GLOBAL AIDS RESPONSE PROGRESS REPORT 2012, BARBADOS

Ministry of Health, Barbados

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For the reporting period January 2010 to December 2011

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ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASOB	AIDS Society of Barbados
AZT	Zidovudine
BCC	Behaviour Change Communication
BEA	Barbados Evangelical Association
CALC	Country Assessment of Living Conditions
CARE	Comfort Assist Reach out Educate Barbados
CARICOM	Caribbean Community
CBO	Community-based organisation
CHAA	Caribbean HIV/AIDS Alliance
CHART	Caribbean HIV/AIDS Regional Training Network
CI	Confidence Interval
CSD	Commission on Sustainable Development
CSO	Civil Society Organisation
DfID	Department for International Development of the United Kingdom
DYA	Division of Youth Affairs
FBO	Faith-based organisation
GDP	Gross Domestic Product
HAART	Highly Active Anti- Retroviral Therapy
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IADB	Inter-American Development Bank
IDU	Injecting Drug User
IEC	Information, Education and Communication
KABP	Knowledge, Attitudes, Beliefs and Sexual Practices
LRU	Ladymeade Reference Unit
MARP	Most-at-Risk Population
M&E	Monitoring & Evaluation
MEHR	Ministry of Education and Human Resource Development
MOH	Ministry of Health
MIS	Management Information System
MSM	Men who have Sex with Men
NACA	National Advisory Committee on AIDS
NAP	National AIDS Programme
NCPI	National Commitments and Policy Instrument
NCSA	National Council on Substance Abuse

NGO	Non-Governmental Organisation
NHAC	National HIV/AIDS Commission
NHS	National HIV Surveillance
NICU	Neonatal Intensive Care Unit
NS	Not Stated
PAHO	Pan-American Health Organization
PITC	Provider Initiated Testing and Counselling
PLHIV	Persons living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSIA	Poverty and Social Impact Analysis
QEH	Queen Elizabeth Hospital
RBPF	Royal Barbados Police Force
SHIP	Sexual Health Information Programme
SIDS	Small Island Developing State
SLC	Survey of Living Conditions
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
UGLAAB	United Gays and Lesbians Against AIDS Barbados
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USD	United States Dollars
UWI	University of the West Indies
UWIHARP	University of the West Indies HIV and AIDS Response Programme
VAW	Violence against Women
VCT	Voluntary Counselling & Testing
WHO	World Health Organisation

I. STATUS AT A GLANCE

1.1 Stakeholders Participation

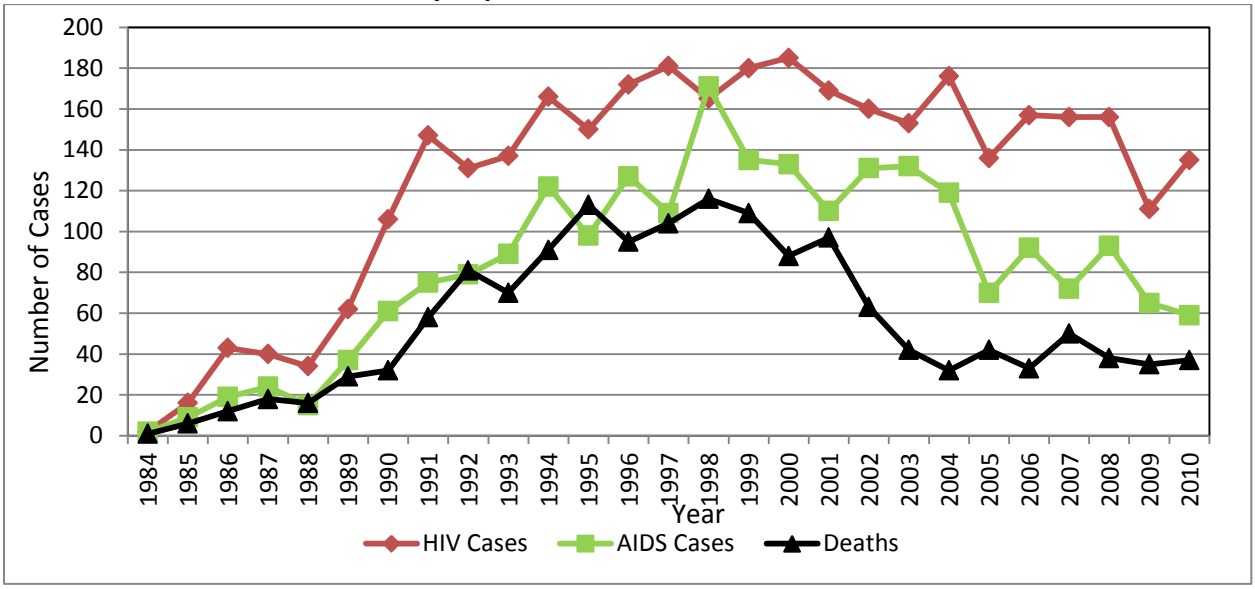
This report was prepared in collaboration with a broad cross section of stakeholders from government, private and civil society organisations (CSO); including faith-based organisations (FBOs). Stakeholders were consulted throughout the report preparation process, particularly during data collection and verification. (See Annex 3)

1.2 Status of the Epidemic

The HIV/AIDS epidemic in Barbados commenced with the first two reported cases occurring in 1984. From the start until December 2010, 3,426 people were diagnosed with HIV. Of those diagnosed, 65.6% were also diagnosed with AIDS. By the end of 2010, 1,508, of the 3,426 people with HIV, died and 1,918 of those diagnosed with HIV were still alive. Figure 1 demonstrates the annual trends in the epidemic. The prevalence of HIV in the general population (15-49 year olds) is estimated to be 1.2% at the end of 2010.

Anti-retroviral therapy was introduced into Barbados in 2002 as part of the Government's expanded response to HIV/AIDS. Between 2001 and the end of 2010, there was a dramatic decline in mortality rates from 10% to 2% among persons living with HIV (PLHIV) which mainly attributed to the availability of Anti-retrovirals (Barbados HIV/AIDS Surveillance Report 2010).

Figure 1: Annual trends of new HIV cases, new AIDS cases and deaths of people with HIV, 1984 – 2010



Source: The Barbados HIV/AIDS Surveillance Report 2010, 2012

1.3 Policy and Programme Response

The Government of Barbados is committed to giving the highest priority to the response to HIV. The National HIV/AIDS Commission (NHAC) formerly under the Office of the Prime Minister is now under the Ministry of Family, Culture, Sports and Youth. The multi-sectoral effort seeks to engage the 18 line ministries, private sector, non-governmental organisations (NGOs) and FBOs. They are five core ministries with dedicated HIV/AIDS Coordinators that meet regularly with the NHAC to implement the National Strategic Plan. The line ministries prepare and submit annual HIV Work Plans for which funding is received as part of the annual budgetary process.

The NHAC, in collaboration with its stakeholders, prepared a National AIDS Policy, which was debated and approved by Cabinet in 2008. A National HIV Strategic Plan for HIV Prevention and Control was developed for the period 2008-2013 with major focus on most-at-risk populations (MARPs). The Ministry of Health has developed policies and guidelines for prevention, treatment and care such as the Prevention of Mother-to-Child Transmission (PMTCT) policy.

1.4 Overview of Indicator Data

Table 1: Overview of Global AIDS Response Progress Report 2012 for Barbados

Target 1

Reduce sexual transmission of HIV by 50% by 2015

General Population

1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission - **37.7% KABP 2011**

1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15- **19.1% KABP 2011**

1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months-Partial data (15-25) - **24.5% KABP 2011**

1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse-**Partial data (15-24) - 14.1% KABP 2011**

1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results **- Partial data (15-24) 23.8% KABP 2011**

1.6 Percentage of young people aged 15-24 who are living with HIV **- 0.11% MOH 2010; 0.10% MOH 2011.**

Sex Workers

1.7 Percentage of sex-workers reached with HIV prevention programmes**-No data available,**

1.8 Percentage of sex workers reporting the use of a condom with their most recent client **–No Data available**

1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results-**No data available**

1.10 Percentage of sex workers who are living with HIV-**No data available**

Men who have sex with men

1.11 Percentage of men who have sex with men reached with HIV prevention programmes-**No data available**

1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner- **No data available**

1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results-**No data available**

1.14 Percentage of *men who have sex with men* who are living with HIV **–No data available**

Target 2

Reduce transmission of HIV among people who inject drugs by 50% by 2015

2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes - **Not Applicable**

2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse **- Not Applicable**

2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected - **Not Applicable**

2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results - **Not Applicable**

2.5 Percentage of people who inject drugs who are living with HIV - **Not Applicable**

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 antiretrovirals to reduce the risk of mother-to-child transmission **– 88.5% MOH 2010; 95.5% MOH 2011**

3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth - **65.4% MOH 2010; 80.0% MOH 2011**

3.3 Mother-to-child transmission of HIV (modelled) **- 0% 2010; This is based on actual data and is not modelled**

Target4

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

4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy- **80.7% MOH 2010; 80.7% MOH 2011**

4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy - **89% MOH 2010; 95.5% MOH 2011**

Target 5

Reduce tuberculosis deaths in people living with HIV BY 50% BY 2015

5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV - **100%-MOH 2010; No cases MOH 2011**

Target 6

Reach a significant level of annual global expenditure (US 22-24 billion) in low and middle income countries**- USD $7, 162, 504 NHAC 2009-2010; USD $6, 977, 287 NHAC 2010-2011**

Target 7

Critical enablers and synergies with development sectors

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) **–Agreed results included in appendix**

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 – **No Data available**

7.3 Current school attendance among orphans and non-orphans aged 10–14 - **100% MEHR, 2011**

7.4 Proportion of the poorest households who received external economic support in the past 3 months - **27%, 2011 (Welfare data/poorest households)**

II. OVERVIEW OF THE AIDS EPIDEMIC

The Barbados National Strategic Plan has highlighted the need for the population to enjoy a good quality of life. In terms of public health, the plan outlines a strategy to reduce the spread of HIV and minimise its impact. Current estimates reveal that Barbados has a relatively high HIV prevalence in the general population at 1.2%.

2.1 AIDS Epidemic 1984 to 2011 – Trends and Dynamics

Between 1984 and the end of 2010, the cumulative total of people diagnosed with HIV was 3,426 and of these, 65.6% were also diagnosed with AIDS. During this period, the total number of deaths among persons with HIV was 1,508 and 1918 persons were believed to be alive by the end of 2010 (see Table 2).

Table 2: Cumulative HIV cases, AIDS cases and HIV deaths from 1984 to 2010

Sex	HIV Cases	AIDS Cases	HIV-related deaths	PLHIV
Male	2,145 *(62.6%)*	1,529 *(68.0%)*	1,093 *(72.5%)*	1,052 *(54.8%)*
Female	1,281 *(37.4%)*	719 *(32.0%)*	415 *(27.5%)*	866 *(45.1%)*
Total	**3,426**	**2,248**	**1,508**	**1,918**

Source: NHS 2011

Taking the population into account, data and trends in annual rates of new HIV and AIDS cases, and mortality rates among people with HIV are detailed in Table 3. The number of new HIV diagnoses peaked in 2000 when 185 persons were newly diagnosed with HIV in Barbados. Among individuals that were newly diagnosed with HIV, men have consistently outnumbered women. However, the difference between sexes narrowed between 2005 and 2009 when similar numbers of men and women were diagnosed with HIV. However, in 2010, this gender gap widened again in favour of more men being diagnosed with HIV.

Table 3: Annual number and rates of new HIV cases, new AIDS cases and HIV-related deaths from 1984 to 2010

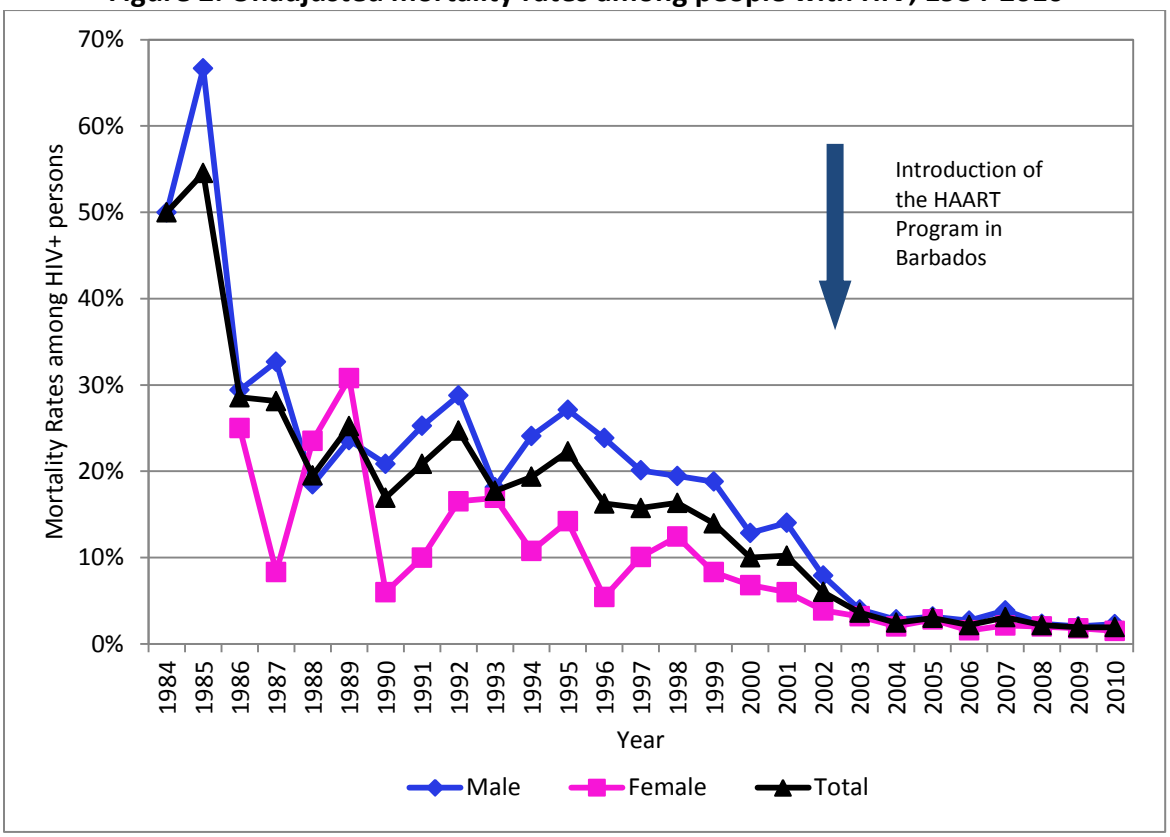
Year	HIV Cases				AIDS Cases				Deaths among people with HIV			
	Male	Female	Total	*HIV cases per 100, 000*	Male	Female	Total	*AIDS cases per 100, 000*	Male	Female	Total	*Annual mortality Rates among people with HIV*
1984	2	0	2	*0.8*	2	0	2	*0.8*	1	0	1	50%
1985	14	2	16	*6.2*	8	1	9	*3.5*	5	0	5	55%
1986	35	8	43	*16.6*	15	4	19	*7.4*	11	2	13	29%
1987	35	5	40	*15.4*	22	2	24	*9.3*	17	1	18	28%
1988	25	9	34	*13.1*	9	6	15	*5.8*	12	4	16	20%
1989	45	17	62	*23.4*	28	9	37	*14.2*	21	8	29	25%
1990	79	27	106	*40.4*	49	12	61	*23.3*	29	3	32	17%
1991	109	38	147	*55.8*	61	14	75	*28.5*	50	8	58	21%
1992	84	47	131	*49.5*	60	19	79	*29.5*	63	18	81	25%
1993	87	50	137	*51.6*	60	29	89	*33.9*	47	23	70	18%
1994	117	49	166	*62.3*	95	27	122	*45.8*	73	18	91	20%
1995	100	50	150	*56.0*	80	18	98	*36.6*	86	27	113	23%
1996	109	63	172	*64.0*	92	35	127	*47.2*	82	13	95	16%
1997	104	77	181	*67.0*	77	32	109	*40.4*	75	29	104	16%
1998	100	65	165	*60.8*	115	56	171	*63.0*	77	39	116	17%
1999	103	77	180	*66.1*	91	44	135	*49.5*	79	30	109	14%
2000	107	78	185	*67.6*	86	47	133	*49.0*	60	28	88	10%
2001	102	67	169	*61.5*	81	29	110	*40.0*	70	27	97	10%

Year	HIV Cases				AIDS Cases				Deaths among people with HIV			
	Male	Female	Total	*HIV cases per 100, 000*	Male	Female	Total	*AIDS cases per 100, 000*	Male	Female	Total	*Annual mortality Rates among people with HIV*
2002	102	58	160	*57.9*	83	48	131	*47.4*	44	19	63	6%
2003	93	60	153	*55.1*	70	62	132	*47.6*	25	17	42	4%
2004	105	71	176	*63.1*	70	49	119	*42.7*	20	12	32	2%
2005	72	64	136	*48.6*	39	31	70	*25.4*	24	18	42	3%
2006	80	77	157	*55.8*	56	36	92	*33.1*	22	11	33	2%
2007	94	62	156	*55.2*	42	29	71	*25.1*	34	16	50	3%
2008	93	63	156	*55.0*	55	38	93	*32.8*	22	16	38	2%
2009	58	53	111	*39.0*	41	25	66	*23.5*	20	15	35	2%
2010	91	44	135	*47.3*	42	17	59	*20.7*	24	13	37	2%
Total	**2,145**	**1,281**	**3,426**	-	**1,529**	**719**	**2,248**	-	**1,093**	**415**	**1,508**	-

Source: NHS 2011 and International Database (IDB), US Census Bureau 2012

Since the peak of HIV cases in 2000, there has been a gradual downward trend in the total number of newly diagnosed PLHIV to a low in 2009. The 111 persons diagnosed with HIV that year were the lowest number of new annual HIV cases detected since 1990 when the epidemic started to take full effect. The downward trend in annual HIV cases being diagnosed suggests a decline in HIV transmission in Barbados. Table 3 also shows the HIV cases per 100,000 persons, which provides a more complete idea of the trend in HIV cases over the years since population size is taken into account. Another important trend observed is the steady decline in mortality rate among persons with HIV to 2% in 2010. This trend is further illustrated in Figure 2.

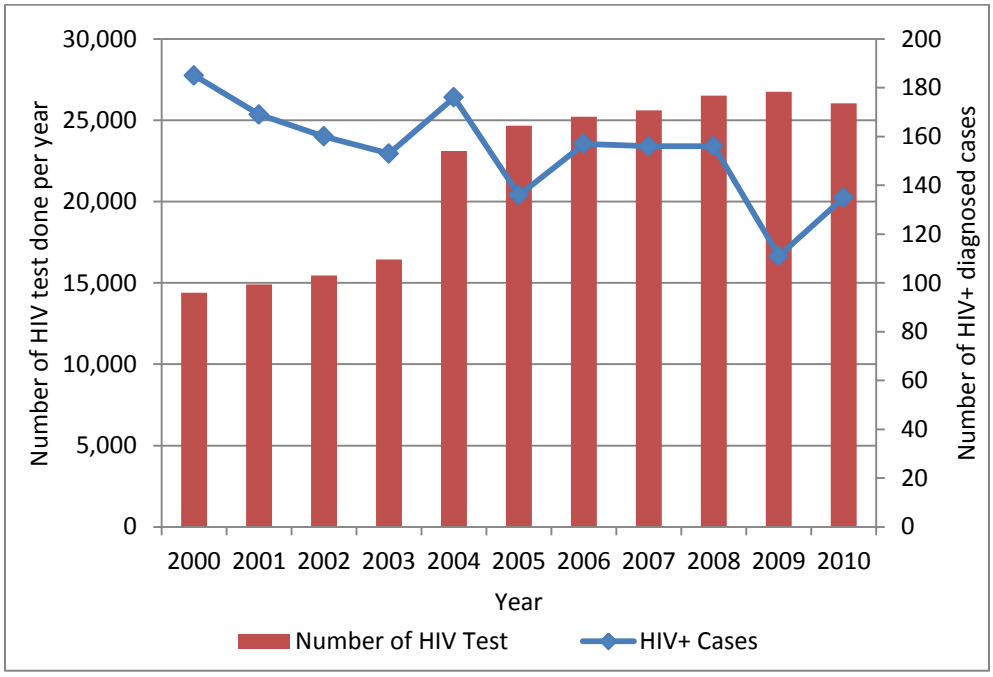
Figure 2: Unadjusted mortality rates among people with HIV; 1984-2010



Source: The Barbados HIV/AIDS Surveillance Report 2010, 2012

The surveillance team also analysed the trends in the annual number of HIV cases diagnosed in relation to the annual number of HIV tests done nationally. It is understood that significant changes in the HIV testing patterns could influence the number of new HIV diagnoses observed. Figure 3 below illustrates the annual trends in diagnosed HIV cases in comparison to the total number of HIV tests done in Barbados between 2000 and 2010.

Figure 3: Comparison of HIV testing trends and HIV cases diagnosed between 2000 and 2010

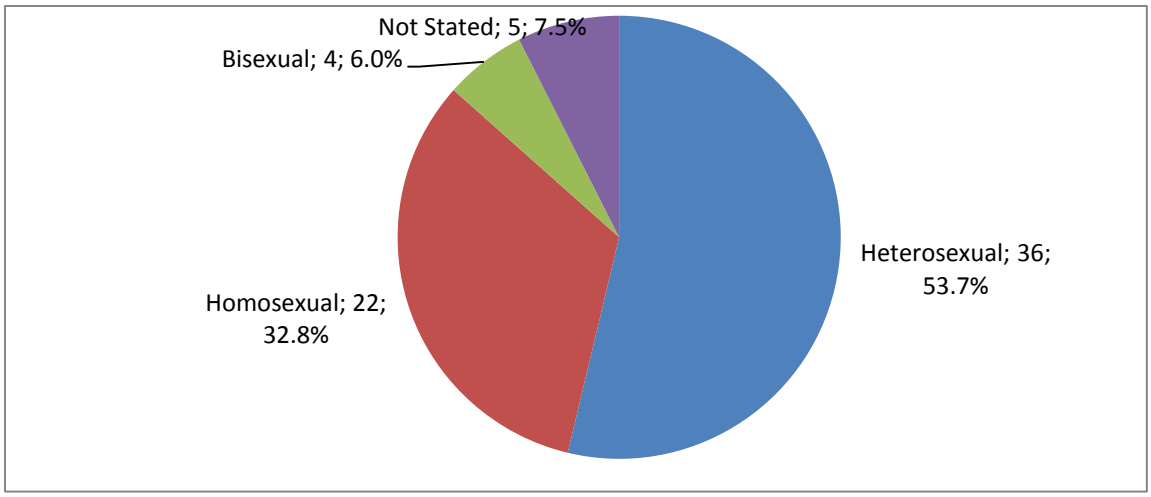


Source: The Barbados HIV/AIDS Surveillance Report 2010, 2012

2.2 Nature of Epidemic

The current trends suggest a mixed epidemic - that is, a generalized HIV epidemic with *probable* higher HIV prevalence in key populations. There is anecdotal evidence to suggest that some of the groups most at risk groups are men who have sex with men (MSM), sex workers (SW) and prisoners. However, validation of this assumption is yet to occur through the conduct of specific research studies. The Ministry of Health has commenced a behavioural and sero-prevalence survey for MSM and a similar study is slated to begin for sex workers by 2013. Figure 4 demonstrates self-identified sexual preferences of men newly diagnosed with HIV in 2010. Nearly 40% of this cohort was MSM suggesting that this marginalized population may be disproportionately affected by HIV in Barbados.

Figure 4 : Self-identified sexual preferences of HIV+ men in 2010



Source: Ladymeade Reference Unit, 2012

2.3 HIV/AIDS Surveillance 2010

In 2010, 135 persons were newly diagnosed with HIV in Barbados. There were also 59 new AIDS cases detected among known cases of HIV and 37 deaths. As demonstrated in Table 4, men were disproportionately affected.

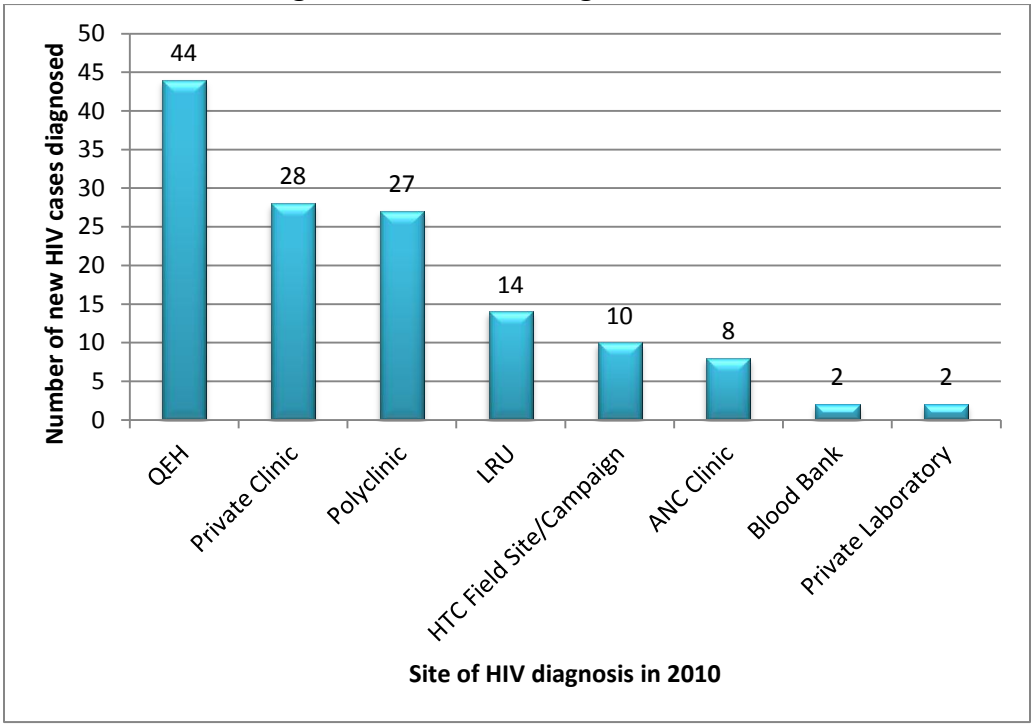
Table 4: The Number of HIV/AIDS cases and HIV Deaths in 2010

Sex	New HIV Cases	AIDS Cases	HIV Deaths
Male	91 *(67.4%)*	42 (*71.2%)*	24 *(64.9%)*
Female	44 *(32.6%)*	17 *(28.8%)*	13 *(35.1%)*
Total	**135**	**59**	**37**

Source: NHS database, 2011

Nearly one-third (44/135) of the new HIV cases in 2010 were diagnosed at the Queen Elizabeth Hospital (QEH). This 32.5% of new cases suggests that persons are still being diagnosed late in their disease as diagnosis was made during hospitalization at the island's main hospital rather than at a primary care setting. The place at which people with HIV were diagnosed in 2010 is illustrated below.

Figure 5: Site of HIV diagnosis in 2010



Source: The Barbados HIV/AIDS Surveillance Report 2010, 2012

2.4 PLHIV Receiving Medical Care and Treatment

The Ladymeade Reference Unit (LRU) is a standalone specialty clinic and laboratory that provides comprehensive management services for patients infected with HIV. In 2010, the mean age of registration for men was 40 years as opposed to 32 years for women. It should be noted that men were predominantly affected in all areas, having a higher incidence of HIV, AIDS and deaths.

Table 5: Patients who registered for care at the LRU in 2010

Age Group	Sex		Total	
	Male	Female	n	%
10 - 19	4	2	6	5.8
20 - 29	13	12	25	24.3
30 - 39	16	8	24	23.3
40 - 49	24	7	31	30.1
50 - 59	12	4	16	15.5
60 - 69	1	0	1	1.0
Total	**70 (68.0%)**	**33 (32.0%)**	**103**	**100.0%**
Median age at registration (years)	**40.3**	**32.1**	**38.0**	
Median CD4 at registration (cells/mm^3)	**252**	**455**	**297**	

Source: SHIP® 2011

The median CD4 count for men was significantly lower than women 252 cells/mm^3 compared to 455 cells/mm^3 in females. This suggests that men are diagnosed and thus access medical care in the late stages of HIV disease. These data point to a need for implementation of outreach programmes targeting men in general, to encourage HIV testing r earlier diagnosis and linkage to care.

2.5 HIV Surveillance in Antenatal Clinics and PMTCT

HIV surveillance is essential for an effective PMTCT programme. The monitoring of clients allows for early detection of HIV and treatment to reduce the impact of HIV on mothers and the risk of HIV transmission to children. The HIV/AIDS Programme monitors and co-manages all known HIV+ pregnant women and newborns as part of this comprehensive PMTCT programme. The Ministry of Health conducts routine HIV surveillance in public antenatal clinics and is expanding this system to monitor HIV testing trends in private antenatal clinics. Recent data reveal that over 99% of women accessing public antenatal services are tested for HIV. Because

of the PMTCT programme, the central feature of which is the use of ARVs to reduce the risk of HIV transmission from mother to child, vertical transmission rates have been reduced from 27.1% to less than 2.5% (St. John et. al 2006) and to an even lower rate of 0.75% (St. John 2011).

2.6 Behaviours/Sexual Practices and Challenges

After eleven years of an expanded response, the programme is still experiencing challenges in inducing behavioural change as there is a disconnect between knowledge levels and sexual practices. As demonstrated in Table 6, knowledge levels among young people are quite high and have shown an upward progression from 2001 to 2005/2006. This is attributed to the Information, Education and Communication (IEC) programme implemented by the NHAC in collaboration with the MOH and other partners. However, data from behavioural surveys demonstrate that high levels of knowledge did not translate into a change of behaviour. The National AIDS Programme (NAP) is cognizant of this failure and is seeking to address this glaring deficiency.

Table 6: Knowledge and Behavioural Gaps among Barbadian Youth 2001-2011

Variables	**Year**				
	2001	2003/2004	2005/2006	2009	2011
Age group	15-19	10-18	15-24	15-24	15-24
Knowledge/prevention					
Abstinence	17.1%	82.1%	92.7%	84.7%	N/A
Be Faithful	30.6%	77.8%	92.3%	79.3%	74.9
Condom use	46.9%	87.3%	93.7%	76.7%	73.1%
Behaviour					
Multiple partners	49.8% male partners 47.3% female partners	36%	80%	24.8%	24.5%
Consistent condom use	17.1	<3%	No data	40.9%	14.1%

Source: KABP Youth Surveys, Division of Youth Affairs

Despite knowledge of transmission of HIV, persons are still engaging in risky behavior. This is further exasperated by the fact that persons engaging in these behaviours rarely use condoms.

Another challenge experienced by the NAP is the persistence of stigma and discrimination, which restricts programme efforts to reach key populations at higher risk such as SW, MSM, youth, prisoners, and PLHIV. Many factors such as small population size, intricate family and social networks, societal conservatism and negative perceptions of government services, may cause some people to go underground thus preventing them from accessing.

Even though homosexuality is not illegal and laws against sex work are not enforced in Barbados, the attendant stigma hinders accessibility of services for key populations. The NHAC has sought to address these programme challenges by developing the Barbados National Prevention Plan to guide prevention programming efforts for key populations at higher risk for HIV (MSM, SW, PLHIV and prisoners). It should however, be appreciated that non-governmental organisations (NGOs) and civil society organisations (CSOs) might be in a better position to reach some of these MARPs. Persons working in these areas could more easily serve as the vehicle for extending programme coverage beyond the general population to key populations at higher risk as well as increasing access and referrals to the treatment and care programme.

2.7 Testing

HIV testing in Barbados is widely accessible throughout both the public and private healthcare sector. However, laboratory testing for HIV is only done at one government laboratory (QEH). Table 7 below demonstrates the overall trend in total HIV tests done between 2000 and 2010.

Table 7: Total number of HIV tests done 2000-2010 in relation to the number of new HIV diagnoses

Year	# HIV tests done	# of new HIV cases diagnosed
2000	14,403	185
2001	14,908	169
2002	15,456	166
2003	16,447	153
2004	23,111	176
2005	24,669	136

Year	# HIV tests done	# of new HIV cases diagnosed
2006	25,214	157
2007	25,605	156
2008	26,512	156
2009	26,744	111
2010	26,045	135

Source: HIV Surveillance Unit, MOH 2012

III NATIONAL RESPONSE TO AIDS EPIDEMIC

The Government of Barbados along with key NGOs and community-based organisations (CBOs) continue to place HIV high on the agenda. The NAP is committed to controlling the HIV epidemic through strategic prevention programmes and comprehensive treatment and care services for PLHIV residing in Barbados.

3.1 Knowledge and Behavioural Change

A. Target 1: Reduce sexual transmission of HIV by 50% by 2015

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

In the 2011 KABP survey, 37.7% of all respondents correctly identified five ways of preventing HIV transmission and rejected major misconceptions. Even though at a glance this may appear low, persons scored high on correctly identifying individual areas of sexual transmission as seen in the table below.

Table A.1: Percentage of Youth 15-24 years who correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV

Questions	Males	Females	15-19	20-24	Total
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners	73.6%	76.5%	72.3%	77.6%	74.9%
Can a person reduce the risk of getting HIV by using a condom every time they have sex	71.9%	74.5%	68.8%	77.6%	73.1%
Can a healthy looking person have HIV	93.1%	94.8%	92.2%	95.6%	93.9%
Can a person get HIV from mosquito bites	73.3%	76.5%	71.3%	78.3%	74.7%
Can a person get HIV by sharing food with someone who is infected	67.7%	74.5%	73.0%	68.4%	70.8%
Answered all 5 questions correctly	36.3%	39.4%	33.7%	41.9%	37.7%

Findings from the 2009 KABP study among youth ages 15-24 indicate that knowledge of HIV did not transition to less risky behaviour. Some aspects of respondents' sexual lifestyles, practices and perceptions remain a cause for concern. The research suggests that greater efforts must be directed towards the integration and development of targeted HIV prevention programming for young people designed to effectively foster behavioural change.

1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

The 2011 KABP Youth Survey revealed that 19.1% of the respondents between 15-24 years reported to having sexual intercourse before the age of 15 years. This represents a nominal decline of 0.5% over the figure reported in the 2010 UNGASS report of 19.6%. When comparing males to females, 22% of males reported having had their first sexual encounter before the age of 15, compared to 15.5% of females.

Table A.2: Percentage of persons 15-24 who had sexual intercourse before the age of 15years

Indicator	Sex		Age Range		Total
	Females	Males	15-19	20-24	
# of respondent (15-24) who report the age at first sex as under 15 years	39	67	62	44	106
# All respondents 15-24	251	303	282	272	554
Percentage	15.5%	22.1%	22.0%	16.2%	59.7%

1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months

Barbados is yet to conduct a national adult survey but the youth department has been conducting KABP surveys every 2-5 years to inform their youth programmes. The relevant questions in relation to HIV helps to provide the data needed to address youth issues in the island and plan appropriate behaviour change programmes. The Division of Youth Affairs (DYA), as part of the NAP, also tries to capture the requested youth data to satisfy the global targets. The 2011 KABP Youth Survey revealed that 24.5% of youth ages 15-24 had multiple sex partners. This figure represents an insignificant decrease of 0.3 percentage points from the 24.8% reported in the 2009 Country Report for this population. When broken down by sex, the 2011 data revealed that nearly three times as many males had multiple partners when compared with females (See Table A.3).

Table A.3: Percentage of persons 15-24 who have had multiple partners in the last 12 months, 2011

INDICATOR	F	M	15-19	20-24	Total
# of respondents who have had sexual intercourse with more than one partner in the last 12 months	36	100	57	79	136
# of respondents	251	303	282	272	554
Percentage	14.3%	33%	20.2%	29%	24.5%

Source: KABP Youth Survey, Division of Youth Affairs 2011

1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse.

No data were available for the 15-49 adult population, however, data on the youth population (ages 15-24) are provided. These data, although not generalizable to the wider population, provides an indication of higher risk sex among the adult population.

Table A.4: Percentage of persons 15-24 who had multiple partners and used a condom at last sex

Indicator	15-19	20-24	15-24	
			F	M
# of respondents who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	31	47	16	62
# respondents who reported more than one sex partner	282	272	251	303
Percentage	11.0%	17.3%	6.4%	20.5%
Total	14.1%			

Source: KABP Youth Survey, Division of Youth Affairs, 2011

It is interesting to note that only 14.1% of persons that had multiple partners used a condom with their last partner. This suggests that youth are engaging in risky behaviour that would expose them to sexually transmitted infections including HIV. The data from the 2009 KABP youth (15-24) survey revealed that a greater number of persons used condoms the last time they had sex with their regular partners (46.1%) than with their non-regular partners (26.3%) whereas 32.5% indicated condoms were not used at last sex with regular partner and 9.5% stated condom use was non-existent at last sex with non-regular partner (Table A.5). It should also be noted that there was a very high non-response rate especially when questioned about sex with non-regular partners.

Table A.5: Condom Use with Regular and Non-Regular Partners*

Condom Use	Regular Partners		Non-Regular Partners	
	Frequency	%	Frequency	%
Yes	149	46.1	85	26.3
No	105	32.5	29	9.0
Don't Know/Don't Remember	6	1.9	40	12.4
No Response	63	19.5	169	52.3
Total	323	100.0	323	100.0

*The data in this table is based on those who indicated they had had sex

Source: KABP Youth Survey, Division of Youth Affairs, 2011

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

There is no data in the format required for the 15-49 age-group, but partial data are available from the 2011 KABP Youth survey for youth age 15-24. In the 2011 KABP youth survey, respondents were asked if they received an HIV test and knew the result. Table A6 demonstrates that approximately 24% of youth were tested and knew their results. This is, however, not surprising as adolescents and youth still tend to shy away from health services and some require parental consent. The adoption of an Adolescent Health Policy and the creation of youth friendly spaces and services could be some of the avenues to address this problem.

Table A.6: Percentage of Youth 15-24 who had an HIV test and knew their result, 2011

INDICATOR	F	M	15-19	20-24	Total
# Respondents who have been tested for HIV during the last 12 months and who know they results	74	58	35	97	132
# Of all respondents 15-24	251	303	282	272	554
% Tested and Know Results	**29.5%**	**19.1%**	**12.4%**	**35.7%**	**23.8%**

Source: KABP Youth Survey, Division of Youth Affairs, 2011

The MOH has a decentralized HTC programme. The programme has country-wide coverage via eight polyclinics. Outreach community testing is also conducted by the Counsellors/ Social workers working in the HIV/AIDS Programme of the MOH. However, HIV testing conducted through this medium represents only part of all tests done in Barbados. Table A.7 details HTC data from 2005-2010 of persons tested that received results and post-test counselling.

Table A.7: HTC Programme of the HIV Programme 2005-2010

Year	2005	2006	2007	2008	2009	2010
No. pre-counselled and tested	4465	4684	4135	5591	5904	5053
No. post-test counselled and given results	4379	4614	4025	5207	5789	4835
% Tested and know results	98.1%	98.5%	97.3%	93.1%	98.1%	95.7%

Source: HIV Surveillance Unit, MOH, 2012

Even with increased numbers of persons tested for HIV, the percentage of persons knowing their results continue to be high since client follow-up and post-test counselling is an important aspect of HTC.

1.6 Percentage of young people aged 15-24 who are living with HIV

Table A.8: Percentage of ANC Clients aged 15-24 who are living with HIV

Indicator 1.6	15 – 24 Age group	
	2010	2011
Numerator : Number of antenatal clinic attendees (aged 15 – 24) whose HIV test results are positive	1	1
Denominator : Number of antenatal clinic attendees (aged 15 – 24) tested for their HIV infection status	933	1003
Percentage	0.11%	0.10%

Source: HIV Surveillance Unit, MOH, 2012

HIV prevalence among pregnant women was measured by collecting data of pregnant women attending ANC at the eight government polyclinics and two satellite clinics, as well as the QEH. In 2010, the percentage prevalence was estimated at 0.11% while 2011 was similar at 0.10%.

This demonstrates a decrease from 1.1% in 1999 to 0.10% in 2011. The data collection instrument is shown in annex 4. Table A.9 compares ANC data over a seven-year period.

Table A.9: HIV Prevalence of Antenatal Clients 15-24 years

AGE	2005	2006	2007	2008	2009	2010	2011
15-24	0.47	0.60	0.36	0.11	0.44	0.11	0.10

Source: HIV Surveillance Unit, MOH, 2012

Sex Workers

Prevention

1.7 Percentage of sex-workers reached with HIV prevention programmes

No data are available for this indicator.

1.8 Percentage of sex workers reporting the use of a condom with their most recent client

No data were available for this indicator.

Impact

1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results

No data are available for this indicator.

1.10 Percentage of sex workers who are living with HIV

No data are available for this indicator.

Men who have sex with men (MSM)

Prevention

1.11 Percentage of men who have sex with men reached with HIV prevention programmes

No data available.

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

No data available.

Impact

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

There are no data available for this indicator.

1.14 Percentage of *men who have sex with men* who are living with HIV

No data available.

Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015

This target is not applicable to Barbados as the country has not identified a problem with injecting drug use. The HIV epidemic in Barbados, like the wider Caribbean, is associated with high-risk sexual behaviours, such as early initiation of sexual activity, multiple sexual partners, other risky sexual behaviours, as well as drug abuse. Persons may become particularly vulnerable to HIV infection through impaired judgment and unprotected sex that could follow moments of clouded consciousness associated with drug and alcohol abuse.

Prevention/Risk reduction

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

No needle programmes exist in Barbados as they are not applicable to our setting. In Barbados, transmission by contaminated injection equipment has not been reported and there is no need for needle distribution or exchange at this time. However, in a NCSA Drug Use and Risky Sexual Behaviour- Tertiary 2007 survey, most of the 551 respondents indicating drug use and sexual activity used alcohol (87%) and marijuana (86%) but 11 (18.1%) participants indicated using heroine. It should be noted that there is no indication within the survey of how the heroin was used whether injected, inhaled or smoked.

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

This indicator is not relevant to Barbados. However, 2007 NCSA Drug Use and Risky Sexual Behaviour Tertiary survey indicated that 10.0% of all respondents engaged in sexual intercourse while under the influence of drugs.

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

This indicator is not applicable as injecting drug use is not a concern in Barbados.

Impact

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

This indicator is not applicable as injecting drug use is not a concern in Barbados and is therefore not a known mode of transmission of HIV.

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

This indicator is not applicable as injecting drug use is not a concern in Barbados and is therefore not a known mode of transmission of HIV.

3.2 Care, Treatment and Support

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 antiretroviral drugs to reduce the risk of mother-to-child transmission

The denominator uses actual numbers from the PMTCT programme and excludes terminations. The PMTCT programme started in 1995 and has effectively reduced the vertical transmission of HIV from 27.1% to less than 2.5% with the introduction of HAART (St. John et. al, 2006). ARVs are accessed through the LRU and women are managed to ensure that they have joint

antenatal and postnatal care by an HIV specialist and a paediatrician for the purposes of PMTCT. The goal of the programme is to reduce the transmission of HIV from mother to child through the use of ARVs and through prevention interventions. The data below point to a successful PMTCT programme with 88.5% and 95.5% of HIV positive pregnant women receiving ARVs during pregnancy to reduce mother to child transmission. The programme's success can be attributed to improved access to care and the good health system infrastructure.

Table C.1: Percentage of HIV+ pregnant women receiving ART in 2010 & 2011

Indicator	2010	2011
Numerator: Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce mother-to-child transmission	23	21
Denominator : Estimated number of HIV-positive pregnant women within the past 12 months	26	22
Percentage	88.5%	95.5%

Source: HIV Surveillance Unit, MOH, 2012

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

Table C.2: Percentage of Infants born to HIV + Women receiving a virological test

Indicator	2010	2011
Numerator: Number of infants who received an HIV test within 2 months of birth, during the reporting period (Infants tested should only be counted once).	17	17
Denominator : Number of HIV-positive pregnant women giving birth within the past 12 months	26	20
Percentage	65.4%	85.0%

Source: HIV/AIDS Surveillance Unit, MOH, 2012

The paediatric HIV epidemic in Barbados is carefully monitored and managed. 65.4% and 85% of infants born to HIV positive mothers were tested, within the time frame specified by the indicator definition, in 2010 and 2011 respectively. At each infant's first visit a virologic test is performed and co-trimoxazole prophylaxis (CTX) is initiated. The protocol requires a virologic test between 6-8 weeks, however, if an infant presents to clinic after this period for whatever reason, the virologic test would be done and CTX would be initiated simultaneously. Patients and mothers are routinely followed up and treated as necessary.

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

In 2010 and 2011 there were no infants who contracted HIV from their mothers. These data are not modelled; actual total numbers were used. Stringent PMTCT management protocols are in place and between 2006 and 2010, the HIV transmission rate was 0.7%. There has not been an infected infant since 2007.

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

4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy

Table D.1 shows a breakdown of persons receiving ART in 2010 and 2011, 80.7% of those persons eligible for treatment received treatment in both years. These data are based on actual figures and are not modelled.

Table D.1: Percentage of adults and children receiving ART in 2010 & 2011

Age Group	2010	2011
<1	0%	0%
1-4	0%	0%
5-14	100%	100%
15+	80.6%	80.6%
Total	80.7%	80.7%

Source: HIV Surveillance Unit, MOH, 2012

Table D.2 Percentage of adults who are eligible for ART who were on HAART 2002 – 2011

Year	% of Adults (>15 years) on HAART at the end of each year		
	Female	Male	Total
2002	94.4	95.2	**94.8**
2003	93.9	95.0	**94.5**
2004	91.3	93.1	**92.3**
2005	90.0	92.3	**91.2**
2006	90.8	92.9	**92.0**
2007	90.1	90.2	**90.2**
2008	88.1	87.1	**87.6**
2009	89.4	87.4	**88.3**
2010	81.6	79.8	**80.6**
2011	80.5	80.7	**80.6**

Source: SHIP database, LRU, 2011

Between 2002 and 2011, the proportion of eligible patients at the LRU on therapy declined from 94.8% to 80.6%. This data is based on actual figures and not modelled. Many reasons are postulated as discontinuance of ARVs due to "medication fatigue" or default from follow-up or death. However, more analysis is needed to understand the precise reasons for the decrease. The slight differences noted in tables D.1 and D.2 are due to the fact that the latter includes children whereas D.2 only looks at eligible adults who are on HAART.

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

An important aspect of programme monitoring is determining the proportion of PLHIV with advanced infection that is on therapy in accordance with the treatment protocol in Barbados. Table D.3 demonstrates that of those persons who started therapy in 2009, 89.0% of them were still on therapy 12 months later in 2010 and of those who started therapy in 2010, 95.5% of them were on therapy 12 months later in 2011.

Table D.3: Percentage of adults and children alive on ART at 12 months after initiating treatment

Age Group	2010			2011		
	Male	Female	Total	Male	Female	Total
<15	0/0	0/0	0/0	0/0	0/0	0/0
15+	43/49	30/33	73/82	35/37	28/29	63/66
Total	87.8%	90.9%	89.0%	94.6%	96.6%	95.5%

Source: Paediatrics Clinic and LRU SHIP Database, 2012

Target 5: Reduce tuberculosis deaths in people living with HIV BY 50% BY 2015

5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV

Barbados has managed to prevent and control tuberculosis (TB). In 2010, they were five cases of TB of which two were co-infected with HIV, which were adequately treated. In 2011, they were no incident cases of TB recorded. Table E.1 shows the trend in TB/HIV co-infections over the period between 2004 and 2011 ranging between 0 and 5, with all persons being adequately treated.

Table E.1: TB/HIV Co-infection 2004 to 2011

Year	Total # of incident TB cases	# of TB/HIV Co-infection		
		Male	Female	Total
2004	19	5	0	5
2005	7	1	1	2
2006	5	0	0	0
2007	8	0	2	2
2008	3	1	1	2
2009	3	0	0	0
2010	5	2	0	2
2011	0	0	0	0

Source: MOH, 2012

3.3 National Commitment and Action

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

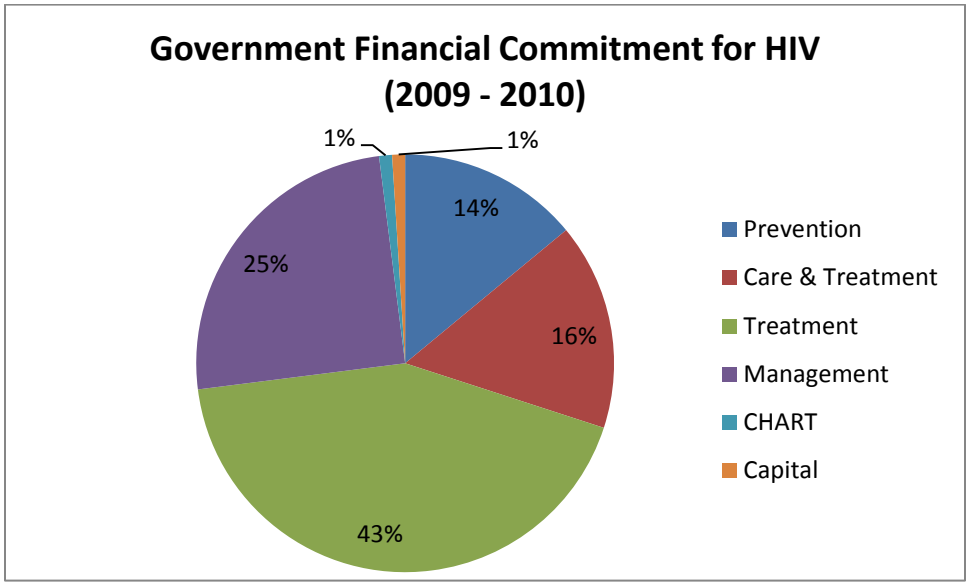
A desk review of expenditure on HIV programmes over the last two years revealed that a total of USD $7, 162, 504.00 was spent during the financial year 2009-2010 and USD $6, 997, 287.00 in 2010-2011. Both years showed similar expenditure in the category of HIV. The most funds were spent on treatment, 45% in 2010-2011 and 43% in 2009-2011.

Table F.1: National Expenditure on HIV (USD)

Programmatic Components	2009-2010	2010-2011
Prevention	1, 009, 421.00	937, 971.50
Care & Support	1, 134, 796.00	1, 432, 466.00
Treatment	1, 078, 125.00	3, 785, 047.00
Management	1, 776, 719.00	1, 659, 556.00
CHART	100, 094.00	92, 545.00
Capital expenses	72, 770.00	27, 673.00
Total USD	7, 162, 504.00	6, 997, 287.00

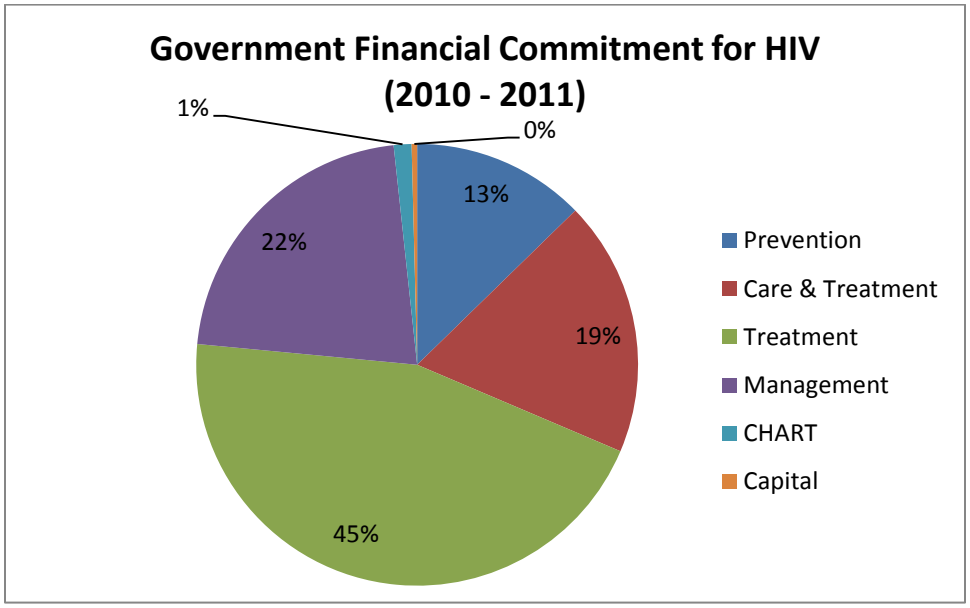
Source: NHAC/MOH Finances, Accounts Departments, 2012

Figure F.2: Percentage of funds spent on HIV by category, 2009-2010



Source: Generated from NHAC/MOH Finances, Accounts Departments, 2012

Figure F.3: Percentage of funds spent on HIV by category, 2010-2011



Source: Generated from NHAC/MOH Finances, Accounts Department, 2012

Target 7: Critical enablers and synergies with development sectors

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)

This indicator analyses the progress made in the development and implementation of national level HIV polices, strategies and laws. It is divided into two parts designed to be completed by government (part A) and civil society (part B). Eight government agencies namely: the National HIV/AIDS Commission (2); Ministry of Health; Ministry of Tourism; Ministry of Education and Human Resource Development; Ministry of Housing and Lands; Ministry of Labour; Ministry of Social Care and Constituency Empowerment; and the International Transport Division completed the questionnaire. Six representatives from civil society organizations namely: Movement Against Discrimination Action Committee (MOVADAC); CARE Barbados (2); AIDS Society of Barbados; St. John HIV Education Committee; Barbados Employers Confederation; and the Caribbean HIV & AIDS Alliance completed the questionnaire.

Many of the respondents found the questionnaire tedious, ambiguous and some of the questions irrelevant to the Barbados setting. There was variance response in some of the answers. A validation consultation was held with all relevant persons from the government and Civil Society to reach consensus on each question. A consensus of the key achievements included:

- A comprehensive prevention plan, which was developed with the inclusion of all partners including CSOs;
- Reduction of Stigma & Discrimination working more with PLHIV regarding the development of strategies;
- Inclusion and recognition of the importance of housing; and
- Sensitization and behaviour change communication programmes with persons with disability.

Some challenges identified:

- There is a need for national targets as well as organisational targets developed for the prevention plan to achieve a collaborative approach towards a national target for HIV prevention;
- There is a need for buy-in from partners and a greater team effort; and
- A reduction of political support from leaders was perceived.

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

This indicator is relevant to Barbados. However, data on intimate partner violence are not collected by the country as stipulated by this indicator.

7.3 Current school attendance among orphans and non-orphans aged 10–14

The Government of Barbados has adopted a proactive approach to ensure school attendance of all school aged children. The School Attendance Unit within the Ministry of Education and Human Resource Development (MEHR) is mandated to ensure that all school-aged children 5-16 year are attending school. Therefore school attendance of orphans and non-orphans is 100%.

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

No direct data available for this indicator.

IV. BEST PRACTICES

Barbados has many examples of "best practice" in the area of HIV prevention and control that has resulted in notable accomplishments as recently determined after a comprehensive evaluation of the health sector response to HIV and STIs in Barbados. This evaluation was conducted by PAHO in 2011 as part of a Mid-Term Review of the Government of Barbados' second HIV/AIDS World Bank project.

According to PAHO, the Government of Barbados implemented a sound public health approach in response to the HIV/AIDS epidemic which ensured availability of HIV services. Key features of the early response include:

1. Establishment of the National AIDS Programme in the Ministry of Health with a multi-sectoral approach;
2. The formation of the National Advisory Committee on AIDS (NACA) in 1988 to oversee prevention and control efforts and to advise on national policy;
3. Use of health promotion strategies from the onset (public awareness, advocacy);

This early response evolved when the National AIDS Programme was expanded in 2001 in which accessibility to an array of essential services was enhanced. When HAART was introduced in 2002 this was done in the context of comprehensive medical care services at the LRU, the HIV specialty clinic. Treatment services are supported by access to routine laboratory monitoring for PLHIV (CD4 and Viral load testing) and care services include psycho-social support for PLHIV.

The PAHO evaluation highlighted that as a direct result of the interventions of the health sector, Barbados achieved MDG 6 and Universal Access targets (halting new infections, showing a decline in HIV transmission and achieved ARV coverage of >80% for those in need) and regional targets for the elimination of MTCT of HIV and congenital syphilis (PAHO 2012). Additionally, the treatment programme has also resulted in dramatic declines in HIV related morbidity and mortality.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

As alluded to earlier, an evaluation team from PAHO conducted an assessment of the Health sector response to HIV and STIs in Barbados in 2011. This was done for a Mid-Term review of the Government of Barbados' second HIV/AIDS World Bank project. The final report of this evaluation was presented to the GOB in March 2012 and it highlighted what the successes and major challenges of the NAP are. The evaluation team also made recommendations for remedial action which are currently being considered by the Government.

The following is an excerpt from the PAHO evaluation Report (2012):

> "*The Barbados Health System has achieved significant outcomes and had a positive impact on the HIV epidemic. This has been possible as a result of the sustained leadership and political support to the HIV/AIDS Prevention and Control Programme of the Ministry of Health, which has been successful in developing interventions and services in response to HIV. However, MH HIV/STI Prevention and Control Programme is vertical and centralized, with minimum integration into existing health system services and structures. The evaluation noted a disproportionate investment in HIV that, if not addressed, will hamper sustainability of the overall health response. Re-orienting the existing programmatic structure and services to rationalize resources without compromising achievements is the key challenge to the Health System and will require strong leadership and governance in the Ministry as a whole. The National HIV/AIDS Commission and the HIV/AIDS Prevention and Control Programme of the Ministry of Health, as well as key stakeholders interviewed for this assessment identified a number of key issues and recommendations for the MH to lead and manage the necessary changes, as well as for its HIV/AIDS Prevention and Control Programme.*
>
> *The multi-sectoral response to HIV/STI involves a complex structure for national coordination and management of resources, resulting in duplication and a number of issues that present many challenges for the Health System. There is tension between the National HIV/AIDS Commission and the Ministry of Health's HIV/AIDS Prevention and Control Programme. While the overall responsibility for coordination of the multi-sectoral response the National HIV/AIDS Programme has been assigned to the Commission and its Secretariat, located in the Ministry of Family, Youth Affairs, Sports and Environment, the HIV/AIDS Prevention and Control Programme in the Ministry of Health is response for the execution of over 70 percent of the programme activities and financial resources. There is a lack of clarity about the respective functions of the two entities although it is broadly understood that the Commission is responsible for the*

multi-sectoral response, whereas the HIV/AIDS Prevention and Control Programme is responsible for the health sector component. However, the Evaluation Team was unable to find any harmonized organization chart showing and describing the roles and responsibilities of these two entities and the distinctions between them. Confusion in leadership and governance roles and responsibilities was also clear from the Team`s discussions with senior representatives of the two bodies. There is general consensus that the current structure of the national HIV response is not facilitating efficient multi-sectoral coordination and collaboration. Wider issues that need to be tackled outside of health (such as human rights and stigma and discrimination in society) are not fully operationalized by the NHAC. This should be one of the key elements of the multi-sectoral response.

The above-mentioned challenges have direct implications for the HIV/AIDS Prevention and Control Programme and its ability to deliver and scale up the Health System response in line with universal access targets. A functional analysis of the Commission and the HIV/AIDS Prevention and Control Programme in this evaluation indicates a programme structure with a mix of functions and imbalance of focus. An intervention is clearly needed to reposition the NHAC and the HIV/AIDS Prevention and Control Programme for strategic and programmatic leadership. This, indeed, needs to occur within the decentralization framework and within a revised plan of action for the remaining component of the World Bank loan, currently being discussed.

There is an urgent need to reorganize/reorient the current structure of the overall National HIV/AIDS Programme."

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Barbados, like other Small Island Developing States (SIDS) in the Caribbean, faces several challenges including relative poverty; an extremely narrow resource base; an unsustainable high external debt; and intra-regional mobility further exacerbated by the advent of the Caribbean Single Market and Economy (CSME). As the country searches for development partners' support it is committing its own resources to NAP.

The World Bank's classification of Barbados as a high income country, poses significant challenges to the country's ability to fund and implement its National AIDS Programme. Categorisation as a high income country has made it more difficult to raise resources in the international lending market. When loans have been available, they have proven impractical due to unfavourable lending conditions. Despite this, the country receives limited external funding for HIV, minimal bi-lateral funding and multi-lateral support predominantly in the form of technical assistance.

Table 8: Major Sources of Assistance Provided to the NHAC & Ministry of Health 2010 and 2011

Agency	Beneficiaries	Type of Assistance	Assistance Value	Focus area of Support
Centers for Disease Control	**Ministry of Health**	**Technical; Financial**	**USD $ 400, 000 (2010)** **USD $ 280, 000 (2011)**	**CDC Cooperative Agreement; Laboratory Strengthening; Strategic Information Strengthening**
Caribbean Health Research Council	**NHAC**	**Training; Technical**	**N/A**	**Monitoring and Evaluation; Development of guidance documents for Mid-Term Review; Capacity building**
Caribbean Health Research Council	**NHAC**		**N/A**	**Impact Evaluation of NSP**
Pan American Health Organization	**Government of Barbados**	**Technical**	**N/A**	**Conduct of the assessment of World Bank Project; Strategic Information, Laboratory, Prevention; Treatment, Care and Support**
UN Women	**NHAC**	**Financial**	**N/A**	**Gender & HIV**
PEPFAR	**NHAC**	**Financial**	**USD $535.50**	**Prevention Summit**
UNIFEM	**NHAC**	**Financial** **Technical**	**N/A**	**Parliamentarians Dialogue & Community Mobilisation**
World Bank	**NHAC**	**Technical** **Financial**	**USD $7.38m** **USD $2.44m (2010)** **USD $4.94m (2011)**	**Second GOB/IBRD HIV/AIDS Prevention and Control Project**
IADB	**NHAC**	**Technical**	**N/A**	**Project Management**
Total USD			**USD $13, 588.25**	

Source: NHAC and Ministry of Health, 2012

Table 8 shows the major sources of the money spent in 2011. Support from development partners has primarily come from the World Bank through the Second GOB/IBRD HIV Prevention and Control Project (USD $35m). It supports the implementation of the NSP 2008-2013 and assists the response in the Organisation of Eastern Caribbean States (OECS) which comprises a viable sub-region.

With the exception of the World Bank and Centers for Disease Control, most of the support provided has been in the form of technical assistance. The development partners can best support the attainment of the UNGASS targets by harmonising their country-level programmes paying particular attention to the cultural and programme context. Additional assistance could be provided with the mobilisation of scarce resources.

VII. MONITORING AND EVALUATION ENVIRONMENT

The NAP recognises that M&E is critical to the success of the overall HIV prevention and control programme since continuous assessment is needed to determine the efficiency and effectiveness of interventions. The NAP also emphasizes the need for accurate and timely strategic information which should form the basis of programme design and redesign. However, there is no adequate and coordinated approach to M&E and strategic information related to HIV and STIs in Barbados. This is one of the salient shortcomings of the HIV response and is arguably a reflection of challenges in leadership and governance of the NAP.

VIII. ANNEXES

Annex 1:

National Commitments and Policy Instrument (NCPI) Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation:
Both Parts A and B were administered to the respondents where possible or if requested. In cases where the respondent was not available for interviews or time constraints existed, the questionnaire was given to the prospective respondent to complete and reviewed along with the Assistant Director, National HIV/AIDS Commission to ensure clarity and completeness.
Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
The NCPI was presented to relevant stakeholders at a specially scheduled meeting and agreement sought on the answers to questions on an item-by-item basis.
Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
NCPI not relevant to the Barbadian context specifically the civil society section assumes that CSOs fill the gaps left by government when in Barbados this is not the case. • **Codes not mutually exhaustive – does not allow for 'not sure' or 'don't know' response options** • **Confusion about some terms e.g. page 127 q4 Part A 'specific needs' – does this refer to the country's determination of what its prevention needs are or is it referring to how the country ranks in terms of international best practice** • **Some double barrelled questions** • **Some questions are leading** **The NCPI needs to be accompanied by guidelines on how to interpret and complete certain questions.**

Annex 2: National Commitments and Policy Instrument (NCPI)

This document has been uploaded electronically to the UNAIDS website (www.unaids.org).

Annex 3: List of NCPI Respondents

NCPI Respondents

*[Indicate information for **all** whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]*

NCPI – Part A [to be administered to government officials]

Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]					
		A.I	A.II	A.III	A.IV	A.V	A.VI
Ministry of Health	Dr. Anton Best Senior Medical Officer of Health, Communicable Diseases	✓	✓	✓	✓	✓	✓
Ministry of Health	Dr. Dale Babb, Clinical Medical Officer		✓			✓	
National HIV/AIDS Commission	Ms. Alexis Nurse, Behaviour Change Communication Specialist	✓	✓	✓	✓	✓	
National HIV/AIDS Commission	Miss Nicole Drakes, Assistant Director	✓	✓	✓	✓	✓	✓
Ministry of Tourism	Miss Madge Dalrymple, HIV Coordinator	✓			✓		
Ministry of Education and Human Resource Development	Rev. Hughson Inniss, HIV Coordinator	✓			✓		

Ministry of Housing and Lands	Miss Francia Best, HIV Coordinator	✓			✓		
Ministry of Labour and Social Security	Ms. Rhonda Boucher, Project Coordinator	✓			✓		
Ministry of Social Care, Constituency Empowerment and Community Development	Mrs. Veronica Belle, HIV Coordinator	✓			✓		
International Transport Division	Ms. Angela Brandon-Hall, Deputy Chief Technical Officer (Ag.)	✓			✓		

NCPI – Part B [to be administered to civil society organizations, bilateral agencies, and UN organisations]

Organization	**Names/Positions**	**Respondents to Part B**				
		[indicate which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	B.V
Movement Against Discrimination Action Committee (MOVADAC)	Patsy Grannum, member	✓	✓	✓	✓	✓
CARE Barbados	Ms. Ingrid Hope, President	✓	✓	✓	✓	✓

CARE Barbados	Mrs. Patricia Phillips, member	✓	✓	✓	✓	✓
AIDS Society of Barbados	Mr. Robert Best, President	✓	✓	✓	✓	✓
St. John HIV Education Committee	Mr. Richard Harris, Chairman	✓	✓	✓	✓	
Barbados Employers Confederation	Mr. Takaidza Chafota, Industrial Relations Officer	✓	✓	✓	✓	✓
Caribbean HIV & AIDS Alliance	Mr. Teddy Leon, Senior Programme Officer - Barbados & Grenada	✓	✓	✓	✓	✓
United Gays and Lesbians Against AIDS Barbados	Mr. Sylvester Shepherd, Financial Director	✓	✓	✓	✓	

Annex 4: Data collection ANC instrument

QUARTELY AGGREGATE REPORT FOR ANC

National HIV Surveillance Unit
Ministry of Health Barbados

CLINIC: _____

Completed by: _____

Month: _____ **Year:** _____

Age	Number of ANC bookings	Number of HIV tests at booking	Number of HIV positive diagnosis	Number of new positive diagnosis	Number of second HIV tests
9 - 14					
15-19					
20-24					
25-29					
30-34					
35-39					
40-44					
45-49					
50+					
Unknown					
Total					

Month: _____ **Year:** _____

Age	Number of ANC bookings	Number of HIV tests at booking	Number of HIV positive diagnosis	Number of new positive diagnosis	Number of second HIV tests
9 - 14					
15-19					
20-24					
25-29					
30-34					
35-39					
40-44					
45-49					
50+					
Unknown					

Total					

Month: _____ Year: _____

Age	Number of ANC bookings	Number of HIV tests at booking	Number of HIV positive diagnosis	Number of <u>new</u> positive diagnosis	Number of second HIV tests
9 - 14					
15-19					
20-24					
25-29					
30-34					
35-39					
40-44					
45-49					
50+					
Unknown					
Total					

Feb. 21, 2011