the number of new cases has averaged 50.5 and the 20 - 39 age groups is most affected during the last two years.

The controlling of the transmission of the disease continues to be a major developmental challenge. The highest incidence of HIV transmission is through Heterosexual relationship. Data in regards to the Most-at -Risk Population remains a challenge because persons are unwilling to be identified as been a member of these groups. There is under reporting of Men who have sex with other men which may be due to fear of stigma and discrimination.

Inclusiveness of stakeholders in the report writing process:

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. The twin island state has acknowledged the new 2011 Political Declaration on AIDS; which affirms the epidemic as 'a global emergency and one of the most formidable challenges to human life and dignity'. Further, HIV & AIDS is a national and developmental issue that requires the integration of HIV and AIDS policy and programmes into national development plans.

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

The MOH recognizes that the Global Response Progress Report reflected new targets. These undoubtedly places each country in a position to set ambitious national HIV & AIDS targets that will 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 further accepts the "Three Ones" principles as the appropriate organizational framework for scaling up access to services. These principles aim to achieve the most effective and efficient use of resources and greater harmonization and coordination of the national response through:

- ✓ One agreed HIV Action Framework that provides the basis for coordinating the response for all partners,
- ✓ One National AIDS Coordinating Authority, with a broad-based multi-sector mandate, and
- ✓ One agreed country level Monitoring and Evaluation System.

Government is firmly committed to the Caribbean Cooperation in Health (CCH) 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, the approach

to HIV and AIDS intervention in the country; mirrors closely the health framework established in the PANCAP Caribbean Regional Strategic Framework (CRSF) on HIV and AIDS (2008 – 2012). Antigua & Barbuda has adapted the goals of the CRSF, its six priority areas along with their associated strategic objectives and expected 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, access and use condoms as an option to prevent the transmission of STIs, including HIV and undesirable pregnancies.

The fulfilment of these objectives demands the involvement of a wide cross section of society such as: Civil Society Organizations - inclusive of FBOs, and Government. Antigua & Barbuda recognizes the importance of collaboration between key stakeholder in the development and implementation of HIV programming. A reflection this collaborative partnership is evident in this report as its preparation is the consultative effort of all relevant stakeholders thereby fulfilling of the requirement for a multi-sector approach to HIV Prevention interventions.

The methodology used in the preparation of this report involved discussions with stakeholders and partners directly involved in the national response to AIDS as well as a review of relevant documents. The documents reviewed are attached as Annex 1 and the list of those who participated in the discussions are attached as Annex 3.

Status of the epidemic

The first case of case of HIV in Antigua & Barbuda was diagnosed in December 1985. The numbers of persons diagnosed has steadily increased annually over the past twenty-five years to a cumulative total of 919 to the end of December 2011, with a male to female ratio of 1:1.2

The data for the reporting period indicate that the major mode of HIV transmission is through unprotected heterosexual contact. Additionally, it is evident that the economically active population as well as persons in the reproductive age group are mostly affected and infected with HIV.

An evaluation of the HIV notification by age for the period under review shows that the epidemic is concentrated within the age group 25-29 (See Table 1 below).

Table: 1: HIV cases 1985-2011 by Sex, Antigua and Barbuda

YEAR	MALE	FEMALE	TOTAL BY YEARS	DEATHS	TOTAL CUMULATIVE CASES
1985 - 1987	3	2	5	2	3
1988	9	8	17	0	20
1989	5	4	9	1	28
1990	3	3	6	2	32
1991	10	6	16	8	40
1992	15	5	20	9	51
1993	23	4	27	12	66
1994	19	11	30	12	84
1995	9	9	18	12	90
1996	8	18	26	8	108
1997	13	10	23	6	125
1998	17	13	30	3	152
1999	19	25	44	10	186
2000	39	28	67	12	241
2001	21	11	32	15	258
2002	23	15	38	9	287
2003	24	15	39	6	320
2004	23	21	44	10	354
2005	29	33	62	10	406
2006	28	35	63	25	444
2007	31	35	66	7	503
2008	42	46	88	8	583
2009	25	21	46	7	622
2010	32	39	**71**	8	684
2011	17	15	**32**	15	702
TOTAL	**487**	**432**	**919**	**217**	**702**

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

Factors driving the transmission of the epidemic include: unprotected sex, gender inequality, sex tourism, sex work and transactional sex among the youths. Although the use of condoms during

sexual intercourse is widely promoted in the country, there is a tendency for some persons to practice discontinuation of condom use after a short period in their relationship without knowing the HIV status of their partner.

Care, Treatment and Support

HIV Care and Treatment is still centralised and is managed by a Clinical Care Coordinator (CCC) who heads the Clinical Care Team. This ensures continuity in the standardization, improvement in the quality of care, treatment and support for PLHIV, as well as strengthens surveillance, monitoring and evaluation by the Health Information Division (HID) and programmatic effectiveness by National AIDS Programme (NAP).

Highly Active Antiretroviral Therapy (HAART) and treatment for opportunistic infection continue to be available from the public hospital pharmacy at no cost to PLHIVs'. Through PANCAP, anti-retroviral drugs are provided to Antigua and Barbuda under The Global Fund Round 9 Grant. Care and treatment services are provided free of cost regardless of the individuals immigration status. Specialist services in the areas of ophthalmic care, Ear, Nose and Throat Care, Dermatological Care and Dental Care remain available free of cost to all PLHIV on a need basis.

Report from the Patient Monitoring System at Health Information Division (HID) indicates that in 2010, there were one hundred and eighty-nine (189) persons with advanced HIV infection and who had ART initiated. At the end of the period, one hundred and sixty three (163) persons were actually on ART. During that period, sixteen (16) persons died while hospitalized due to AIDS related illness, seven (7) persons were lost to follow up and three (3) were transferred out due to migration.

In 2011, there were two hundred and sixteen persons (216) with advanced HIV infection. Of that amount one hundred and eighty six (186) were on ART at the end of 2011. During the same period there were three (3) person deceased and twenty seven (27) persons were lost to follow up (See Table 2). In 2011 there was a slight increase in AIDS cases due to the rise in the prevalence of HIV.

Table.2: HIV/AIDS cases 2010-2011, Antigua and Barbuda

Years	**Total Cumulative HIV+ case**	**AIDS**	**%**

1985 - 2010	684	189	27,7%
1985 - 2011	702	216	30,8%

Source: Health Information Division – Ministry of Health, Social Transformation and Consumer Affairs.

Though not systematically organised, a number of Civil Society and Faith Based Organisations work with the NAP to provide education and information on HIV and AIDS related issues. There are three HIV support networks Health, Hope and HIV Network (3H Network), Antigua & Barbuda HIV AIDS Network (ABHAN) and CAREN which continue to play an active role in HIV interventions. They work collaboratively with the NAP in the provision of educational activities, and putting a public face to HIV and AIDS.

Policy and programme response

Antigua and Barbuda remains committed to its mission of substantially reducing the transmission and impact of HIV through sustainable systems of universal access to HIV prevention, treatment, care and support.

Political involvement in HIV and AIDS prevention interventions has increased during the period under review. There is a drive to ensure programme sustainability and the fostering of an enabling environment. This is driven by the formulation of policies which are well supported by the political directorate.

The commitment was further enhanced by a 60,000 dollars per annum budgetary allocation as subsistence for PLHIVs in the country. In addition, the government continues to play a pivotal role in the empowerment and utilization of the skilled individuals. Three individuals previously employed under The Global Fund project are now employed within the MOH to strengthen the capacity of the NAP and improve the government's ability to address Human rights issues relating to PLHIVs and their dependents.

A cumulative Human Rights Report for the period 2010-2011 is attached as Annex 2

Provision has also been made by the government within the office of the Ombudsman to address issues pertaining to workers rights including those associated with HIV and AIDS.

Despite noted successes, the country still faced challenges in the reduction of HIV infection. These included the effects of a retracted local economy and a sizable decrease in donor spending which threaten to negatively impact sustainability of not only HIV prevention programmes but also the HIV health services.

During 2011, a National HIV in the Workplace policy was developed under the auspices of the Labour Department with assistance from the International Labour Organization (ILO). The final draft is presently being reviewed by the Office of Legal affairs.

The Ministry of Education also developed a draft HIV policy for the Education Sector; comprising of the following goals:

- to coordinate a strategic response to health issues within the Education sector
- to provide accurate information on the prevention and control of HIV and AIDS and other life threatening illnesses

Most fitting is the Aim of the Policy which speaks to – "influencing attitudes and facilitating behavioural change among stakeholders while safeguarding the rights of persons who are living with and are affected by HIV and AIDS in an emotionally and physically safe environment".

A new Strategic and Action Plan sponsored by PANCAP was developed in 2011 to cover the period, 2012 to 2016. It focuses on the diminution of HIV infection and the lessening of Stigma & Discrimination as identified under the following Priority Areas:

1) Promote an enabling environment that fosters Universal access to HIV Prevention, Treatment, Care and Support.
2) An expanded and coordinated multi-sector response to the HIV epidemic.
3) Prevention of HIV transmission.
4) Treatment, care and support.
5) Institutional system development.
6) Barbuda development programmed.

It is intended that access to services will be scaled up through strategies designed to achieve the

following goals:

i. To reduce the estimated number of new HIV infections by 33% of the last three years average by 2016.

ii. To reduce mortality due to advanced HIV by 33% of the last three years average.

iii. To achieve 100% confidential referrals of all requesting PLHIV to relevant national social support agencies.

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-sector efforts to ensure universal access to HIV and AIDS services.

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.

The national response to HIV remains under the direction of the Chief Medical Officer and the Permanent Secretary within the Ministry of Health. Activities are conducted through the AIDS secretariat which is the focal point for HIV and AIDS related matters. The department works closely with other government ministries, PLHIV and Civil Society to implement HIV & AIDS strategies and programmes.

The collaboration between these organisations has enhanced the HIV and AIDS advocacy efforts. The Ministry of Health has collaborated in public-private partnership with different agencies. One such collaboration is between the Ministry of Health, PANCAP, Scotiabank and Caribbean Broadcast

Media Partnership (CBMP) to organise Regional Testing Day annually.

Prevention

The PMTCT programme has achieved a 99% uptake of HIV testing services among pregnant women during the last two years (2010 -2011). Surveillance of HIV data from Antenatal Clinic and Maternity Ward has shown an increase in the prevalence from repeat pregnancies. In addition, HIV-positive mothers are given free infants formula and discouraged from breast-feeding until the child is weaned.

The total percentage of HIV positive pregnant women is 0.80% in 2011 compared to 0.66% in 2010 (See Table 3 below). This notable increase is due to high uptake of HIV testing among pregnant women. The higher incidence of HIV infection occurred in the 25 to 34 age group in both years.

Table. 3: Pregnant women percentage HIV positive in Antigua and Barbuda, 2010-2011

Age Group	2010		2011	
	Tested	**HIV +**	**Tested**	**HIV +**
<15	2	0	3	0
15-24	385	2	370	3
25-34	522	5	590	6
35 +	**144**	**0**	**169**	**3**
TOTAL	**1053**	**7**	**1132**	**12**
HIV + Percent		0.66%		0.80%

Data accessed from Antenatal and Maternity Record MSJMC 2010/2011

Antiretroviral therapy is given to all pregnant women at 28 weeks gestation to delivery. The infant receives Post Exposure Prophylactic (PEP) for six weeks after delivery and Cotrimoxazole (Bactrim).

All infants are followed-up by the NAP and the Paediatrics clinic to ensure holistic adherence. A DNA PCR Dry Spot Specimen is collected from the infant 1 month to six weeks after birth for HIV Testing and an Eliza test is done at eighteen (18) months. If the infant is negative with both tests he/she is transferred for follow-up in the District clinic. If positive the infant remains in the Out Patient Paediatric at MSJMC hospital.

Voluntary Counselling and Testing (VCT)

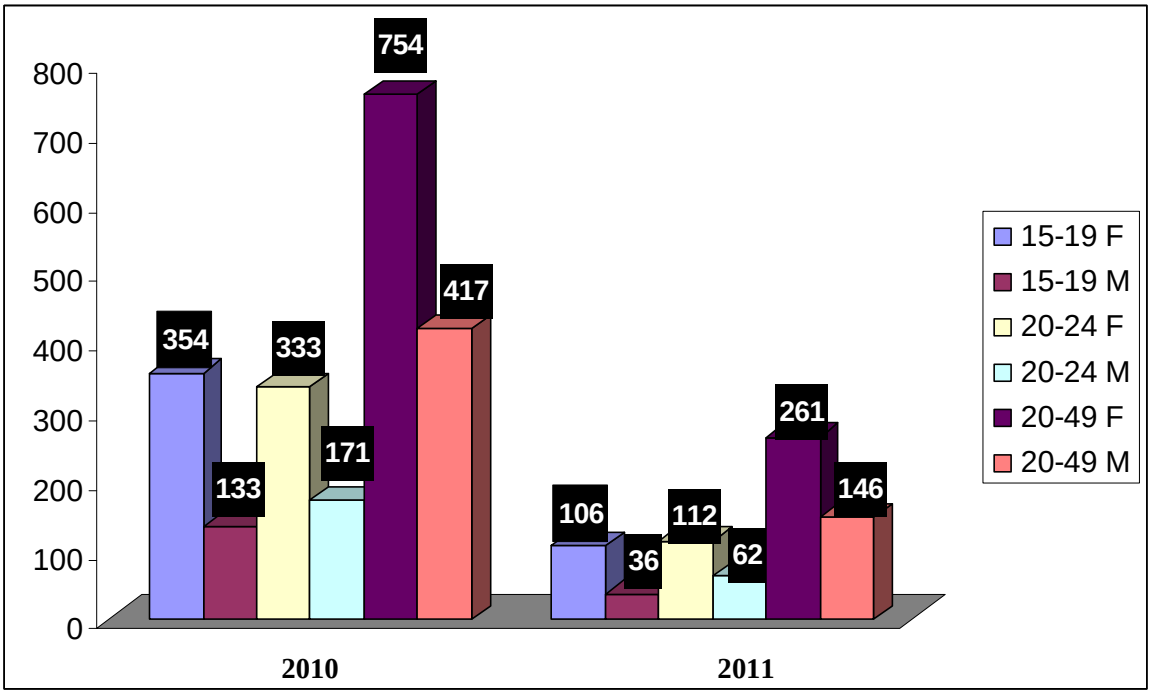
Voluntary Counselling and Testing (VCT) services are also available free of cost at Eight (8) community health centres, the National AIDS Secretariat, Antigua Planned Parenthood, and laboratory of the public hospital in Antigua and Barbuda. By extension, VCT services can also be accessed at a cost from medical laboratories and some private physicians' offices. Please see table 4 - figure 1 below of VCT sites accessed according to age group and sex for the period 2010-2011

Table 4: VCT sites accessed by Age Group and Sex Antigua and Barbuda 2010-2011

Years	15-19		20-24		20-49	
	F	M	F	M	F	M
2010	354	133	333	171	754	417
2011	106	36	112	62	261	146

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

Figure: 1 VCT by Age Group and Sex 2010 - 2011



In 2010 in collaboration with Centre for Disease Control (CDC), Antigua and Barbuda was assisted in the development of their Rapid testing algorithm. The process of decentralization of HIV Rapid

testing has begun with the certification of six VCT HIV Rapid Test Counsellors and testers within the National AIDS Programme.

A standard drug kits for managing STIs are provided free of charge by the Ministry of Health. Treatment of STIs' is done in the public Main Health Centre. The clinic is staffed with a Medical Doctor and two Nurses.

Condoms

The sustainable use of condoms is strongly emphasized to help reduce the transmission of other STIs. Condoms are distributed on a daily basis free of cost to persons who access them from the NAP. Other government institutions which include Community Clinics, Directorate of Gender Affairs, Immigration Department, Antigua Planned Parenthood Association and Antigua Port Authority. The Caribbean HIV/AIDS Alliance and other support groups are also involved in the free distribution of condoms.

During festive occasions, the NAP in collaboration with its partners distributes free condoms to persons on the streets, night clubs, recreation grounds, Carnival Mass Troupes and Carnival Shows. Condoms can also be accessed at Community outreaches conducted by the NAP and other supporting agencies.

To further enhance the sustainability of condom supply, the NAPS has partnered with other government and nongovernmental agencies some with whom the department has engaged in a reciprocal relationship. This sustainability effort is made possible through contributions from the government of Antigua and Barbuda (A&B), UNFPA and Caribbean HIV/AIDS Alliance.

In 2010, a total of 76,221 pieces of condoms were distributed and in 2011 a total of 185,901 pieces of condoms were recorded as being distributed by the NAPS. Of significance was the distribution of 15,000 pieces of condoms during Carnival Celebrations in 2011(See table 5 - figure 2). A recording system designed to track the condoms from the contributors to the general public is maintained by the NAP.

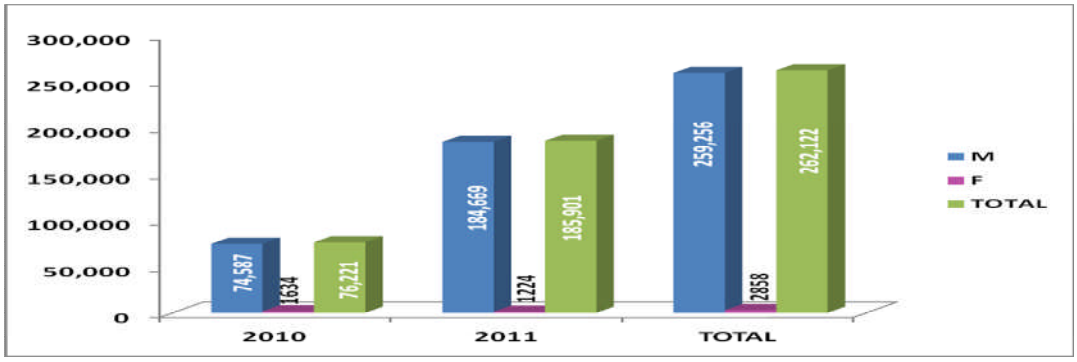
Table 5: AIDS Secretariat - Ministry of Health Condom Distribution 2010-2011.

	M	**F**	**TOTAL**

2010	**74,587**	**1634**	**76,221**
2011	**184,669**	**1224**	**185,901**
TOTAL	259,256	2858	262,122

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

Figure 2: Condom Distribution by sex 2010 – 2011. Antigua and Barbuda



As seen in the figure 2, there has been a significant increase in the number of condoms which were distributed in 2011 in comparison with 2010, of 185,901 and 76,221 respectively. This reveals that the total amount of condoms distributed in 2011 was 41% more than the previous year. For both years more male condoms were distributed than female ones.

Community Outreaches:

The NAP HIV Prevention programme interventions are strengthened through quarterly outreach programmes which involve educational sessions, HIV counselling and Testing, Condom demonstrations and distribution. The sister island of Barbuda is also included with the NAP making quarterly HIV prevention outreaches. On each quarterly visit, HIV prevention messages are taken to the primary and secondary schools, churches, the streets, hospital and the office of the Barbuda Council. Free and confidential HIV counselling and testing are conducted during these outreach activities.

Educational Programmes:

Public education and awareness efforts continue to be a major intervention in the spread of HIV

infection, since prevention through educational programmes is crucial to the prevention and control of transmission of the HI virus. There have been intensive behavioural change communication campaigns with increasing collaboration between the NAP, the media, non-governmental organizations, community based organizations and other governmental bodies. Through these efforts the expansion of behavioural change communication across all sub-groups in the community inclusive of the MARPs were facilitated. During the period under review, 2010 and 2011, the HIV prevention intervention efforts have targeted a number of strategic areas. These include: MSMs, SWs, in school youths, Youth on the block, women and the workplace.

In 2010 forty three education sessions were facilitated by NAPS staff in schools, colleges, other government organizations and FBOs whilst thirty two were conducted in 2011. This intervention was further enhanced by the increased capacity of the NAPS through the attendance of its staff to local, regional and international workshops and training sessions.

In 2010 the staff of the AIDS Secretariat attended twenty-four training sessions and nineteen in 2011. These sessions have improved the capacity of the NAPs to carry out various intervention efforts into the prevention and control of HIV and AIDS. These included short courses on: Monitoring and evaluation, Stigma and Discrimination, Programme Planning, Filing, Leadership and Development.
There are Civil Society Organisations which engage in public education of MARPS. The services and activities conducted by these organisations are discussed below.

Caribbean HIV AIDS Alliance (CHAA)

Caribbean HIV AIDS Alliance (Antigua) through funding from USAID continues to target the Most-At-Risk-Populations (MARPs) through community outreach effort by Animators. Their outreach activities to the vulnerable include education on HIV/AIDS; other STIs' and Voluntary Counselling and Testing (VCT), and condom use continues to work with the AIDS Secretariat. During these visits they distribute condom, and other commodities such as Dental Dams and lubricants. Table 6 below shows the different places targeted by CHAA during their community outreach to MARPs.

Table.6: Places of risk identified in Antigua and Barbuda, 2010-2011

Access Point	Number	Workers	Total
Bar/clubs	91	9	100
P homes	93	1	94
Other	43	1	44
Blocks	34	0	34
Brothels	5	1	6
Malls/shops	4	0	4
Barber shops	3	0	3
Clinics/hosp	0	0	0
Total	**273**	**12**	**385**

Caribbean HIV/AIDS ALLIANCE report 2011.

This is desegregations 'MARPs reached' and tracks the number of contacts with the particular client type. The data-capture forms were designed to indicate whether persons being reached are representatives of a particular MARP group such as MSM, PLHIV or SW. Community Animators also target "male at risk" defined as client of sex workers; once client has disclosed he had sex with a sex worker. (See table 7 below).

Table: 7 MARP by client group

CLIENT TYPE	TOTAL
MSM	**97**
MSM/SW	0
MSM/PLHIV	0
MSM/Male at risk	5
MSM/SW/PLHIV	0
MSM/Male at risk/PLHIV	0
Male at Risk	7
Male at risk/PLHIV	0
SW	**224**
SW/PLHIV	0
NS	4
TOTAL	**337**

Caribbean HIV/AIDS ALLIANCE report 2011.

Health, Hope & HIV Foundation Inc.

Health, Hope and HIV Network affectionately known as 3H was birthed out of the AIDS Secretariat but became a registered non-profit company in 2002. It is the preferred national Network of PLHIV on the island, with most of its funding from the government and people of Antigua & Barbuda, followed by donor agencies funding of its projects.

The 3H Network started with three HIV positive individual, having a discussion on the disease and how it affects those infected and affected. One of the individuals remarked that in-spite-of all the negatives surrounding the disease - "**I** still have my **Health**" the other said "and I have **Hope**" after which the third person said "and I have **HIV**" giving the organization its name the **Health, Hope & HIV Network.**

3H has grown and is govern by an Executive Committee which comprise of all populations served. We now have on roll 100 members comprising of men, women and children, most of who are infected with HIV.

One of our strengths is Advocating on behalf of PLHIV and this has been evident in the region. In 2009 we were the recipient of the PAHO/WHO MISOPLWHA AND PARTNERS – Barbados and Eastern Caribbean award in the category of NGO contribution. The award read: "*For your sterling, significant, dedicated, continuous, unselfish and tremendous contributions in advancing development in Barbados and the Eastern Caribbean especially in the area of addressing HIV & AIDS through the eradication of stigma & discrimination against PLHIV*". Additionally, in 2006 we were the proud recipient of the *CRN+ Michael D. Fox Award for being the best PLHIV Network in the Caribbean.*

In order to meet our goals and to serve key populations effectively, 3H has established excellent relationship and mutual partnership with key stakeholders such as the AIDS Secretariat, Gender Affairs, FBOs, Planned Parenthood, Mount St. John's Medical Centre, Ministry of Health and Education, Caribbean HIV/AIDS Alliance, Police Force and the private sector.

Target population: 1. PLHIV 2. MSM 3. Sex Workers 4. Youth

The services offered by the 3H Network are listed below in Table1 Figure 1.

Services to Key Populations	HIV & AIDS Services
• HIV Counselling • Training • Advocacy • Support Group (provide a safe space) • Personal Development Initiative (Volunteer @ the office and are trained to conduct Focus Group Discussion- prepare, develop and present topics - conduct interviews etc) • Peer Counselling • Psychosocial support • Hospital visitation • Community-based peer education and outreach • Risk reduction counselling (delivered through peer outreach) • Male & Female Condom and lubricant promotion and distribution • HIV counselling • Behaviour Change & Adherence Counselling • HIV care, support and treatment referral • Access to health/social services – referral • Structural issues (both community mobilization initiatives and those which address stigma and discrimination)	• Education • Prevention • Care and treatment referral • Support • Adherence counselling • Food & personal care items distribution • HIV Case Management • Nutritional Assessment, Management and Counselling • Referrals • Psycho-social support (PLHIV & Family) • Home-Based Care • Hospital, Home & Prison visits • Pick-up and deliver medication • Weekly support meetings • Advocacy • Human Rights Desk for PLHIV • Weight, blood pressure and blood sugar management • Male & Female Condom and lubricant promotion and distribution • Behaviour Change Counselling • Prevention with positive • Harm reduction counselling • Hospital Care Kits (Adults and Maternity)

Table 1 : Figure1 Services offered by the 3H Network

Women Against Rape (WAR)

Women Against Rape (WAR) is a National organisation formed in response to the unprecedented reported number of rape (34) in Antigua/Barbuda in 2007 The approach began with wide media campaign and sensitizing the general population to the effects of rape on women, families and communities. Dialogue was initiated with Ministry of Health and Police officials in order to establish

a collaborative approach in the prevention and management of Rape. Media campaign also focussed on educating individuals on access to health care in an effort to prevent the transmission, of Sexual Transmitted Infections including HIV and unintended pregnancy. The programme strategy is based on the outcome of a private consultation held on March 8th 2008 at the Heritage Hotel timely delivery of Post Exposure Prophylaxis to all victims of Sexual Violence – a means of Prevention.

Violence and the threat of violence can hamper people's ability to adequately protect themselves from HIV infection and assert healthy sexual decision-making. In many countries, sex workers, people who use drugs and sexual minorities experience illegal law enforcement in the form of violence, rape, harassment and arbitrary arrest.

WAR has extended programme delivery by establishing services to vulnerable and potentially vulnerable groups and partnerships with local, Regional and International Organisations. To this end, regular community outreach activities with groups including FBOs, Sports Group and school based groups focus on preventive interventions and referrals. Condom distribution and demonstration form an integral part of the services. Condoms were accessed from Caribbean HIV/AIDS ALLIANCE (CHAA) and recently from the Aids Secretariat.

The Antigua & Barbuda HIV/AIDS Network Inc. (ABHAN)

The Antigua & Barbuda HIV/AIDS Network Inc. (ABHAN) is a non-profit organization, dedicated to educating, empowering and advocating for individuals infected and affected by HIV and AIDS. ABHAN adopted a comprehensive bio-psychosocial approach to HIV prevention, treatment, care and support since its inception as a means of reducing the transmission of HIV with adherence to treatment as a means of prevention of new infections. Through our programs, ABHAN aims to increase the number of individuals who know their HIV status and therefore enter into treatment early if HIV positive. ABHAN continues to increase access to education, medication, treatment, care and support of infected individuals and their families by providing multi-sectoral linkages and community participation, including community outreach events. In addition, our prevention programs focuses on reducing the number of individuals who become infected with HIV, especially targeting the sexual and reproductive health of the most vulnerable groups, women and youth. The goal is to empower vulnerable individuals to stay healthy, and free of HIV and STDs via employing a public health

approach because HIV prevention remains the most effective strategy in reducing the transmission of the disease. Young people are at the centre of our response as we strive to increase their knowledge about HIV, AIDS and STDs and provide access to youth friendly services.

In order to achieve our goals ABHAN implemented the Peer/Buddy HIV/AIDS Treatment Adherence Program (PBTAP). The two main goals of the PBTAP are: (1) Recruit and retain patients into treatment and care and ensure that they adhere to their treatment regimen. (2) Deliver a comprehensive package of services including case management leading to decreased risky sexual behaviour, improved immune system functioning, and general health improvement.

This fully implemented program has operated in partnership with the American University of Antigua Medical School (AUA) since 2009. PBTAP is a part of a community-based, bio-psychosocial treatment and support program that integrates and coordinates community support services and medical care for MARPs. The program provides direct support services by specially trained Peers (PLWHA)/Buddies (AUA medical students), in the form of social interaction, emotional support, monitoring of medication adherence, and facilitation of health care. PBTAP strives to dispel negative attitudes about the disease and to promote the positive well-being of those infected and affected by HIV and AIDS through the provision of support and companionship. The program includes basic and ongoing training modules for Peer and Buddy Volunteers, gathering of resources and for communication (phones, transportation, and meeting place), and multimodal interventions for PLWHA.

Treatment care and support interventions

INTERVENTION	**COMMENTS**
Social marketing of condoms	The NAP continues the social marketing of male and female condoms along with other commodities such as dental dams.

School-based HIV education for youth	The NAP continues with it collaboration with the Ministry of Education towards ensuring HIV/AIDS education and life-skills are delivered in all Schools. Additionally, the 3H Network with funds from UNESCO continues to distribute copies of the book *"VOICES"* to government and private secondary schools. "Voices" is the compilations of the stories of PLHIV and has a discussion guide that is used by guidance counsellors and Social Studies teachers to initiate discussion and promote HIV prevention among teenagers.
Voluntary Counselling and Testing	Training of Health care workers continues and the HIV testing algorithm was developed with assistance from CDC. The NAP continues with its training of health care providers and staff development.
Programmes for sex workers	In collaboration with CHAA and the 3H Network MARPs in Antigua and Barbuda continue to be reached with HIV prevention programmes.
MSM and other most-at-risk populations	In collaboration with CHRC, CDC and University of California San Francisco the Ministry of Health is seeking to develop a suitable methodology to collect from MARPs this subgroup.
HIV counselling and testing community outreach	Efforts to provide intensified efforts in the country continue. There is an increase in the up-take of testing services.
Blood safety	Safety of blood supply is maintained at MSJMC lab in accordance with the World Health Organization standards. The laboratory continues to ensure that quality assurance is achieved.
PMTCT	There has been an increase in the uptake of PMTCT services and treatment continues to be provided free of cost to all HIV positive Mothers and their partners.
Programmes to ensure safe injections in health care settings	Needles and syringes are not reused and are safely discarded in bio-hazard disposable sharps containers. There is no reuse policy for needles and syringes in Antigua & Barbuda.

Mechanism to ensure that PLHIV receive appropriate medical care, home care and supportive palliative care	The NAP continues its work in collaboration with the Health, Hope and HIV Network (3H Network), CAREN and Antigua & Barbuda HIV AIDS Network (ABHAN) to ensure PLHIV receive needed and appropriate care. Specialist medical services such as Dental Care, Ophthalmology and Dermatological care is provided free of cost.
Mechanism to address S & D	There is a Human Rights Desk to report violation of human rights and acts of discrimination of HIV positive individuals. (See Annex for a cumulative Report)

Summary of epidemic in Antigua and Barbuda

Antigua and Barbuda, a three-island chain comprise the inhabited islands of Antigua (108 square miles), Barbuda (68 square miles) and the uninhabited island of Redonda (1/2 square mile) which is a nature reserve. The country has been the gateway to the Caribbean since the end of the 18th century thanks to its advantageous location.

The main driver of the economy is tourism which attracts foreign exchange, increased employment and government revenue. This dependence, coupled with the introduction of casinos and gambling spots, has resulted in the growth of sex work. The 2001 Census of Population and Housing projected a resident population for the years 2010 and 2011 to be ninety thousand, eight hundred and one (90, 801) comprising of forty two thousand, eight hundred and seventy-one (42,871) or fifty seven percent (57%) males and forty-eight thousand, one hundred and fifty nine (48,159) or fifty three percent females (53 %). (See table 8 below).

Table 8: Estimate Resident Population 2010 – 2011 Antigua and Barbuda

2010			
Age-1-5-Yr	**Total**	**Male**	**Female**
Total	**90,801**	**42,642**	**48,159**
0	1,686	839	847
1	1,685	871	814
2	1,716	889	827
3	1,735	917	818
4	1,738	864	874
5-9	8,724	4,350	4,374
10-14	8,375	4,057	4,318
15-19	7,471	3,543	3,928
20-24	7,159	3,421	3,738
25-29	7,556	3,476	4,079
30-34	8,246	3,668	4,578
35-39	7,896	3,566	4,330
40-44	6,556	2,958	3,598
45-49	5,109	2,387	2,723
50-54	3,859	1,820	2,040
55-59	2,822	1,275	1,547
60-64	2,225	1,019	1,206
65-69	1,865	853	1,012
70-74	1,582	694	888
75-79	1,207	556	651
80-84	859	364	495
85-89	479	175	304
90-94	216	71	145
Over 94	35	9	26

Source: Health Information Division

In 2010, the crude birth rate was 13.68 per 10,000 populations, infant mortality rate 10.46 per thousand live births, the crude death rate in 2010 was 5.56 per 10,000 populations; maternal mortality rate of 0.81 per 10,000 population and the total Fertility Rate was 315.7.

Approximately 1.04% of the population is indigent and the literacy rate is approximately 99%. On the other hand 12,341 or 13.84% of the population were poor but not indigent.

The health system is financed through public taxation, levies, private insurance and the Social

Security Fund. User fees, the main source of revenue in the private sector, have a negligible role in public sector financing. During the period 2010-2011, government expenditure on health averaged 8.8% and 10.2% of the national budget respectively. The recurrent expenditure in health for the year 2010 was EC $ 41,669,990.00 and 2011 expenditure was EC $ 44,511,136.00. International, non-governmental and national agencies continue to provide technical and financial support to the NAP.

Since December 1985 when Antigua & Barbuda reported its first case of HIV infection, in a homosexual male a cumulative total of approximately 224 persons have died from AIDS-related illnesses.

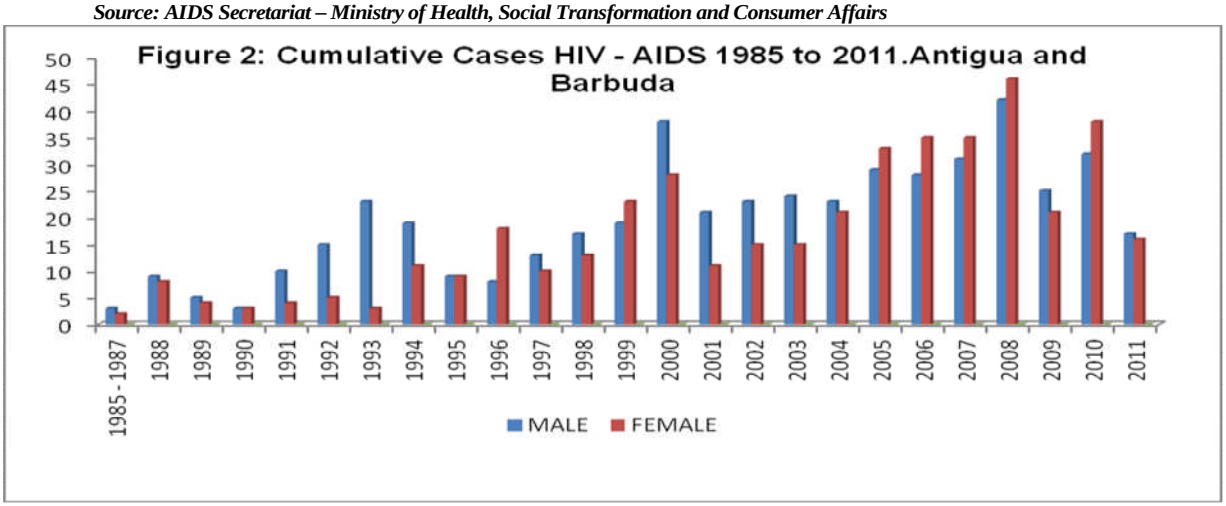
In view of the fact that since the advent of free ART in September 2004, the death rate among HIV-positive persons who access care and treatment and adhere to their medication has shown a slow progression to AIDS and death due to AIDS related illnesses. Heterosexual transmission remains the leading mode of HIV transmission.

Figure two (2) below shows the total number of HIV Cumulative Cases from 1985 to 2011. Approximately 53% or 487 cases were Male, 47% or 432 were Female (See table 9 - figure 2).

Table 9: HIV Cumulative Cases from 1985 to 2011

1985-2011				
F	**%**	**M**	**%**	**TOTAL**
487	53	432	47	**919**

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



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

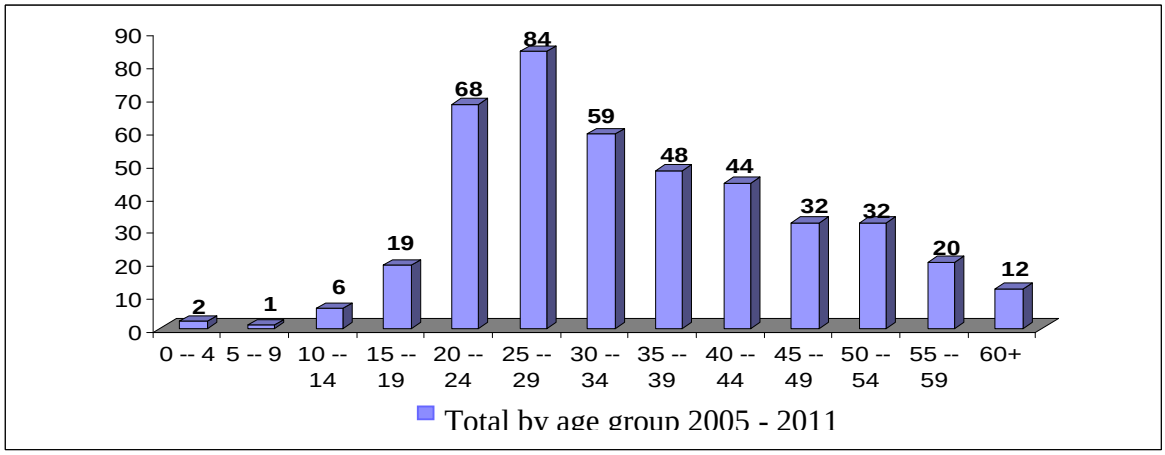
The available data indicate that the economically active population is most affected by the AIDS epidemic with the majority of notified cases of HIV occurring in persons between the ages of 20 and 54 years. In is evident that women have out-numbered men among HIV positive persons (See table 10 and figure 3) and among the reported cases of AIDS, there are more males compared to females. Anecdotal evidence suggests that the most at-risk groups are the youth, MSM and FSW.

Table 10: Total Cases of HIV by age group 2005-2011

AGE GROUP	TOTAL 2005-2011
0 -- 4	2
5 -- 9	1
10 -- 14	6
15 -- 19	19
20 -- 24	**68**
25 -- 29	**84**
30 -- 34	**59**
35 -- 39	**48**
40 -- 44	**44**
45 -- 49	**32**
50 -- 54	**32**
55 -- 59	20
60+	12
Total	**427**

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

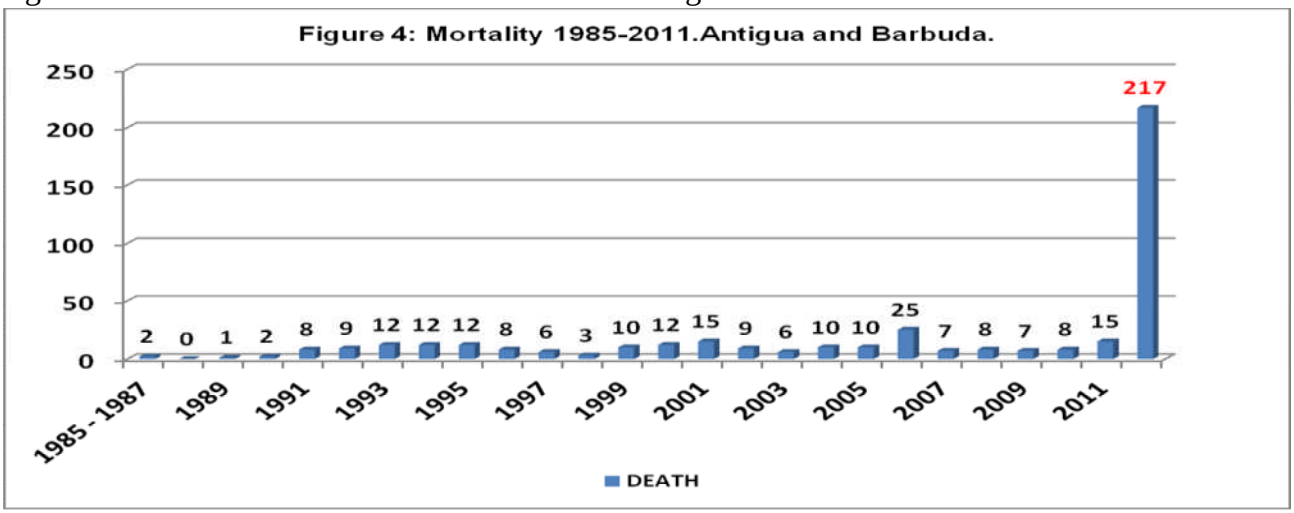
Figure 3: Total HIV cases by age group 2005 – 2011



There has been a steady exponential increase in the number of persons infected with HIV over the years. This is likely due to the increase of unprotected sexual encounter by both heterosexuals and homosexuals.

In 2011, we have seen a drop in HIV transmission, which, if sustained in the coming years will be attributed to behaviour change as a result of the information, education and communication programmes conducted by the NAP and its partners.

Figure 4 below shows total number related deaths in Antigua and Barbuda from 1985 to 2011



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

The data above suggest that in Antigua and Barbuda there is a low lethality rate at 23.6% since the start of the HIV and AIDS epidemic in 1985.

For the period 2010 - 2011, there were one hundred and three (103) reported cases of HIV. Forty nine (49) males and fifty four (54) were females were tested positive for HIV with this period. (See table 11 below).

Table 11: HIV cases by sex 2010 and 2011 in Antigua and Barbuda

Sex	**2010**	**2011**	**Total**
Male	32	17	49
Female	39	15	54
Total	**71**	**32**	**103**

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

The majority of persons with HIV infection are in the Age group 15-49. One hundred and three (103) HIV positive cases were reported for the period 2010 – 2011. Fifty (50) cases between the ages 15 to 49 (22 males and 28 females) and two individuals under the age of fifteen in 2010 and twenty-four (24) reported cases (12 males and 12 females) in 2011. The data also showed that the number of reported HIV cases is higher in women than in men. (See figure 6 below).

Between the ages 15 - 24 years, there are a greater proportion of females infected than males. This is probable due to girls having more opportunities for high-risk activities like commercial sex work, transactional sex, and inter-generational sex. Females are also physiologically more vulnerable to infection than males and they are also affected negatively by power inequality which inhibits their ability to sustainable negotiation of safe sex practices.

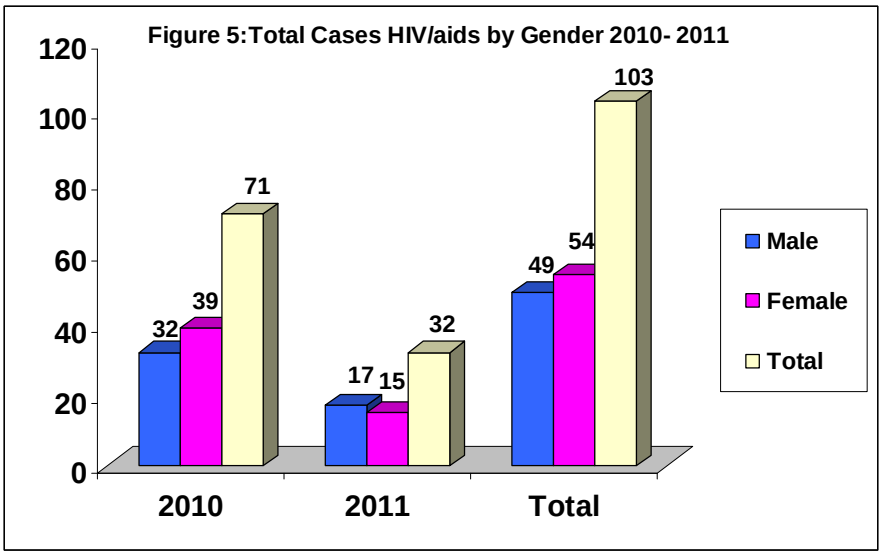
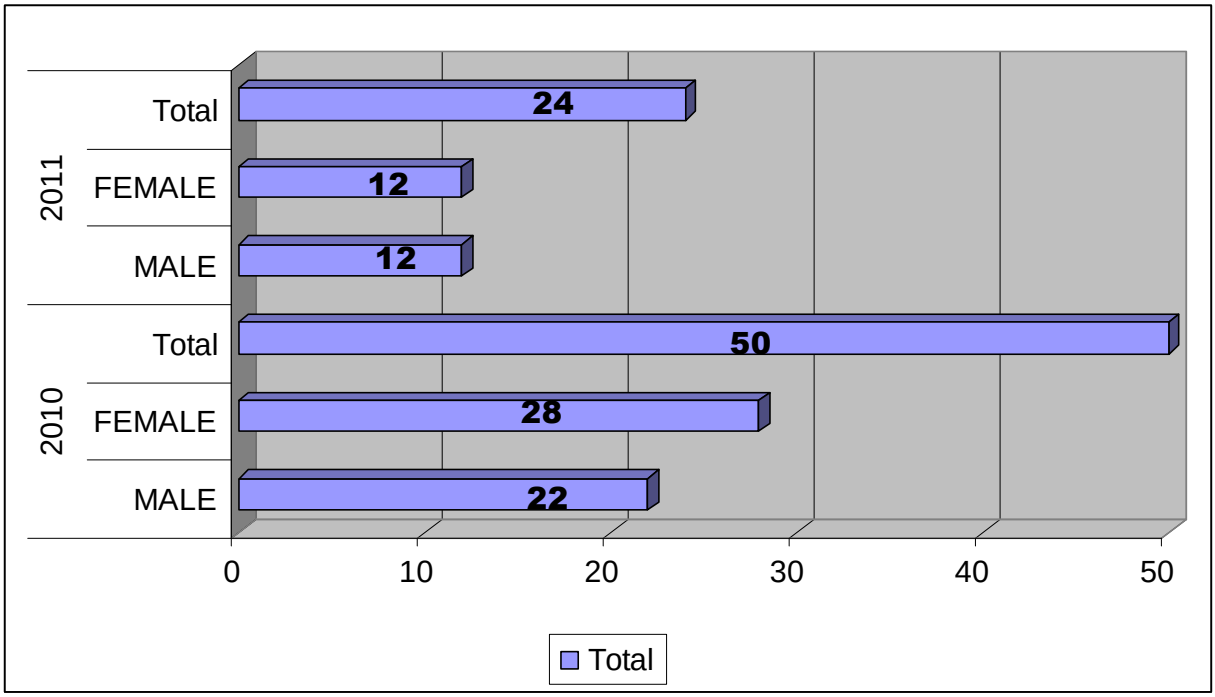


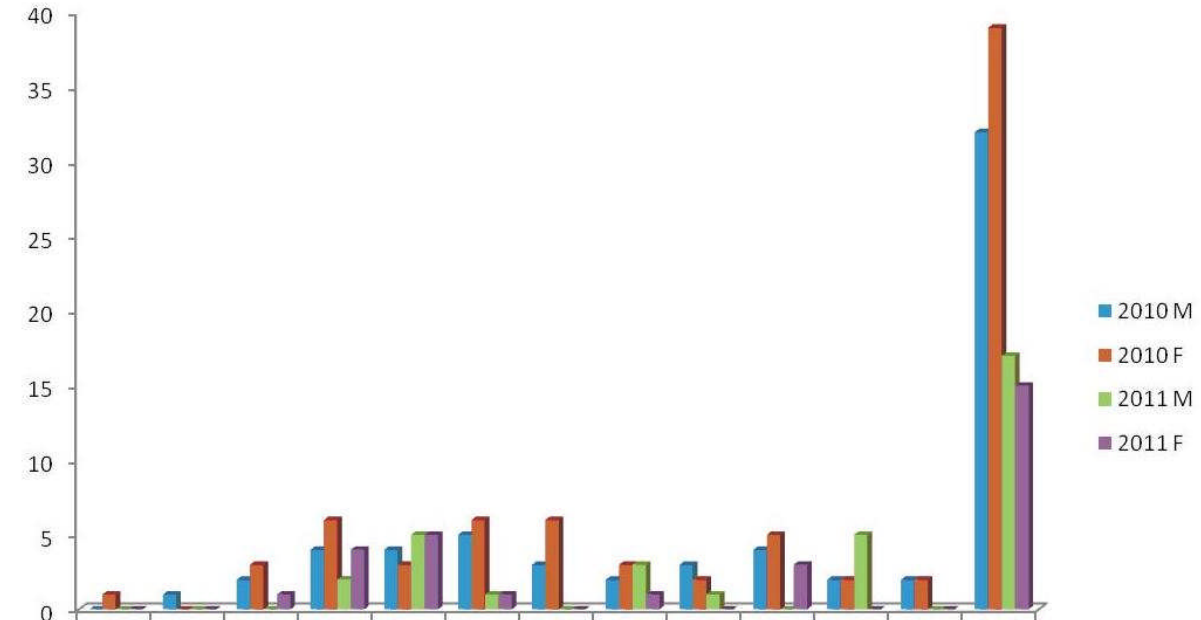
Figure 6: HIV cases age group 15 to 49 in Antigua and Barbuda 2010 - 2011



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

Figure 7 below shows total number of HIV reported Cases in 2010 and 2011. There were fifty two (71) cases of HIV, 73.2% or 71 cases were found to be in the age group 15-49 years in 2010. Of the 32 cases diagnosed in 2011, there were 75% between the same age group.

Figure 7: HIV/AIDS Desegregate by Age and Sex 2010 – 2011



	0 - 9	10 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55-59	60+	Total
2010 M	0	1	2	4	4	5	3	2	3	4	2	2	32
2010 F	1	0	3	6	3	6	6	3	2	5	2	2	39
2011 M	0	0	0	2	5	1	0	3	1	0	5	0	17
2011 F	0	0	1	4	5	1	0	1	0	3	0	0	15

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

Most of the HIV positive cases were found in the 30 to 34 age group in 2010; in 2011 the age group with the highest infection rate was the 25 – 29. It was widely spread out within several groups. Of much cause for concern is the increasing incidence in the older age groups which may be suggesting that these individuals maybe engaged in either unprotected or high risk sexual practices.

Information from Health Information Division (HID) Patient Monitoring System (PMS) shows that in 2010 there were 58 newly diagnosed AIDS cases and in 2011 31 cases.

The total deaths in 2010 were seven (7) males and one (1) Female and 2011 fifteen (15) deaths (14

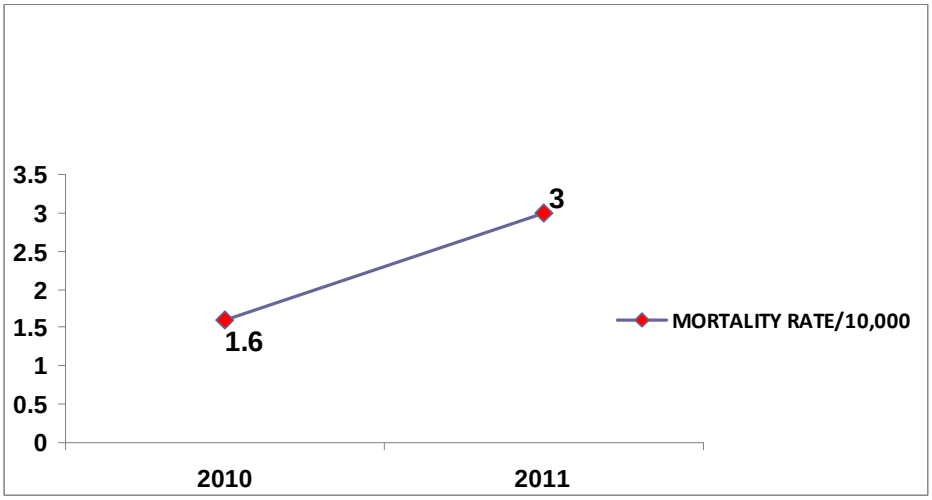
males and 1 female), (See table 13 and figure 8). We note that the mortality rate is an increasing trend in 2011 (3.0) this is due to growth of total accumulated cases (702).

Table13 HIV and AIDS mortality 2010/2011

	No. Cases	Death			Mortality Rate
		F	M	TOTAL	
2010	71	1	7	8	1.6
2011	32	1	14	15	3
TOTAL	103	2	21	23	2.2

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

Figure 8: HIV/aids Mortality Rate 2010 - 2011 Antigua-Barbuda



The total hospitalization for 2010 was 21 cases, with 9 deaths resulting in 42.8%. In 2011, 30 persons were hospitalized, 14 were lost to AIDS related illness with a percentage of 46.6. Of this total eleven (11) were males who were diagnosed with advanced HIV infection. The Ministry Of Health over the past two years have been focused its attention on strategies to target males with health educational messages. The expected outcome of this strategy is to reduce the negative health-seeking behaviour of males (waiting until they are too ill before seeking health care) and increase access VCT services.

Advanced HIV:

Screening tests for HIV in 2010 and 2011 indicated a 0.31% and 0.7% sero-prevalence rate for 2010 and 2011 respectively.

HIV screening is carried out routinely for pregnant women attending antenatal clinics. This represents the only population that has been monitored. Additionally, others are tested upon admission for delivery. The table 14 below shows the percentage of HIV-positive persons attending antenatal clinics 2010-2011.

Table14: Number pregnant women tested for HIV at Antenatal and Maternity ward for the period 2010 - 2011

PMTCT	**2010**	**2011**
No. tested	993	861
No. tested positive	3	6
HIV pos. %	0.31	0.7

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

The percentage of HIV positive pregnant women increased in 2011 by 1.06 % which may be the result of an increased uptake of testing. This is in line with the regional estimated prevalence for the Caribbean which was estimated at 1.0% for the ages 15 – 49 by the estimates update for 2009 that is published by UNAIDS.

Target 1.Reduce sexual transmission of HIV by 50 per cent by 2015
Indicators for the general population

Target 1.1: Percentage of young women and men aged 15–24 years who correctly identify ways of preventing Sexual Transmission of HIV and who reject Major Misconceptions about HIV Transmission.

The information for this indicator is a KAPD Survey in six Countries of the Organisation of Eastern Caribbean States (OECS) 2011 Antigua and Barbuda is included in the six countries. The findings of the survey indicate that 48.7% divided by sex male 54.3% and Female 45.7% of the Population aged 15-24 years who identified the correct ways of preventing the sexual transmission of HIV and rejected major misconceptions.

Target 1.2: Percentage of young women and men aged 15–24 years who have had sexual intercourse before the age of 15 years.

Information from the KAPB survey 2011 indicates that 19.1% of the respondents in the age group 15-24years had sex (oral, vaginal or anal penetrative sex) before the age of 15 years. 29.7% Male and 11.8% female.

Target 1.3: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months.

The percentage of women and men aged 15–49 who have had sexual intercourse with more the than one partner in the last 12 months is 15.3%, 24% male and 8.8% female.

Target 1.4: Percentage of women and men aged 15–49 who had more than one sexual Partner in the past 12 months reporting the use of a condom during their last Sexual intercourse.

The KABP survey 2011 indicates that 67.0% of respondents in the age group 15-49 years reported using a condom the last time they had sexual Intercourse, 69% male and 61.7% female.

Target 1.5: Percentage of women and men aged 15-49 who received an HIV test in the Last 12 months and who know their results.

A KAPB indicates that 33.7 % Males and 66.3 % Female received an HIV test in the last 12 months and know their HIV status.

Target 1.6: Percentage of young women and men aged 15–24 years who are HIV infected

The percentage of persons aged 15-24 Years who were infected with HIV in 2010 is 0.11% (15) and 2011 0.04% (7 persons) respectively.

Table 24: The estimated projected population in the age group 15-49 years for 2010 and 2011

AGE GROUP	**2010 -2011**		
	Male	**Female**	**Total**
All Ages	29,855	35,287	65,142
15 - 49 yrs	23,018	26,974	49,992

Source: 2001 Census of Population and Housing

Based on the 2001 Census of Population and Housing, the projected estimated resident population for 2010 and 2011 is 65, 142 persons comprising the age group 15-49 years. This includes 23,018 males and 26,974 females. Of this total there are 6, 964 males and 7,666 females in the 15-24 age group.

For the period 2010 to 2011, there were 103 persons testing positive to HIV. Data collected from the MSJMC Lab indicate that there were 71 persons tested positive to HIV in 2010, twenty (32) males and 39 females and in 2011, 17 males and 15 females.

For the period 2010 to the end of December 2011, the percentage of persons aged 15-24 Years who were infected with HIV in 2010 is 0.11% (15) and 2011 0.04% (7 persons) respectively.

Target 1.7 Percentage of most-at-risk (female sex workers) populations reached with HIV prevention programmes:

Antigua and Barbuda has not conducted any recent surveys with MARPs. The AIDS Secretariat currently targets female sex workers in the wider population. Since no BSS for MARPs have been done during the period under review, there is no data available for reporting on this indicator. To address this situation, the Ministry of Health (MOH) in 2011 made a request and received technical assistance from CHRC, CDC, and University of California San Francisco to conduct a survey to inform the NAP on strategies for prevention interventions with Sex Workers and Men who have sex with men.

Consideration has been given to the respondent driven sampling methodology which is been utilized by other Caribbean countries in similar studies. However, given the small sample size and unique characteristics of inward and outward migration flows of MARPs it was determined that a methodology be designed for peculiarities of small island such as Antigua and Barbuda.

Notwithstanding this, the MOH and the NAP have partnered with Civil Society, NGO's and other Governmental agencies which carry out intervention in the sub population in question. See the summary of activities carried out by CHAA, one of the partners involved Tables 6 & 7.

Table 21 Number of most at risk population reached in 2010 and 2011 respectively.

Categories	**2010**	**2011**
Number of people reached through HIV prevention activities (Males)	129	109
Number of people reached through HIV prevention activities (Females)	364	228
Number of condoms distributed	53,374	4799

Source: Caribbean HIV/AIDS Alliance (CHAA) QRT report

Target 1.8: Percentage of female and male sex workers reporting the use of a condom with their most recent client.

Data for this indicator are not available because of the challenges experienced with surveys in small at-risk populations and as outlined in the pilot BSS survey among MSM and FSW done in 2006.

There is presently technical assistance being given to develop a survey instrument to collect information from MSM and Sex Workers.

Target 1.9: Percentage of Sex Workers who have received an HIV test in the past 12 months and know their results.

There are no official records containing information on the use of the health services by most-at risk populations as they are included in the general population with respect to health care services and they will not necessarily identify themselves as part of that population when seeking care. Data for this indicator are not available.

Target 1.10: Percentage of Sex Workers who are living with HIV.

There are no official records containing information on the use of the health services by most-at risk populations as they are included in the general population with respect to health care services and they will not necessarily identify themselves as part of that population when seeking care. Data for this indicator are not available

Indicators for men who have sex with men

Target 1.11 Percentage of men who have sex with men (MSM) reached with HIV prevention programmes:

There is no data on this indicator although there are civil society organization have been providing services to MSM. Please check indicator 1.7

Target 1.12: Percentage of men who have sex with other men reporting the use of a condom the last time they had anal sex with a male partner

Information on this indicator is not available.

Target 1.13: Percentage of men who have sex with other men that have received an HIV test in the past 12 months and know their results.

Information on this indicator is not available.

Target 1.14: Percentage of men who have sex with other men who are living with HIV.

Information on this indicator is not available.

Target 2.Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015.

Antigua and Barbuda has no data on people who inject drugs because no BSS on injection drug users has ever been done in the country. Therefore none of these indicators can be answered.

Target 2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes

No data available

Target 2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

No data available

Target 2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected

No data available

Target 2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results

No data available

Target 2.5 Percentage of people who inject drugs who are living with HIV

No data available

Target 3.Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths

3.1 Percentage of HIV-positive pregnant women who receive anti-retrovirals

to reduce the risk of mother-to-child transmission

During the period 2010 and 2011, eight health facilities, Antigua Planned Parenthood Association, Antenatal Clinic at Mount St. John's Medical Centre (MSJMC) and the Hannah Thomas hospital in Barbuda offered free Voluntary Counselling and Testing services.

Below are tables showing data from the MSJMC Antenatal Clinic records in table 19 below. In 2011 one (1) client express no interest in getting an HIV test and therefore refused testing.

Table 19: Number of women on ART in the PMTCT programme 2010 - 2011

PMTCT	**2010**	**2011**
No. of patients seen at Antenatal Clinics	974	1017
No. of patients tested for HIV prior to booking	791	559
No. of patients pre-test counselled for HIV Antenatal Clinics	123	196
No. of patients tested for HIV in ANC	121	195
No. of patients testing negative for HIV	121	193
No. of patients testing positive for HIV	0	2
Known HIV Cases prior to pregnancy	4	8
No. of patients on ART	4	12

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

From the data collected, the percentage of HIV-positive pregnant women who received ART 2010 and 2011 is 100% and 100% respectively.

Patients who are admitted to the Maternity unit without an HIV test is pre-test counselled and offered a free HIV test.

Below is a table reflecting the amount of patients who have been counselled and tested at the Maternity Ward at Mount St. John's Medical Centre (See table 20 below).

Table 20: Number of women tested for HIV at Maternity Ward 2010 – 2011

PMTCT	2010	2011
No. of patients counselled for HIV at maternity	81	107
No. of patients tested for HIV at maternity	81	107
No. of patients tested HIV negative at maternity	79	103
No. of patients tested HIV positive at maternity	3	4

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

Blood units are collected and screened annually according to WHO standards. In 2010 eight hundred and ninety-one (891) units of blood were tested. Eight hundred and eighty-six (886) tested negative to HIV and five tested positive. In 2011 eleven hundred and forty seven (1147) units of blood were tested for HIV. Eleven hundred and forty-five units (1145) tested HIV negative and two (2) tested HIV positive. The HIV prevalence for blood donors in 2010 and 2011 were 0.56 % and 0.17% respectively.

There is two public laboratory and four private laboratories. Screening of blood and blood products for HIV and other STIs are carried out at the public and private laboratories and reports are submitted to the AIDS Secretariat on a regular basis.

The report includes information on age, sex, reasons for requesting the test and the results of the test. The table below shows the number of units of blood collected and screened during 2010 and 2011.

From the data collected the percentage of donated blood units screened for HIV for 2010 and 2011 was 100% and 100% respectively (See table 18).

Table 18: Number of blood units collected and screened 2010 – 2011

Sources of referral	2010	2011

	Blood screened	HIV pos.	Blood screened	HIV pos.
Blood donors	891	5	1147	2
STI patients	150	9	57	3
Antenatal clients	305	5	302	1
Insurance clients	9	2	20	0
Routine	2038	55	977	26
Total	**3303**	**71**	**2503**	**32**

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

3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

All infants born to HIV infected mothers receive their DNA/PCR at six weeks after Birth. There were five (5) infants tested in 2010, and each test had a negative result. In 2011 five (5) infants were referred for testing, three infants were tested negative to HIV, one (1) DNA PCR Detected and one (1) results still pending.

3.3 Mother-to-child transmission of HIV (modelled)

PMTCT Services are provided in conjunction with antenatal and delivery services at the MSJMC. The PMTCT services includes pre-test and post-test counselling which providing HIV-positive pregnant women with counselling on infant feeding and the importance of condom use to prevent HIV transmission; and the provision of prophylactic Triple therapy ARVs and Bactrim to the HIV-positive mother and to her newborn (within 72 hours of birth) and the provision of DNA PCR for the infant one month to six weeks after delivery.

Target 4.
Have 15 million people living with HIV on antiretroviral treatment by 2015

Indicators

4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*

In Antigua and Barbuda ARV is given to all HIV infected persons regardless of immigration status. ARVs are paid for under the PANCAP Global Fund Round 9 Grant. Care and treatment services are according to the international and Caribbean guidelines for care and treatment.

The table above indicates an increase in the number of persons accessing and adhering to ARV Therapy in 2010 and is evidence of a sustained increase in 2011. However; there was a 0.1% decrease in the percentage of persons accessing ARVs in 2011 compared to those accessing in 2010.

Table 22: Number of adults and children with advance HIV/AIDS receiving ARV therapy, lost to follow up or have died.

	2010		**2011**	
	Number	**%**	**Number**	**%**
Advance HIV Cases	189	27.6	216	30.7
Number Adhering to	163	86	186	86.1
Number Lost to	18	9.5	16	7
Deaths	8	4.2	15	6.9

Source: HID HIV PMS

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

Table 25 shows the **n**umber of persons known to be HIV positive and receiving ARV treatment. It also observes an 86.2 % in 2010 and 86.1% in 2011.

Table 25: Percentage of adults and children HIV - ARV treatment 2010 - 2011

	2010		2011	
Number Adhering to ARV	Number	%	Number	%
	163	86.2	186	86.1

Source: HID HIV PMS

Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015

Tuberculosis (TB) which has re-emerged as a Public Health threat internationally has become a cause for concern in Antigua and Barbuda. All suspected TB cases are hospitalised for additional investigation and treatment. All clients diagnosed with TB are tested for HIV. In both 2010 and 2011, 5 HIV/TB cases (co-infections) were diagnosed and treated in hospital.

Upon discharge from hospital care, they are monitored by the Nurse epidemiologist who is responsible for investigating all TB reported cases, conduct PPD screening of contacts, coordinate the follow-up of treatment and conducts the DOTS programme.

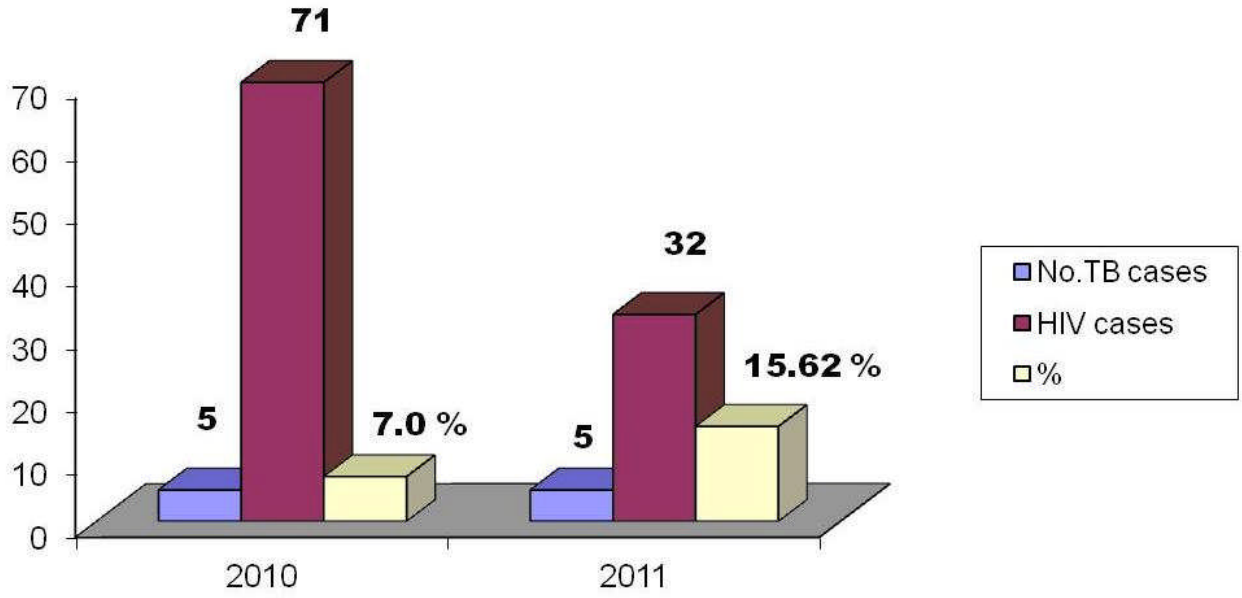
The client is referred to the CCC for HIV treatment and care and also to the Contact tracing team at the AIDS Secretariat.

In table below the number and percentage of HIV/TB cases compared to those diagnosed with HIV in 2010 and 2011 is represented. All TB clients and their contacts are screened and they are followed up in their respective District Clinics upon discharge from hospital (See table 23 – figure 10).

Table 23: Incidence of TB cases PLHIV 2010- 2011

	2010	**2011**
No. TB cases	5	5
HIV cases	71	32
%	7.0	15.62

Figure 10: Incidence of TB cases PLHIV 2010-2011



Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries

For the financial year 2010 to 2011, the Government of Antigua and Barbuda received **technical assistance through PEPFAR, r**egional and international donors along with the government allocated budget of 802,769.00 ECD. Contributions from local business entities and fund raisers amounted to 12,336.23 ECDs in 2010.

In 2011, international and regional contributions decreased to 768,556.63 EC Dollars whereas the government's spending increased to 860,032.00. Local Donors contributions and fund raisers increased to 25,585.75 ECD.

This shift in local expenditure is encouraged and it is hoped that this will be sustainable as the current world economic crisis places tremendous difficulty on donor agencies to continue the financial injection they are presently making into HIV intervention.

See below Table 17 Domestic, Regional and International HIV and AIDS expenditure for the period 2010 and 2011.

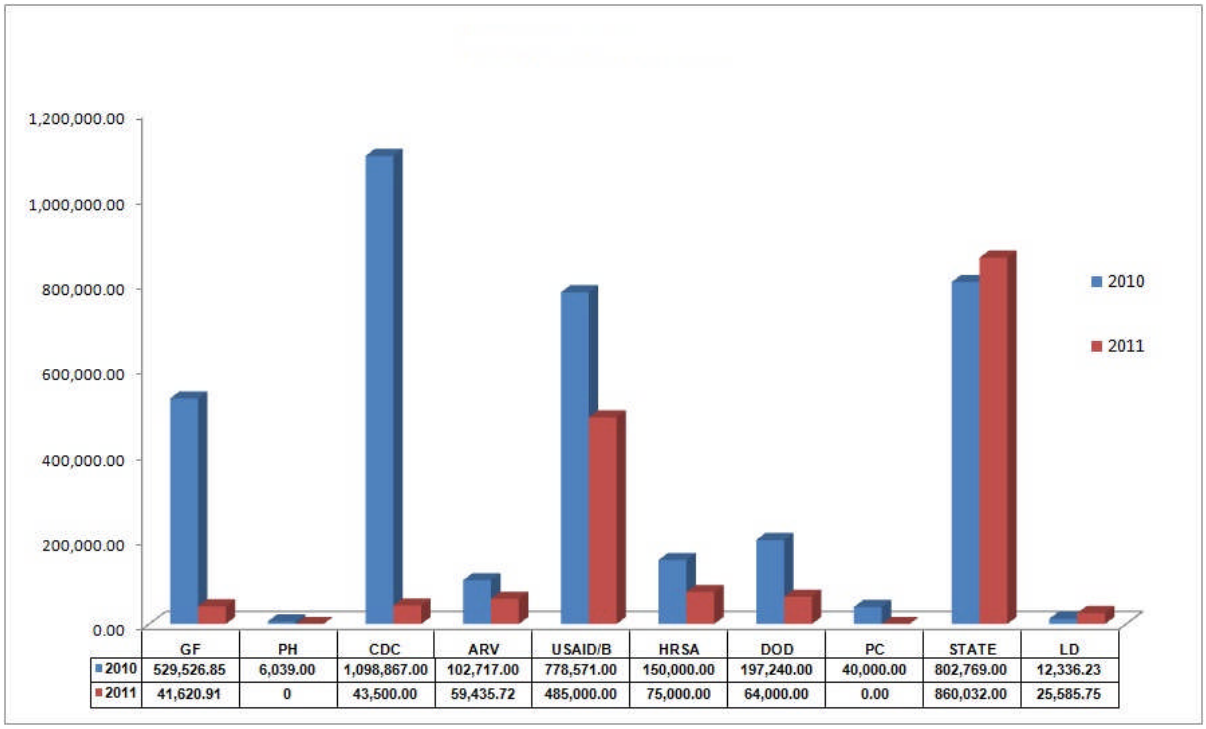
Table 17: **Domestic,** Regional and International spending 2010-2011

HEADING	2010	2011

GF	529,526.85	41,620.91
PAHO	18,606.86	18,606.86
CDC	1,098,867.00	43,500.00
ARV	102,717.00	59,435.72
USAID/B	778,571.00	485,000.00
HRSA	150,000.00	75,000.00
DOD	197,240.00	64,000.00
PC	40,000.00	0.00
STATE	802,769.00	860,032.00
LD	12,336.23	25,585.75
TOTAL	**3,718,066.08**	**1,654,174.38**

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

Figure 9: International AIDS spending by categories and financing 2010 – 2011



For the period 2010-2011, a review of the Antigua and Barbuda's Estimates indicated that Funds for the NAP were allocated as shown in table 16 below.

Table 16: Government financial commitment for the NAP

Year	Amt. allocated	Amt. Spent
2010	**$ 815,105.23 ECD**	**$ 815,105.23 ECD**

2011	**$ 885,617.75 ECD**	**$ 885,617.75 ECD**

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

Information on actual expenditure is not itemized into the categories recommended by UNAIDS. Monies are dispersed by the Ministry of Finance as requests are made to carry out various activities of the NAP. Funds are released from the Programme Sub-Head according to the Annual Estimates of the Ministry of Health. A periodic reporting of expenditures of international donor funding were done during the period under review.

Target 7. Critical enablers and synergies with development sectors
Indicators

7.1 National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)

National Composite Policy Index covers areas gender, workplace programmes, stigma and discrimination, prevention, care and support, Human rights, civil society involvement, and monitoring and evaluation Please National Composite attached.

7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.

Gender violence continues to be an issue as indicated by the two organisations providing support to women who are affected by physical and sexual violence.

There have been no national surveys on gender violence in Antigua and Barbuda. Women Against Rape (WAR) reported that data collected from clients indicate that 89% of the clients experienced physical or sexual violence from a male intimate partner in the past 12 months.

There were one hundred and twenty Women aged 15-49 who currently have or had an intimate partner who reported experiencing physical or sexual violence by at least one of these partners within the past 12 months**.**

The Directorate of Gender affairs is a government department which provides services for clients who experience gender-based violence.

In Antigua and Barbuda it has been said and debated in many quarters that gender-based violence has a direct link to HIV and this phenomenon is yet to be addressed. With the statistics provided it is clear that women are still vulnerable to HIV through gender – based violence physiologically, socially and economically. Yet many are still not comfortable to talk about it even though more and more women are sensitized about their rights and have knowledge and access to services.

Some women are still seen as the property of some men thus very often, they cannot control with whom or under what circumstances they have sex and are still afraid to discuss the use of protection with their partners.

Below in Table is a tabulated form of gender-based violence statistics.

DIRECTORATE OF GENDER AFFAIRS
GENDER - BASED VIOLENCE STATISTICS 2010

TYPE OF ABUSE	**TOTAL NUMBER**	**SEX OF VICTIM**		**SEX OF PERPETRATON**	
		MALE	**FEMALE**	**MALE**	**FEMALE**
Rape & Sexual Violence (Adult)	35	-	**35**	35	-
Child Rape & Sexual Violence (under 18 years of age)	4		4	4	
Physical Abuse (Adult)	92	1	91	91	1
Psychological /emotional abuse (Adult)	185	58	127	127	58
Financial Abuse :	94	5	89	89	5
Verbal Abuse:	154	58	96	96	58
Sexual Abuse (in domestic violence)	22	-	22	22	-
TOTAL NUMBER OF DV CASES	260	30	**230**	230	30
Number of Rape and S.A. cases in adults and under 18	39			39	-
Other Cases , advice, counselling etc	27	4	23	-	-
Human Trafficking	**3**	-	3	2	4
TOTAL NUMBER OF CASES FOR 2010	**329**				

DIRECTORATE OF GENDER AFFAIRS
GENDER - BASED VIOLENCE STATISTICS 2011

TYPE OF ABUSE	TOTAL NUMBER	SEX OF VICTIM		SEX OF PERPETRATOR	
		MALE	FEMALE	MALE	FEMALE
Rape & Sexual Violence (Adult	6 This represents the number of individuals who access the service and were sent by the police.	-	**6**	6	-
Child Rape & Sexual Violence (under 18 years of age)	10 This represents the number of individuals who access the service and were sent by the police.		10	10	
Physical Abuse (Adult)	93	5	88	88	5
Psychological/emotional abuse (Adult)	283	43	240	240	43
Financial Abuse :	201	2	199	199	2
Verbal Abuse:	283	43	240	240	43
Sexual Abuse (in domestic violence)	38	-	38	38	-
TOTAL NUMBER OF DV CASES	**283**	**43**	**240**	**239**	**44**
Number of Rape and S.A. cases in adults and under 18	16				-
Other Cases , advice, counselling etc	**43**	18	25	25	16
Human Trafficking	**22**	-	22		**1**
TOTAL NUMBER OF Cases for 2011	**364**				

Myths about condoms use, together with risk behaviour, put women at more risk and vulnerable to HIV and other STIs. While we focus our attention on the prevention of HIV within our society, the prevalence of STIs is cause of great concern and a collaborative approach is needed between agencies to address the link between Gender Base Violence and HIV.

.3 Current school attendance among orphans and non-orphans aged 10–14*

In Antigua and Barbuda, education is free and compulsory for all children aged 5 to 16 years. The fact that education is mandatory in the country suggests that all children including orphans who are HIV positive must attend school.

Although there are reports that there are orphans and vulnerable children (OVC) resulting from the AIDS epidemic in Antigua and Barbuda there are no records or official data to confirm these

Reports. Presently there are three HIV orphans in government care and three in the care of relatives.

To ensure that the school environment remain safe for students and teachers Health and Family life education (HFLE) is taught. Below is a table depicting the amount of school where HFLE is taught to students.

Table---- **HFLE in Antigua & Barbuda 2010 - 2011**

Secondary	**Number schools**	**HFLE**
Private	11	2 Christian Family Life Education
Public	13	8 (infused in Guidance) 4 (HFLE separate subject)
Primary		
Private	32	-
Public	29	15 (In some cases subject taught at selected grades)

7.4 Proportion of the poorest households who received external conomic support in the past 3 months

No specific data is available for this indicator as per number of households receiving economic support. But, 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 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.

IV.

Major challenges to achieve the GARPR targets

The AIDS response for Antigua and Barbuda identified the following challenges in carrying out activities of the NAP 2011-2011

CHALLENGES	RECOMMENDATIONS / ACTION
Programme Coordination and Management	
1. An out-dated Care and Treatment Guidelines. Last Treatment guideline which was revised in 2006 and the treatment of HIV and AIDS have improved, evolve and change.	1 Develop a new Care and treatment guideline through technical support from Antigua and Barbuda PAHO BWP. Align the guideline with OECS HAPU Care and Treatment Guidelines. Strengthen the structure of governance of the NAP by reappointment of the National AIDS Committee. Speedy passage of the news Strategic Plan.
2 Limited data on MARPS, especially MSM and SW to conduct effective HIV intervention by the NAP.	2. Presently working with CHRC, CDC and University of California San Francisco to develop an instrument to collect information on these vulnerable at risk populations.
3. The Lack of a monitoring and evaluation officer at the NAP to collect empirical data on the HIV epidemic and disseminate it on at regular and timely intervals to the general	4. Human resource Capacity development by training a NAP staff in Monitoring and Evaluation at CHRC for six months.

4. Lack of recent, relevant and accurate data to report on the various indicators requested	4. Urgent need to develop a research and data collection culture where regular Continue to strengthen a data collection and coordination of services between partners in the public and private sectors with greater involvement of civil society in the design and implementation of HIV activities the NAP. Integrate gender issues into the HIV/AIDS policies and programmes (all components of the NAP).

P***olicy and Legislation***	
1. Unavailability of updated policies, guidelines and protocols on HIV and AIDS.	1. Build an enabling framework of legislation and rights by reviewing and revising existing policies and laws relating to insurance and HIV testing; immigration and HIV positive persons; and the protection of human rights including those of prisoners.
2. Lack of legislation to address deliberate and reckless transmission of HIV; access to medication by client who are afraid to come forward because of stigma and discrimination; disclosure of HIV status; and access to health services by youth.	2. Revise and update the existing Policy Framework on HIV/AIDS and disseminate widely to all stakeholders involved in the response to AIDS.
3. Lack of anti-discriminatory legislation for the protection of PLHIV especially with respect to housing and employment.	3. Review and revise existing policies and programmes which relate to access to health services by youth; the deliberate and reckless transmission of HIV; access to medicines; and disclosure of HIV status.

4. The need to remove de-criminalize laws on buggery and prostitution	4. Revise the Laws to include the de-criminalisation of buggery and prostitution
5. Stigma and Discrimination been experienced by MARPs when accessing protection, work and health services. The protect human rights as it relates to HIV and AIDS.	5. Implement the HIV/AIDS Workplace policy in private sectors. Inform all PLHIV of their rights and avenues of redress. Continue to financially support the Human Rights Desk.
	6. Develop anti-discriminatory legislation by revising existing legislation and policies that promote or reinforce stigma and Discrimination. Sensitivity training for Uniform personnel 7. Promote the existence of a Human Rights desk for lodging complains.

HIV Education and Prevention	
1. Lack of information or the misconceptions related to drug use and risky sexual behaviour such as early sexual experience and multiple partners among the youth.	1. Develop an effective behaviour change programme for the population through a comprehensive BCC Strategy which aims to bring about lifestyle changes in the population.
2. Lack of knowledge about HIV, and its link with substance abuse and sex, to personal life and behaviour especially among the youth.	2. Design and disseminate age-appropriate messages using various art forms; involving target populations and popular artistes (especially in the music industry) in the design of these messages.
3. Methods used to transmit preventive messages are viewed as inadequate and do not have the desired impact on youth.	3. Ensure that messages (posters and brochures) are displayed in non-traditional outlets and places frequently used by the target population.

4. Limited use of popular artistes and other art forms to disseminate information about HIV and AIDS	4. Train teachers in sexual and reproductive health so that they can discuss these topics comfortably with students.
. Discomfort among some teachers in discussing sexual and reproductive health with students.	5. Improve the coverage of PMTCT by meeting the minimum requirements for facilities providing PMTCT services. The components of routine PMTCT for a facility include: • HIV testing with pre- and post-test counselling; • ARV prophylaxis for the mother and new-born; • Infant feeding counselling; and • Provision of family planning services.
6. Limited promotion of the female condom as a barrier method for preventing HIV transmission and other STI among sexually active individuals.	6. Provide standardized VCT services at easily identifiable sites.
7. Limited finance to purchase condoms for distribution to the general public.	7. Improve collaboration between the agencies involved in the distribution of condoms.
8. The high cost of testing reagent to continue offering the general public free and Confidential HIV testing.	8. Increase the number of sites for the distribution of condoms using non-traditional outlets.
Treatment, care and support	
1. Fragmented treatment and care services for PLHIV especially in the areas of monitoring and follow-up care.	1. Establish a comprehensive treatment, care and support unit for PLHIV.
2. Breaches in confidentiality regarding disclosure of HIV status. This acts as a deterrent for HIV testing and for treating HIV-positive persons with ARV drugs.	2. Establish a system for follow-up care for PLHIV on ARV drugs in the 3H foundation.
3. Lack of youth-friendly services.	3. Re-establish services for adolescents and youth in a user-friendly environment.

4. Low uptake of HIV testing, with more women than men being tested.	4. Provide standardised services for inaccessible vulnerable groups in a more comfortable environment.
5. Unwillingness of male and female sex workers to attend clinics for VCT services.	5. Conduct an island-wide assessment of OVC as well as develop and implement policies for the management of OVC.
6. Lack of knowledge about OVC.	6. Strengthen and coordinate services for OVC involving relevant agencies e.g. Big Brother/Big-Sister Association and the Child and Family Guidance Centre.
7. Under-use of VCT services and Care and treatment by nationals.	7. Develop systems and train staff to ensure high-quality HIV testing and counselling services.
8. Limited number of trained staff to provide ART services and a low number of HIV positive clients accessing available services.	
Monitoring and Evaluation (M&E)	
1. Lack of a Monitoring and Evaluation System which will provide technical assistance to ministries and agencies to maintain applications of Operational and Procedural manuals; as well as provide quality management of information.	1. Establish a Monitoring and Evaluation Framework and System to track the performance impact of the NAP as well as provide evidence-based information to local Stakeholders for decision-making and to international donors for funding.
2. Lack of a monitoring and evaluation officer assigned to the National programme	2. Improve M&E skills (capacity building).

3. Lack of funds to conduct population surveys, BSS and research associated with vulnerable and most at-risk groups including Youth, MSM, CSW, orphans and vulnerable children in the population.	3. Develop procedures and guidelines for the M&E Framework so that the efficiency and effectiveness of interventions of the NAP can be documented and reported.
	4. Request technical support to develop the M&E Framework and System.
	5. Strengthen the data collection process of the NAP - ensure that information is collected, collated and disseminated on a timely basis to local, regional and international partners/ stakeholders involved in the response to AIDS

ANNEXES.

1. Documents reviewed.
2. List of Participants interviewed.

Annex one

Documents reviewed

1. Strategic Plan for the National Response to HIV/AIDS, Antigua and Barbuda, 2012-2016.
2. GLOBAL AIDS RESPONSE PROGRESS REPORT Country Report 2009 Antigua and Barbuda.
3. Guidelines on Construction of Core Indicators, 2010 Reporting.
5. KNOWLEDGE Attitude Practice and Behaviour Survey (KAPB) in Six Countries of the Organisation of Eastern Caribbean States (OECS), 2011.
6. Caribbean HIV AIDS Alliance (CHAA) quarterly reports to the AIDS Secretariat.
7. Antigua and Barbuda population Census 2001.
8. Risk reduction forms for HIV testing at the AIDS Secretariat.
9. Living Conditions in Antigua & Barbuda: Poverty in a services economy in Transition (volume 1 August 2007).
10. Patient Monitoring system – Health Information Division.
11. Antigua and Barbuda draft HIV policy for the Education Sector.
12. USAID sponsored - Antigua and Barbuda Health Systems and Private sector Assessment 2011 draft.

Annex two

ANTIGUA & BARBUDA HUMAN RIGHTS DESK

REPORT

Reporting Period: December 2010 – December 2011

1. Total # new cases of HR violations documented during reporting period: 24

2. Total # cases followed-up: 16

3. Total # of cases resolved/closed: 1

4. Total # of case for which PLHIV declined going forward: 7

5. Discriminated person: Heterosexual 9 Bisexual 1 Disabled 0

CSW 0 Inmate 3 Transgender 0 Lesbian 0 MSM or Gay* 11

6. Age range of PLHIV making reports of HR Violations: 0 less than 5 0 5-10 0 10-15

9 15-29 12 30-39 2 40-49 1 50-59 0 60 and over

7. Occupation/educational status of discriminated person:

Student 0 Employed 13 Un-employed 11

8. Discriminated person:

21 Living with HIV 0 Relative of PLHIV 3 Friend of PLHIV 0 Other

9. Description of incident	#	Description of incident	#
Denied employment/ Wrongful Dismissal*	2*	Breech of confidentiality	8
Forced to leave job	2	Victimization/discrimination*	14
Denied access to healthcare/S & D at Health Care Facility*	1*	Secondary discrimination against relative or friend*	1*
Denied acceptance into school	0	Harassment/Verbal abuse	3
Forced to leave home or community*	1	Denied housing	0
Forced to leave school	0	Physical violence	0
Denied access to public transportation	1	Denied healthcare while in police custody	2
Other: Wrongful dismissal from place of employment due to sexual orientation Discriminatory remarks made by pharmacy staff or other			

10. Setting where incident occurred:

	#
School	0
Church	0
Home	1
Community: Vendor, Bus Driver, Friends*	2*+2
Health Facility	8
Government Site e.g. Police Station	4
Prison	3
Private Workplace	4
Other: Public Place	1

11. Person/agent accused of acting in a discriminatory way?

	#		#
Teacher	0	Unknown Individual	1
Student/Classmate	0	Family Member	1
Employer/Prospective employer*	3+1*	Community member	4
Co-worker	0	Police/Prison Officer*	2+2*
An Organization or service provider: Health Care	9	Clergy	0
Other: Ex-partner, auxiliary and nursing staff	1		

12. Location where discrimination occurred:

	#
St. John's	23
St. George	1
St. Mary	0
St. Peter	0
St. Paul	0
St. Phillip	0
Barbuda	0

13. Type of report:

[0] No mistreatment

[3] Non-HIV related mistreatment

[2] HIV-Related mistreatment

[19] HIV related Discrimination

14. Recommendation to discriminated person: #

Referral police/ Commissioner *	3+ 1*
Referral counselling/social services	9
Referral mediator/arbitrator e.g. Union / Labour Division*	1+1*
Referral lawyer	0
Referral Ombudsman	pending
Referral ART or AIDS CCC	6
Referral NGO	4
Referral food support	9
Other action taken: Aided in Employment Assistance in clarifying social security concerns Government Aided Assistance	2 1 1

15. Action/s taken:

0 Contact Attorney at Law

0 Contact Ombudsman

4 Request sensitization intervention

0 Contact Trade Union

5 Write letter of complaint to perpetrator(s) or their employer

30 Telephone calls made

10 Meetings

Other:

16. Total # media initiatives supported by HR Desk:

Articles/ads in printed media 6

Radio/TV/telephone Interviews 21

17. Total # of Media Programs, activities and presentations done: 30

18. Total # of civil society and other organizations reached: 20

19.Total # of persons trained in S & D and Human Rights/received information on S & D & Human Rights

104

Prepared by,
Karen Brotherson (Mrs)
Human Rights Manager and Advocate for PLHIV

ANNEX 3

List of Participants interviewed:

Name:	**Organisation**
Hon. Willmouth Daniel	Minister of Health
Mr. Edson Joseph	Permanent Secretary - Ministry of Health
Mrs. Sara Joseph	Principal Assistant Secretary, Ministry of Health
Dr. Rhonda Sealy-Thomas	Chief Medical Officer
Ms Delcora Williams	Ag. AIDS Programme Manager
Sven Grant	Caribbean HIV AIDS Alliance
Mr. Oswald Hannays	HIV Counsellor and Educator
Pas. Karen Brotherson	Health, Hope and HIV Network
Mrs. Brenda Thomas - Odlum	Director Community Development - Ministry of Health
Ms. Shelia Roseau	Director - Directorate of Gender Affairs
Ms. Norma Jeffery	Substance Prevention Officer
Mr. David Massiah	General Secretary – Antigua Workers Union (AWU)
Gail Aska	Out- Reach officer NAP
Mrs. Vernice Mack	President – Antigua & Barbuda Union of Teachers (ABUT)
Mr. John Cole	Coordinator – Anglican Youth Department
Mr. Henderson Bass	Antigua Employers Federation
Alexandrina Wong	Women Against Rape
Eleanor Frederick	Antigua and Barbuda HIV/AIDS Network
Alverna Innis	Director - Directorate of Gender Affairs
Everton Pigott	PMTCT Coordinator NAP
Nurse Lewis	Nurse –Midwife Antenatal Clinic MSJMC
Sister Victorine Simon	Maternity Ward unit Manager MSJMC
Karen Brotherson	Director Health Hope and HIV Network(3H)
Angelina Robins	District Nurse Midwife STI Clinic
Roger Thomas	Laboratory Technologist
Dr. Abel Blanco	HIV Epidemiologist
Mr. Colin O'Keiffe	Manager PMS HID
Niketta Lake	PMS Data Programmer
Dr. Alana Marta	Communicable Disease Epidemiologist
Mr. Edward Emmanuel	PAHO Programme Officer – Antigua and Barbuda
Oswald Hannays	Data Base Manager NAP
Karena Joseph	VCT data entry Clerk
Dorbrene O'mard	Consultant NSP
Andrea Airall	HFLE Coorddinator