UNGASS COUNTRY PROGRESS

REPORT 2010

BARBADOS

Reporting period: January 2008 to December 2009

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Abbreviations

ABBREVIATION	MEANING
ACET	AIDS Care, Education & Training
AFOI	AIDS Foundation of Barbados Inc.
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
BDS	Barbadian Dollar
BEA	Barbados Evangelical Association
CARE	Comfort Assist Reach out Educate Barbados
CCAS	Caribbean Cytometry & Analytical Society
CCNAPC	Caribbean National AIDS Programme Coordinators
CDC	Centers for Disease Control & Prevention
CDRC	Chronic Disease Research Centre
CFNI	Caribbean Food and Nutrition Institute
CHAA	Caribbean HIV/AIDS Alliance
CHAI	Clinton Foundation HIV/AIDS Initiative
CHART	Caribbean HIV/AIDS Regional Training Network
CHRC	Caribbean Health Research Council
CI	Confidence Interval
COMSEC	Commonwealth Secretariat
CRIS	Country Response Information System
CRN+	Caribbean Network of People living with HIV/AIDS
CSD	Commission on Sustainable Development
CSME	Caribbean Single Market and Economy
CSO	Civil Society Organisation
CTUSAB	Congress of Trade Unions and Staff Associations of Barbados
DfID	Department for International Development of the United Kingdom
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
FSW	Female Sex Worker
GDP	Gross Domestic Product
GOB	Government of Barbados
HAART	Highly Active Anti- Retroviral Therapy
HBsAg	Hepatitis B surface antigen
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HTLV	Human T-cell lymphotropic viruses
IBRD	International Bank for Reconstruction and Development
ICSB	International Consortium for Blood Safety
IDU	Injecting Drug User
IEC	Information, Education and Communication
ILO	International Labour Organisation
IT	Information Technology

ABBREVIATION	MEANING
KABP	Knowledge, Attitudes, Beliefs and Sexual Practices
LRU	Ladymeade Reference Unit
LSBE	Life Skills-based Education
MARP	Most at Risk Population
M&E	Monitoring & Evaluation
MEHR	Ministry of Education and Human Resource Development
MH	Ministry of Health
MII	Ministry of Internatinal Business and International Transport
MIS	Management Information System
MLI	Ministry of Labour and Immigration
MYFS	Ministry of Youth Family and Sports
MSM	Men who have Sex with Men
MSCURD	Ministry of Social Care Constituency Empowerment Urban and Rural Development
MT	Ministry of Tourism
NACA	National Advisory Committee on AIDS
NAP	National AIDS Programme
NASA	National AIDS Spending Assessment
NCPI	National Composite Policy Index
NCSA	National Council on Substance Abuse
NHAC	National HIV/AIDS Commission
ODA	Official Development Assistance
OVC	Orphans and Vulnerable Children
NIS	National Insurance Scheme
NOW	National Organisation of Women
NSP	National Strategic Plan
NUPW	National Union of Public Workers
PAHO	Pan-American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	Persons living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
QEH	Queen Elizabeth Hospital
SHIP	Sexual Health Information Programme
SIDS	Small Island Developing State
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
UGLAAB	United Gays and Lesbians Against AIDS Barbados
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund

ABBREVIATION	MEANING
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund
USAID	United States Agency for International Development
USD	United States Dollars
UWI	University of the West Indies
UWIHARP	University of the West Indies HIV and AIDS Response Programme
VCT	Voluntary Counselling & Testing
WHO	World Health Organisation

I. Status at a glance:

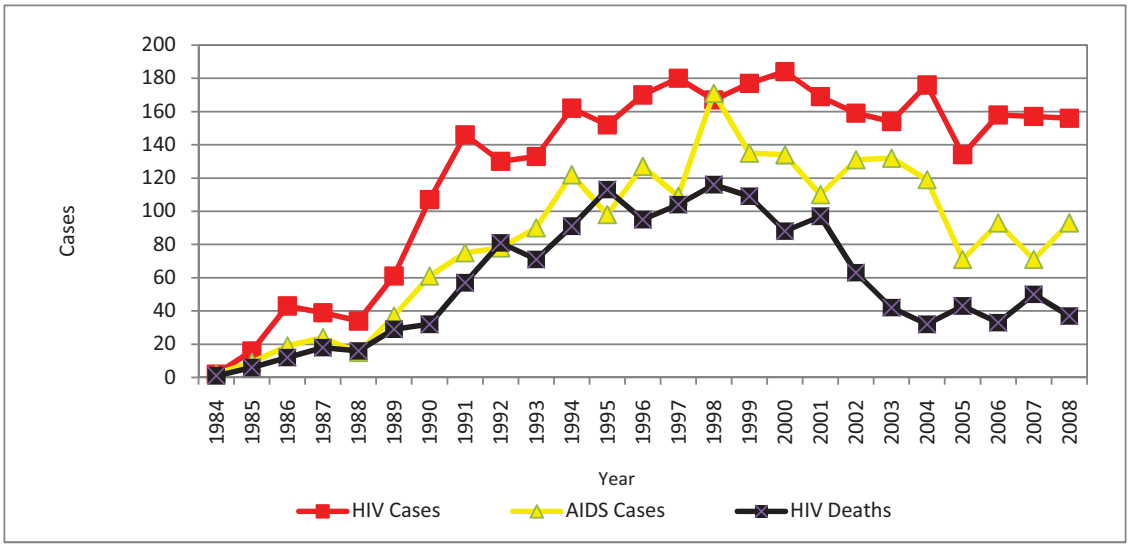
Inclusiveness of the stakeholders in the report writing process

This report was prepared in collaboration with stakeholders from government, private and civil society organisations. Stakeholders were consulted at various stages of the report preparation process, particularly during data collection, actual report development and review. (See Annex 1)

Status of the epidemic

The AIDS epidemic started in 1984 and the major mode of transmission has been through heterosexual contact. Current figures reveal that the epidemic has cemented itself in the 30-39 and 40-49 age groups, each comprising approximately one-third of the new AIDS cases.

Figure 1: Summary Profile of Reported AIDS and HIV Cases 1984-2008



In 2008, 156 people were newly diagnosed with HIV in Barbados. During this time there were 93 newly diagnosed AIDS cases and 37 HIV-related deaths. All three (3) categories of surveillance were dominated by male cases. The number of deaths among people with HIV in 2008 decreased by 26% compared to the number of HIV-related deaths in 2007.

Policy and Programmatic Response

The Government of Barbados continues to be committed to giving the highest priority to the fight against HIV/AIDS as epitomised by the establishment of the National HIV/AIDS Commission (NHAC) which is now under the Ministry of Youth, Family and Sports. Within the public sector, the twenty (20) key line ministries are required to submit annual HIV/AIDS Work Plans for which funding is received as part of the annual budgetary process. Only two (2) ministries: the Ministry of Social Care and the Ministry of Labour have HIV/AIDS Core Groups. The programmatic response to HIV is characterised by the successful engagement of stakeholders; the brokering a model partnership with Trade Unions; and the development of a

comprehensive campaign to mobilise private sector and civil society partners into tangible and meaningful action.

The NHAC has prepared a National AIDS Policy which recognises the contribution of the various sectors in the National AIDS Programme. This policy was approved by Cabinet and debated in Parliament in 2008. The Ministry of Health has developed policies and guidelines for prevention, treatment and care such as the PMTCT policy which was approved by Cabinet and launched in November 2009. The HIV testing policy is being developed and is presently awaiting submission to Cabinet.

Table 1: Overview of UNGASS Indicator Data

National Commitment & Action:

- Amount of national funds disbursed by governments in low and middle income countries
  See Table A1
- National Composite Policy Index
  Indicates steady progress between 2008 and 2009, however during the period civil society engagement has a shown significant increase. The Ministry of Labour launched **the Policy and Code of Practice on HIV/AIDS and other life-threatening illnesses in the Public Sector on October 28, 2009**

National Programmes:

- Percentage of donated blood units screened for HIV in a quality-assured manner
  100%. (QEH, 2009)
- Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy
  100% children receiving ART in 2008 and 2009 (QEH, 2010)
  87% adults receiving ART in 2008 and 2009 (SHIP database, 2010)
- Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to- child transmission
  Indicates in PMTCT coverage of 95.2% in 2007 and 91.4% in 2008 (PMTCT MOH, 2010).
- Percentage estimated HIV-positive incident TB cases that received treatment for TB and HIV
  100% (In 2008, there were 2 TB cases with HIV-Co-infections, and no cases in 2009 MOH, 2009)
- Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results
  98.2% (MOH , 2009) (Data taken from VCT programme records which are disaggregated by gender but NOT age)
- Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results
  85.1% MSM in 2007 (NHAC, 2007) and 73.3% FSW in 2006 (MOH, 2008); data collected from research projects
- Percentage of most-at-risk populations reached with HIV prevention programmes
  N/A (Data not available)
- Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child
  100% (Welfare Department, 2010)
- Percentage of schools that provided life-skills based HIV education within the last academic year
  85.1% (Ministry of Education, 2009)

Knowledge, Sexual Behaviour and Orphans' School Attendance:

- Current school attendance among orphans and among non-orphans aged 10-14
  1:1 (Ministry of Education, 2009) (100% of all orphans in Barbados are in school)
- Percentage of young women and men aged 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
  50.4% (KABP, MYFS 2009)

- Percentage of MARPS who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission
  36.7% FSW (MOH, 2007)(Data not available for MSM in format requested by UNGASS, NHAC 2007)
- Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15
  19.6% (KABP, MYFS 2009)
- Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months
  24.8% only partial data 15-24 (KABP, MYFS) NA
- 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
  40.9% only partial data 15-24 (KABP, MYFS) NA
- Percentage of female and male sex workers reporting the use of a condom with their most recent client
  80.0% FSW (MOH 2008)
- Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
  64.5% (Preliminary figure available; data being analyzed, NHAC 2009)
- Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse
  N/A (Data not available, not a major population of concern)
- Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected
  N/A (Data not available; not a major population of concern)

Impact:

- Percentage of young people aged 15 – 24 who are HIV infected
  0.24 % (Case-based data which will be lower than any estimate of prevalence in that population)
- Percentage of MARPS who are HIV infected
  N/A (Data not available, no population based sero-prevalence survey has been conducted)
- Percentage of adults and children with HIV known to be on treatment still alive 12 months after initiation of ART
  84.1% of adults in 2008 and 94.0% adults (MOH 2010) and 100% of children for both 2008 &2009
- Percentage of infants born to HIV-infected mothers who are infected
  0% (MH 2010)

II. Overview of the AIDS Epidemic

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

AIDS Epidemic 1984 to 2008 – Trends and Dynamics

The first reported case of AIDS in Barbados was in 1984. By the end of 2008 the cumulative total of HIV cases was 3166 and the total number of AIDS related deaths was 1,436. The number of deaths among people with HIV in 2008 decreased by 26% compared to the number of HIV-related deaths in 2007. In the early 1990s AIDS was the leading cause of death in the age group 15-49 years. According to estimates collected by SPECTRUM and AIDSProj with AIDS case surveillance data and antenatal sentinel surveillance data, the prevalence of HIV in the adult population was 1.9% in 2001[1] .

The Ministry of Health has determined the prevalence of HIV based on the number of known PLHIV (numerator) and the population projection estimates from Barbados Statistical Services (denominator). Using case-based data, the minimal prevalence in 2008 was 0.62%. The highest prevalence was seen in the 30-39 age which was 1.38%. Table 2 details the prevalence of the HIV in Barbados in 2008.

Table 2: HIV prevalence in Barbados based on known cases 2008

Age Group	# of PLHIV at the end of 2008			Estimated # of persons at the end of 2008			HIV prevalence at the end of 2008		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
<10	3	8	11	18,052	18,441	36,493	0.02	0.04	0.03
10-19	24	20	44	19,406	19,488	38,88	0.12	0.10	0.11
20-29	130	70	200	18,454	18,778	37,232	0.70	0.37	0.54
15-24	**61**	**32**	**93**	**19,065**	**19,734**	**38,799**	**0.32**	**0.16**	**0.24**
30-39	288	245	533	19,641	19,056	38,697	1.47	1.29	1.38
40-49	218	306	524	22,086	20,497	42,583	0.99	1.49	1.23
15-49	**652**	**633**	**1,285**	**69,838**	**68,393**	**138,231**	**0.93**	**0.93**	**0.93**
50-59	87	197	284	18,481	16,730	35,211	0.47	1.18	0.81
60-69	30	74	104	11,555	9,768	21,323	0.26	0.76	0.49
70+	10	20	30	16,797	11,232	28,029	0.06	0.18	0.11
Total	**790**	**940**	**1,730**	**144,990**	**133,990**	**278,462**	**0.55**	**0.70**	**0.62**

Source: NHS database and Barbados Statistical Services, 2010

1. Nature of the epidemic

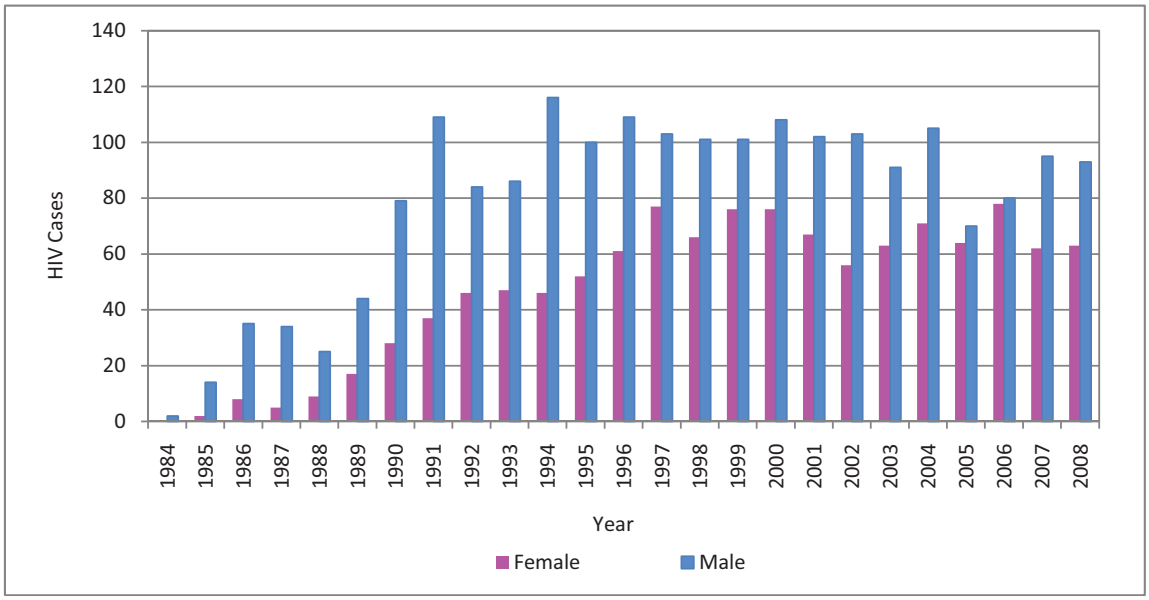
Although the HIV epidemic in Barbados is generalized, implying that HIV prevalence in the general population is relatively high, the prevalence is even higher among MARPS. Some of key populations *believed* to be at higher risk are men in general, MSM, sex workers,

[1] S. Adomakoh et al, Associates for International Development (AID Inc.), the **Barbados HIV/AIDS Impact Project 2001 to 2006,** Ministry of Health

prisoners and drug users. Recently, key research activities have been initiated to determine behavioural patterns in MARPs in the context of HIV.

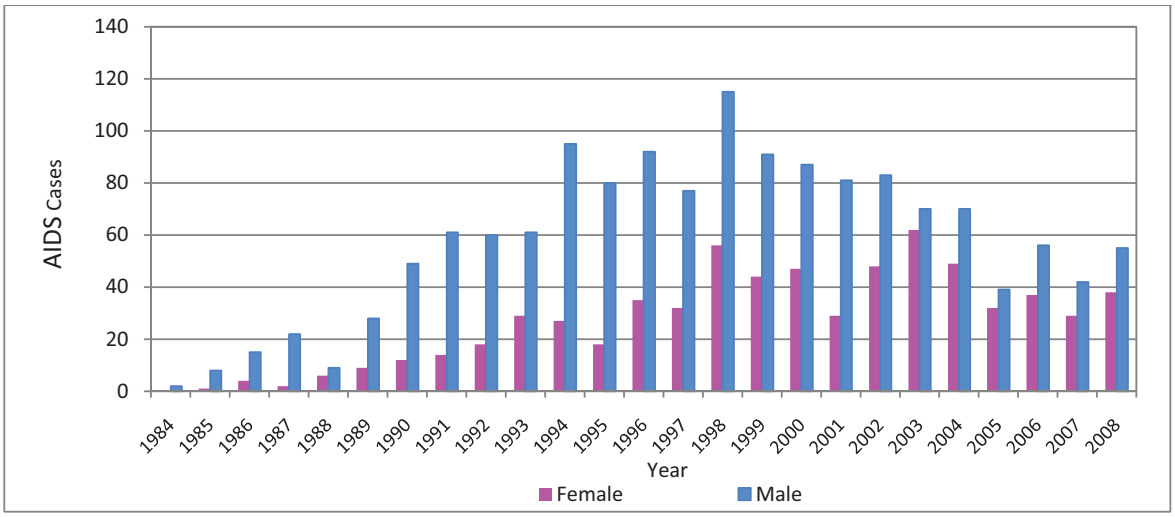
Figure 2 shows the number of HIV cases between 1984 and 2008. The total number of new HIV diagnoses peaked in 2000 with 184 new cases detected that year. Men have consistently outnumbered newly diagnosed with HIV each year. Over the 10 year surveillance period 1999-2008, the average number of newly diagnosed HIV cases was 162 per year.

Figure 2: HIV Cases 1984 – 2008



There was a steady rise in the number of new AIDS cases detected annually with a peak in 1998 in which there were 171 new AIDS cases that year. Subsequently there was a gradual fall in AIDS cases (See Figure 3). This is partially attributed to the introduction of HAART in 2002 for all citizens of Barbados in need of HIV therapy to receive ARVs at no cost.

Figure 3: AIDS Cases 1984 – 2008



People newly diagnosed with HIV should be referred to and access initial assessment for medical care at the LRU *ideally* within six (6) months from the date of diagnosis with HIV. The proportion of PLHIV who accessed medical care within six (6) months of HIV diagnosis was determined according to the year of diagnosis. This analysis was done from 2002 when the LRU and the HAART program were established. In 2008, 72.4% of PLHIV accessed the services at the LRU within six months of diagnosis which is the highest percentage to date (See Table 3).

Table 3: The proportion of PLHIV accessing medical care services in Barbados within six (6) months and after six (6) months of diagnosis 2002 – 2008

Year	Number of people diagnosed with HIV	Number of PLHIV who accessed medical care at the LRU within 6 months of diagnosis	Proportion of PLHIV who accessed medical care at the LRU within 6 months of diagnosis (%)	Number registered at LRU after 6 months from diagnosis	Proportion of PLHIV who accessed medical care at the LRU after 6 months from diagnosis (%)	Never Registered	Proportion never registered
2002	159	89	56.0	13	8.2	57	35.8
2003	154	108	70.1	13	8.4	33	21.4
2004	176	113	64.2	16	9.1	47	26.7
2005	134	92	68.7	10	7.5	32	23.9
2006	158	112	70.9	6	3.8	40	25.3
2007	157	108	68.8	6	3.8	43	27.4
2008	156	113	72.4	6	3.8	37	23.7

Source: NHS and SHIP databases, 2010

Internationally, tuberculosis has re-emerged as a major public health threat particularly due to HIV/AIDS. However, there has not been a corresponding increase in the incidence rate of tuberculosis in Barbados with only three cases of TB being reported in 2009, with no cases of co-infection with HIV/TB being reported.

2. HIV/AIDS surveillance 2008

During 2008, there were 156 people newly diagnosed with HIV in Barbados; 93 (59.6%) were male while 63 (40.4%) were female. In addition, 70.5% of all new HIV cases were adults between the ages of 20 – 49 years. The age group with the greatest proportion of new HIV cases was 30 – 39 years (30.8%). The median age of someone being diagnosed with HIV in Barbados in 2008 was 36.5 years with males being diagnosed with HIV at an older age than females: 40.9 years compared to 30.7 years respectively. New HIV diagnoses according to age and gender are illustrated in Figure 4.

In 2008 there were 93 people newly diagnosed with severe immunodeficiency, or AIDS, in

Barbados. As observed with new HIV cases, there was a male preponderance of AIDS cases with 55 (59.1%) being men and 38 (40.9%) being women. The 30 – 39 and the 40 – 49 age groups each comprised almost one-third of the new AIDS cases. New AIDS cases in 2008 according to age and gender are illustrated in Figure 5.

Figure 4: New HIV Diagnoses in 2008 by age and gender

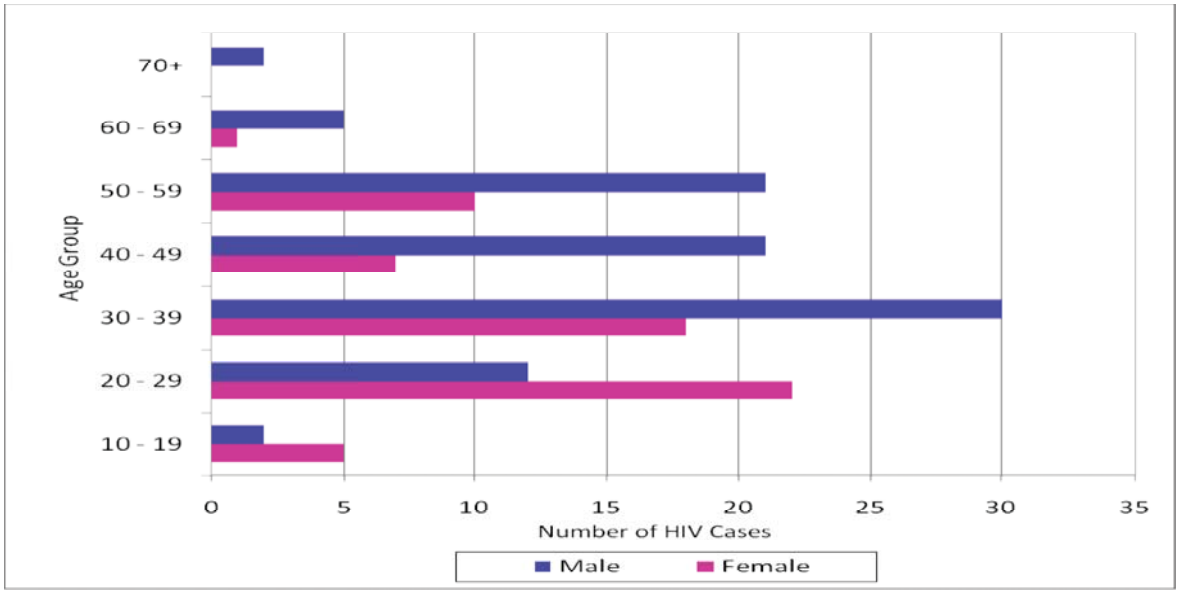
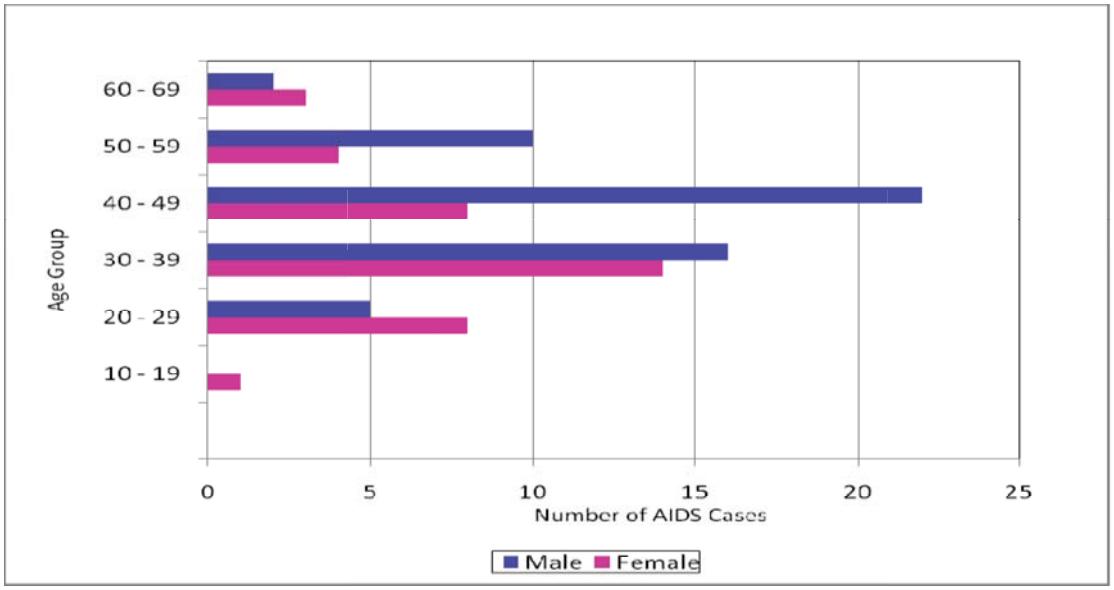
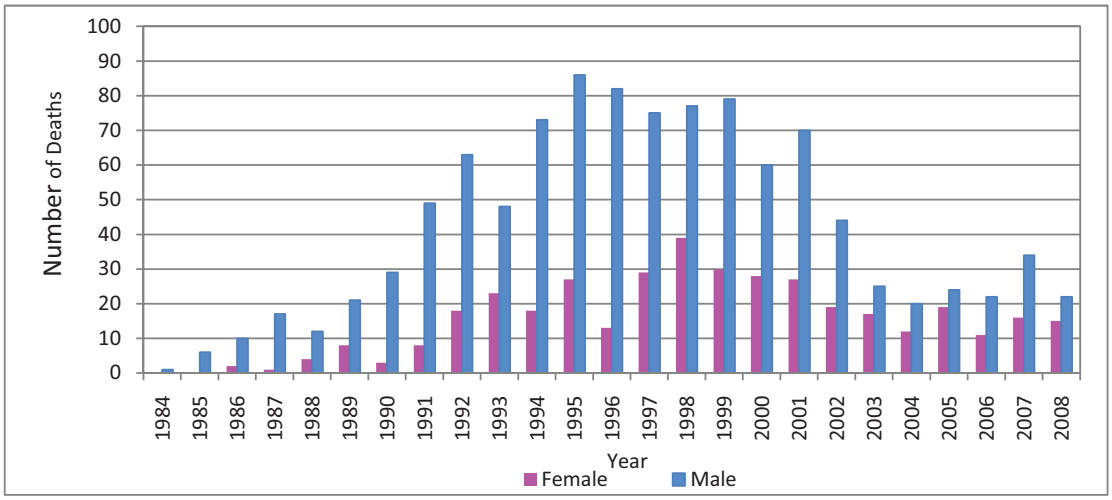


Figure 5: New AIDS cases in 2008 by age and gender



Over this twenty-five (25) year surveillance period, 1,436 people with HIV died. The crude case fatality rate among people with HIV was 45.4% (See Figure 6). 1,049 (73.1%) HIV+ men died compared to 387 (26.9%) HIV+ women. The relative risk of death of men with HIV compared to women with HIV was 2.10 (95% C.I 1.87 – 2.36). In other words, men with HIV were 2.1 times more likely to die than women with HIV between 1984 and 2008. This increased risk was statistically significant ($p<0.001$).

Figure 6: Number of deaths amongst people with HIV; 1984-2008



3. HIV Surveillance in Antenatal Clinics and PMTCT

HIV testing in the Antenatal clinics (ANC) was initiated in Barbados in 1991. In 2004, 89.7% of all pregnant women in Barbados were tested for HIV. 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). The programme's success can be attributed to: improved access to care, the good health service infrastructure and the country's population size. However, in spite of the apparent success, the programme has challenges with the information system (documentation and reporting).

In spite of these challenges, it is believed that Barbados can achieve PMTCT Universal Access targets as testing uptake nears 100%. In 2006, 84.6% of all pregnant women were tested for HIV and in 2007 this number increased to 95.2% which showed appreciable progress in achieving the 100% target. However, in 2008 and 2009 there was a marginal decline from 95.2% in 2007 to 93% and 94.7% respectively of pregnant women screened for HIV at their antenatal booking. However it must be mentioned that the data set used in 2008 and 2009 was more complete since it covered all of the bookings made in the public system whereas in 2006 and 2007 the data for only 8 of the 11 clinics was used.

Table 4: HIV among pregnant women 2005-2007

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

* The data for 2007 are for January to November.

Table 5: HIV among pregnant women 2008-2009

Age Group	2008			2009		
	ANC Bookings	**# Tested for HIV**	**HIV positive**	**ANC Bookings**	**# Tested for HIV**	**HIV positive**
9-14	15	15	0	5	5	0
15-19	456	419	1	448	423	2
20-24	521	495	0	520	485	2
25+	899	830	5	885	846	6
Total	1891	1759	6	1858	1759	10
Percentage	**-**	**93**	**0.34**	**-**	**94.7**	**0.57**

Source: Ministry of Health

HIV prevalence among pregnant women, measured by HIV infection among women attending ANC at government polyclinics and the QEH, has decreased from 1.1% in 1999 to 0.47% in 2005. There has been minor fluctuation in the prevalence over the last 2 years.

Gaps in antenatal surveillance were previously identified and presently efforts are being made to address these gaps and there has been some improvement noted over the last reporting period.

Behaviours/Sexual Practices

One of the programme's challenges is the disconnect between knowledge levels and sexual practices. As Table 5 indicates, knowledge levels among young people are quite high and have shown an upward progression over the 2001-2009 period. This speaks to a substantial measure of success enjoyed by the Information, Education and Communication (IEC) programme. However, the data in the Table taken from three Knowledge, Attitudes, Beliefs and Sexual Practices surveys conducted by the Division of Youth Affairs, also demonstrate that there has been a noticeable failure by the youth to translate knowledge into behaviour change. This data provides a convincing argument for the continued restructuring of the existing IEC programme to encapsulate targeted Behaviour Change Communication (BCC), if the HIV prevention programme is to have a significant impact on behavioural change.

In light of these developments the NHAC has embarked on a series of BCC workshops in an attempt to bridge the gap between knowledge and practices. This has been further supported by efforts to develop a prevention plan targeting key populations at higher risks.

Table 6: Data on knowledge-behaviour gap

VARIABLES	YEAR			
	2001	**2003/2004**	**2005/2006**	**2009**
Knowledge - Prevention	*15-29 years*	*10-18 years*	*15-24 years*	*15-24 yea*
• Abstinence	17.1%	82.1%	92.7%	N/A
• Be Faithful	30.6%	77.8%	92.3 %	79.3%
• Condom use	46.9%	87.3%	93.7 %	76.7%
Behaviour				
• Have Multiple Partners	48.9% (male partners) 43.7% (female partners)	36 persons %?	80 persons %?	24.8%
• Consistent Condom Use	17.1	< 3%	Data not recorded	40.9%
• Number of persons involved with multiple partners	118 out of 735 (16.1%)	36 out 347 (10.4%)	80 out of 273 (29.0%)	115 out of 464 (24.4%)

Source: Report on the National KABP Survey on HIV/AIDS Dec 2001 (Division of Youth Affairs, 2001)
Report on the Secondary School Behavioural Surveillance Survey 2003-2004 (Division of Youth Affairs, 2004)
Report on the National Youth KABP Survey on HIV/AIDS 2005-2006 (Division of Youth Affairs, 2006)
Report on the 2009 KABP Survey database

The effectiveness of the National AIDS Programme is further challenged by the high levels of stigma and discrimination in Barbados which restrict programme efforts to reach most at-risk populations such as youth, MSM, prisoners and persons living with HIV. Factors such as country size, intricate family and social networks and societal conservatism often colour negative perceptions of government services, affecting individual willingness to access these services and contributing to instances of self-stigma and enacted stigma (Adomakoh et al., 2003). These factors also limit programme effectiveness, the willingness of key populations at higher risk to become involved in programmes specifically designed to meet their needs and the implementation of innovative approaches to HIV. Perhaps the biggest challenge facing the national AIDS response is the lack of strategic information pertaining to groups at higher risk. Despite the multi-sectoral character of the National AIDS Programme, there is still room for:

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

Testing

Within the last two years (2008-2009) there has been a substantial increase in the uptake of HIV testing services in the community through the VCT programme of the MOH. There has also been a significant uptake of these services by men especially within the polyclinics, with males accounting for 50.2% of tests done in 2009, an increase of over 20% from the previous

year. As such, even though the VCT services will need to be further refined, this increase in male uptake of the VCT services at the polyclinics is extremely promising and addresses one of the MARPs. This increased uptake of testing by males in the polyclinic setting might possibly be as a result of vibrant men's health programmes which were being conducted at many of the polyclinics during 2009. In contrast, there is still much work to be done in the community based testing with regards to men since although three times as much testing is being done for HIV, there are approximately twice as many women as men being tested in the community (See Table 7).

Table 7: 2009 VCT Coverage

	Testing and Counselling 2009								
	Polyclinic			*Community*			*Total*		
	Male	*Female*	***Total***	*Male*	*Female*	***Total***	*Male*	*Female*	***Total***
Pre-counselled and tested	840	833	**1673**	1606	2625	**4231**	2446	3458	**5904**
Received post-test counseling and results	809	809	**1618**	1578	2602	**4180**	2387	3411	**5798**
% tested and know results	96.3	97.1	**96.7**	98.3	99.1	**98.8**	97.6	98.6	**98.2**

Source: Ministry of Health

III. National Response to the AIDS Epidemic

A. National Commitment and Action

The Government of Barbados continues to be committed to giving the highest priority to the response against HIV and the establishment of the National HIV/AIDS Commission (NHAC) in 2001 under the Prime Minister's Office and its shift to the Ministry of Youth, Family and Sports is one of the signs of this continued commitment. Within the Public Sector, there are twenty (20) key line Government Ministries with two (2) having dedicated HIV and AIDS core groups and each Ministry having an annual Work Plan for which they receive financing as part of the annual budgetary process. The Government's financial commitments for HIV are shown in Table A1.

Government's overall financial commitments for HIV during the last reporting period (2007-2009) have steadily increased with the largest increase being seen in 2008/2009. There has also been an increase in the resource allocation for prevention and care and support from $2.8 million to $6.2 million in 2008 and $12.1 million in 2009. In addition there has been a significant re-distribution of spending within the budgeted area, with a stronger focus being placed on prevention and care and support-related spending, accounting for more than half of the allocations in 2008 and 2009. These efforts are commendable since they are key strategies in reducing the spread of the epidemic. The NHAC has successfully engaged a range of stakeholders; brokered a model partnership with the Trade Unions; and redoubled its efforts to mobilize the private sector and civil society into tangible and meaningful action.

Table A1: Government Financial commitment for HIV

	Financial Year (April- March)							
Components	**2001-2002**	**2002-2003**	**2003-2004**	**2004-2005**	**2005-2006**	**2006-2007**	**2007-2008**	**2008-2009**
Prevention	120,680	643,948	883,909	900,884	1,502,451	1,125,145	3,823,022	8,316,374
Care & Support	1,873,030	1,611,835	1,348,699	1,729,860	1,515,498	1,713,864	2,413,008	3,775,379
Treatment	3,469,801	2,696,603	2,968,490	4,194,801	5,890,027	6,521,192	4,119,257	9,027,054
Management	1,358,971	1,917,892	2,463,564	2,668,092	3,821,253	3,656,253	-	335,920
CHART	-	-	-	-	-	-	-	708,500
Total BDS	6,822,482	6,870,278	7,664,662	9,493,638	12,729,228	13,016,449	10,483,672	22,163,227

Source: NHAC Accounts

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

A National AIDS Spending Assessment (NASA) could not be undertaken due to capacity constraints, namely human and financial resources. A quick desk review shows that domestic public expenditure on AIDS in 2009 was BDS $16,020,913.00 (US $8,010,456.50) (excluding funds from international sources; but inclusive of health, education, social development and other sectoral expenditure). The total amount of AIDS expenditures in 2009 (including international and private sources of funds) was BDs $ 23,806,187.67 (US $11,903,093.83).

Table A2 Major financial sources of International Funding for HIV

International Agency	2008	Focus area of Support	2009	Focus area of Support
CHAI	20,000	Prevention	33,466.80	Prevention- key populations at higher risk
DfID/UK	28,410	Prevention	41,787	Prevention- key populations at higher risk
PAHO	-		138,820.87	Prevention – key populations at higher risk (UGLAAB & CARE)
UNAIDS	-		33,200	BCC workshop – Regional faith-based partners
UNICEF	389,616	Prevention (life skill)	168,000	Prevention (life skill) -MEHR
World Bank	-		7,400,000	Prevention, Care and Support, Treatment, Management, Institutional strengthening
Total BDS	438,026		7,785,274.67	

Source: NHAC Accounts

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

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

In the case of Barbados, Part A was completed by representatives of the National HIV/AIDS Commission; Ministry of Housing and Lands; Ministry of Tourism; Ministry of Labour and Immigration; Ministry of Education and Human Resource Development; Ministry of Social Care, Constituency Empowerment, Urban and Rural Development; the International Transport Division and Ministry of Health. With respect to Part B, twelve (12) representatives from six (6) civil society agencies to whom the questionnaire was sent, completed and returned the questionnaire in a timely manner. [2]

Based on the data collected in Part A, the Government of Barbados has made some progress with respect to policy development and implementation. During the period under review, the Ministry of Labour launched a Policy and Code of Practice on HIV and AIDS and other life-threatening illnesses in the Public Sector on October 28, 2009.

[2] A total of three (3) questionnaires were received two (2) from CARE and one (1) from UGLAAB.

The relationship between Government and civil society is characterized by the active efforts by the former to engage the latter with the result that more civil society organisations are actively engaging in the National AIDS Programme. However, the translation of public sector-CSO dialogue to programme implementation by the organisations has been compromised by resource challenges; namely skill sets and funding. Nevertheless, new initiatives are being undertaken to redress these imbalances and to improve the CSO contribution to the National AIDS Programme.

Public sector partners indicated that much of the questionnaire was irrelevant to their respective organisational programme and the broader National AIDS Programme in Barbados and as a result they found the questionnaire long and tedious to complete. It was recommended that the questionnaire be restructured by sector, for example, health, civil society, education etc.

Similarly, the submission of partially completed questionnaires and the non-response to Part B by each of the twelve civil society organisations may be indicative of:

- The complexity of the questionnaire and the lack of capacity among some civil society partners
- The need to strengthen the involvement of civil society through targeted programme interventions and information campaigns to improve knowledge of the policy and programme environments
- Restricted response categories which preclude full participation
- The question structure contributed to ambiguity and confusion among respondents
- There was the perception that substantial segments of the questionnaire were irrelevant to the organisation (See Annex 2)

B. Prevention

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

The Blood Safety Programme was started in 1984 and at present, there is one HIV blood screening laboratory at the Department of Pathology, Queen Elizabeth Hospital. Approximately 400 blood units are collected and screened every month as shown in Table B1. In 2008 six donors tested HIV positive, while in 2009 four donors tested HIV positive. These translate to HIV prevalence in the cohort of blood donors of 0.13% and 0.08% respectively.

Table B1: Number of blood units collected and screened between 2006 and 2009

Year	Blood Units Collected	
	Screened	HIV Positive
2006	4138	0
2007	3882	1*
2008	4561	6
2009	4821	4

Source: National Blood Collecting Unit

* Partial data (until Nov 2007)

The laboratory follows documented World Health Organisation (WHO) standards operating for HIV screening and participates in one quality assurance scheme (shown in Annex 3) International Consortium for Blood Safety (ICBS), São Paulo, Brazil, for syphilis, HIV, HTLV, HCV and HBsAG.

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

The data for 2009 is not ready as yet for analysis. These statistics are based on actual numbers and not on SPECTRUM calculated estimates. In 2008, (32/35) 91.4% received ARVs for PMTCT. Two persons received single dose Nevirapine, 13 received a combination of 3 ARVs for PMTCT purposes alone and 17 took HAART for PMTCT as well as their own health. 100% of persons who accessed antenatal care received ARVs for PMTCT. The three (3) persons who did not receive any ARVs for PMTCT had only partial (1) or no antenatal (2) care.

Table B2: PMTCT uptake 2006 to 2008

Status of HIV+ Pregnant Women	Year		
	2006	2007	2008
On ARV	33	20	32
# with live births	39	22	35
% on ARV	**84.6%**	**90.9%**	**91.4%**

Source: Ministry of Health

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

It is not possible to report on this indicator at this juncture since no specific large-scale outreach programmes have been implemented.

C. Care, treatment and support

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

Data for this indicator was obtained from the list of patients registered at the Ladymeade Reference Unit (LRU - the government department responsible for the HAART programme) and from Dr. Anne St. John, Consultant Paediatrician, at the Queen Elizabeth Hospital.

These statistics are based on actual numbers and not on SPECTRUM calculated estimates.

Table C1: ART Coverage

Year	Children (< 15 years)			Adults (>15 years)		
	Male (%/n)	Female (%/n)	Total (%/n)	Male (%/n)	Female (%/n)	Total (%/n)
2006	N/A	N/A	100	79.1	92.2	84.4
2007	N/A	N/A	100	79.6	93.8	85.5
2008	100/5	100/5	100/10	87.1/406	88.1/333	87.6/739
2009	100/5	100/5	100/10	87.3/440	87.4/354	87.3/794

Source: Ministry of Health

This being stated, we have observed a marginal increase in the coverage of ART over the past two years and should this trend continue the results are promising. The 100% coverage in the paediatric age group is also worthy of mention and the consistence of the numbers during the last reporting period adds credence to the effectiveness of the PMTCT programme.

The adult data presented here is representative of the persons living with HIV registered at the LRU.

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

The current DOTS programme (modified DOTS in Barbados) is achieving the goal of bringing the spread of TB in Barbados under control.

Over the last six years it has been observed that although there has been a steady rise in the HIV and AIDS patients in Barbados, we have not seen a similar trend in the TB/HIV co-infection. Table C2 gives figures of TB/HIV co-infection over the period 2004-2009.

Table C2: TB/HIV Co-infection

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

Source: Ministry of Health

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

The Government of Barbados provides all (100 %) orphans and vulnerable children (OVC) with basic external support (that is, education, welfare). It should be noted that access to national social services is based on qualification for such services.

In Barbados, the Welfare Department, MSCURD provides two categories of assistance. The first category, national assistance, is further subdivided into monetary grants and assistance-in-kind. The latter refers to the provision of clothing, food and utilities. Table C3 presents data on the number of HIV dependents (that is, children) who received national assistance from the Welfare Department in 2009.

Table C3: Number of Children Receiving National Assistance in 2009

Age Range	Male	Female	Total
0-1	0	0	0
2-3	2	2	4
4-5	3	3	6
6-7	3	3	6
8-9	7	7	14
10-11	4	8	12
12-13	6	5	11
14-15	5	10	15
16-19	5	15	20
Total	**35**	**53**	**88**

Source: Welfare Department

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

In 2008 educational assistance to OVC was BDS $7,342.68 and in 2009, $10,769.69. Between 2006 and 2009 the Welfare department gave BDS $30,801.94 in educational assistance. Though this figure might appear small it is quite substantial given the context of Barbadian social network which provides free public education to all children inclusive of the tertiary level.

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

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

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

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

Table C4: Life skills training in public schools for 2009

Educational level of school	% participation	Number of schools with at least 30 hours of LS training	Number of schools surveyed
Primary school	80.6	58	72
Secondary and High School	100	22	22
Total	**85.1**	**80**	**94**

Source: Ministry of Education

Although life skills are taught at all primary schools, roughly 19.4% of school teachers experience challenges with the adherence to the teaching of the HIV module in the prescribed manner. This being said it must be mentioned that efforts are being made to encourage schools, private and government-assisted, to incorporate life skills as part of their curriculum. Therefore greater focus must be placed on equipping the teachers to teach the HIV module in the prescribed manner.

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

The Government of Barbados is aware of the value of education and this is actively promoted. As such, universal free education is available up to the tertiary level which includes those children between the 10-14 age group. There is a proactive approach to school attendance of all school-aged children through the School Attendance Unit within the Ministry of Education and Human Resource Development (MEHR). The school attendance

ratio for orphans to non-orphans is 1:1.

D. Knowledge and Behaviour Change

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

The country does not collect data in the format as is required for this indicator but, a proxy indicator using data from the VCT programme of the MOH will be presented instead. The VCT programme has a country-wide coverage within the eight polyclinics and in the community at large. However, HIV testing conducted through this medium represents only one-quarter of all tests done in the country.

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

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

In 2007, 97.4% of the people tested received their results. In 2008 the percentage was maintained at 97.5% and while in 2009 there was a slight increase to 98.2% which is consistent with the trends of previous years. On careful examination of the data two important findings must be highlighted. The first is that although there was a two-fold increase in the numbers tested in the community based testing from around 2000 to over 4000 persons between 2007 and 2009, the percentage of persons receiving their result remained stable and even showed a marginal increase in the last year. Secondly, although the trend of more women being tested than men has continued though this period, in 2009 within the polyclinic system there were more males tested than females. In 2009 males accounted for 50.2% of tests done as compared to 30% in 2008, an increase of over 20% from the previous year. This is an important achievement since males characteristically are diagnosed at a later stage than females and have higher morbidity and mortality. This increase in male uptake of the VCT services at the polyclinics is extremely promising and addresses one of the MARPs. The strategy for increasing uptake of HIV testing in men will need to be further refined with the findings of the male lifestyle survey which is now in progress. However this increased uptake of males in the polyclinic setting might possibly be as a result of the vibrant men's health programmes which were being conducted at many of the polyclinics during 2009.
See Tables D3-D5.

Table D1: VCT programme (MOH) coverage in 2005

	Testing and Counselling 2005								
	Polyclinic			*Community*			*Total*		
	Male	*Female*	***Total***	*Male*	*Female*	***Total***	*Male*	*Female*	***Total***
Pre-counselled and tested	850	1282	**2131**	963	1282	**2245**	1813	2564	**4377**
Received post-test counseling and results	833	1282	**2115**	921	1255	**2176**	1754	2537	**4291**
% tested and know results	98.0	100.0	**99.2**	95.6	97.9	**96.9**	96.7	98.9	**98.0**

Source: Ministry of Health

Table D2: VCT programme (MOH) coverage in 2006

	Testing and Counselling 2006								
	Polyclinic			*Community*			*Total*		
	Male	*Female*	***Total***	*Male*	*Female*	***Total***	*Male*	*Female*	***Total***
Pre-counselled and tested	637	1353	**1990**	782	1912	**2694**	1419	3265	**4684**
Received post-test counseling and results	622	1345	**1967**	754	1893	**2647**	1376	3238	**4614**
% tested and know results	97.6	99.4	**98.8**	96.4	99.0	**98.3**	97.0	99.2	**98.2**

Source: Ministry of Health

Table D3: VCT programme (MOH) coverage in 2007

	Testing and Counselling 2007								
	Polyclinic			*Community*			*Total*		
	Male	*Female*	***Total***	*Male*	*Female*	***Total***	*Male*	*Female*	***Total***
Pre-counselled and tested	779	1440	**2219**	856	1060	**1926**	1635	2500	**4145**
Received post-test counseling and results	762	1421	**2183**	818	1036	**1864**	1580	2457	**4037**
% tested and know results	97.8	98.7	**98.4**	95.6	97.7	**96.8**	96.6	98.3	**97.4**

Source: Ministry of Health

Table D4: VCT programme (MOH) coverage in 2008

	Testing and Counselling 2008								
	Polyclinic			*Community*			*Total*		
	Male	*Female*	***Total***	*Male*	*Female*	***Total***	*Male*	*Female*	***Total***
Pre-counselled and tested	442	1042	**1462**	1564	2528	**4092**	2006	3548	**5554**
Received post-test counseling and results	418	1002	**1420**	1512	2485	**3997**	1930	3487	**5417**
% tested and know results	94.6	96.2	**97.1**	96.7	93.3	**97.7**	96.2	98.3	**97.5**

Source: Ministry of Health

Table D5: VCT programme (MOH) coverage in 2009

	Testing and Counselling 2009								
	Polyclinic			*Community*			*Total*		
	Male	*Female*	***Total***	*Male*	*Female*	***Total***	*Male*	*Female*	***Total***
Pre-counselled and tested	840	833	**1673**	1606	2625	**4231**	2446	3458	**5904**
Received post-test counseling and results	809	809	**1618**	1578	2602	**4180**	2387	3411	**5798**
% tested and know results	96.3	97.1	**96.7**	98.3	99.1	**98.8**	97.6	98.6	**98.2**

Source: Ministry of Health

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

The data for this indicator was obtained from a baseline exploratory study of sex workers conducted in 2005-2006 in Barbados. The study population consisted of male and female sex workers who operated in Barbados in the five geographical areas included in the study.

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

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

The data presented in Table D6 on HIV testing among sex workers, is based on preliminary

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

Table D6: Female sex workers tested for HIV who know their results

Result Received	FEMALES TESTED FOR HIV		Total
	AGE< 25 years	AGE>25 years	
Yes	12	10	**22**
No	3	5	**8**
Total	**15**	**15**	**30**
Percentage %	**80.0**	**66.7**	**73.3**

MSM

Preliminary data on MSM was derived from the unpublished Men's Lifestyle Survey (200), a baseline study of men over the age of fifteen (15) years conducted from February 2006 to May 2007. A subset of MSM was sampled using the snowball methodology. From this data as illustrated in Table D7, MSM were more likely to access HIV testing services than heterosexual males.

Table D7: HIV Testing Patterns among Heterosexual & Homosexual Men

Survey Items	Heterosexual (%)	MSM (%)	Total (%)
Ever taken HIV Test	56.9	77.3	60.8
Found out the result	76.0	85.1	78.3
Tested for HIV in the last 12 months	26.7	47.4	33.7

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

Fifty percent (50%) of the young persons ages 15-24 years were able to both correctly identify ways of preventing sexual transmission of HIV and who also rejected major misconceptions about HIV. There was a very small difference between the sexes with males scoring marginally higher than females overall: 52% compared to 49%. When disaggregated by age group the older males between 20-24 and the younger females 15-19 contributed the highest percentile with 27% and 26% respectively.

Further analysis of each individual question which constitutes this indicator reveals that on average between 75-80% of persons gave the correct response. However when considered as a whole, approximately 50% of the respondents had some deficit in knowledge as related to correctly preventing the transmission of HIV. Table D8 (KABP 2009; MYFS)

Table D8: Young people's knowledge about HIV Prevention in 2009

Indicator (n=464)	**Male** (n=239)			**Female** (n=225)			**ALL**
	15-19	**20-24**	**All**	**15-19**	**20-24**	**All**	
One uninfected partner who has no other partner	42.26	38.49	80.75	39.56	38.22	77.78	**79.31**
Using a condom every time they have sex	39.33	37.33	76.57	38.67	38.22	76.89	**76.72**
Can a healthy-looking person have HIV	45.19	41.84	87.03	47.11	43.56	90.67	**88.79**
Can a person get HIV from mosquito bites	41.42	36.82	78.24	42.22	40.44	82.67	**80.39**
Can a person get HIV from sharing food with someone who is infected	39.75	38.08	77.82	39.11	39.56	78.67	**78.67**
All five correctly	**25.10**	**26.78**	**51.88**	**25.78**	**23.11**	**48.89**	**50.43**

Source: KABP 2009; MYFS

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

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

Table D9 shows that less than 40% of the 30 sex workers responding to the questions gave correct responses to all of the questions relating to ways of preventing the sexual transmission of HIV and the rejection of misconceptions about HIV transmission. The results should be taken as merely indicative of the situation in this most-at-risk population because they are based on very small numbers.

Table D9: Female sex workers' knowledge of prevention of sexual transmission of HIV

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

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

A KABP survey was conducted in 2009 where 19.6 % of the study population stated that they had had sexual intercourse before the age of 15. Males predominated this sample accounting for 53 out 91 persons who responded positively to this question. This is in keeping with our

understanding of the behaviour patterns of young males, who are driven to experiment earlier than their female counterparts to prove their masculinity.

Table D10: Sex before the Age of 15 in Barbados

Indicator (n=464)	**Male** (n=239)			**Female** (n=225)			**ALL**
	15-19	**20-24**	**All**	**15-19**	**20-24**	**All**	
% of young people who had intercourse before age 15	13.39	8.79	22.18	11.56	4.89	16.44	**19.61**
# of young people who had intercourse before age 15	32	21	53	26	11	37	**91**

Source: KABP 2009

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

Although the KABP 2009 (MYFS) does not cover the entire age-range, it offers some insight into the local situation as it pertains to this indicator. In the 15-24 age group approximately 25% of individuals interviewed had had intercourse with more than one partner within the last twelve months. Again this was predominated by males: 76 compared to 38 females. It is likely that this trend will be maintained between the 25-49 age group since historically more women tend to settle down into stable relationships during this age range than men.

Table D11: Percentage of young people 15-24 who had high-risk sex

Indicator (n=464)	**Male** (n=239)			**Female** (n=225)			**ALL**
	15-19	**20-24**	**All**	**15-19**	**20-24**	**All**	
% of young people who had intercourse with multiple partners in the last 12 months	14.23	17.57	**31.80**	8.44	8.44	**16.89**	**24.78**
# of young people who had intercourse with multiple partners in the last 12 months	34	42	**76**	19	19	**38**	**115**

Source: KABP 2009 (MYFS)

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

As stated previously the KABP 2009 (MYFS) will be used to offer some insight into the local situation. Of those who responded in the affirmative to questions related to Indicator 16, only 40.8 % (47) stated that they had used a condom during the last time they had intercourse.

Females were marginally higher than males, 42% compared to 41 %.

From these numbers it is evident that there is still much work to be done in terms of implementing strategies aimed at modifying the high-risk behaviour among this age group, which has the highest prevalence of HIV in the population. In spite of the fact that there are many cultural and social barriers which contribute to this situation, new initiatives are being implemented to reach this vulnerable group.

Table D12: Percentage of young people 15-24 who used condoms during high-risk sex

Indicator (n=115)	**Male** (n=76)			**Female** (n=38)			**ALL**
	15-19	**20-24**	**All**	**15-19**	**20-24**	**All**	
% of young people who had intercourse with multiple partner in last 12 months and used a condom	18.42	22.37	**40.79**	15.79	26.32	**42.11**	**40.87**
# of young people who had intercourse with multiple partner in last 12 months and used a condom	14	17	**31**	6	10	**16**	**47**

Source: KABP 2009

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

The data for this indicator (shown in Table D13) comes from a baseline survey of a behavioural study of male and female sex workers in Barbados. The data so far relates to female sex workers only.

Table D13: Condom use by female sex workers

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

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

MSM

Condom use in heterosexual males is low compared with MSM. Supportive male organizations therefore need to be empowered to address male education and BCC in

much the same way as NGOs that are available to MSM have started (See Table D7).

Table D14: A Comparison of Condom use among Heterosexual Males & MSM

Survey Items	Heterosexual	MSM
Always use condom with non-regular partner	21.6%	41.9%
Never use condom	33.8%	3.0%
Condom used during last encounter with non-regular partner	45.6%	64.5%

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

See Section on MSM above.

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

No data is available on condom use by injecting drug users on this indicator as required by UNGASS. There is, however, some information on drug use and sexual behaviour contained in a study conducted by the NCSA entitled '*The Relationship Between Drug Use and Risky Sexual Behaviour*'. This study showed that there were 3.7% injecting drug users (10 people) among the 278 respondents. One hundred and seventy-three (173) drug users had had sex under the influence of drugs of whom twenty-two (22) reported practicing safe sex.

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

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

E. Impact

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

Barbados does not carry out periodic sentinel surveillance of women attending ANC services but relies on routine reports from the 8 government polyclinics and 2 satellite clinics. It was,

therefore decided to collect the data from the booking registers of ANC of these clinics. All of the women seen at the polyclinics for ANC services are offered a test for HIV. The uptake of these services at booking was 93% in 2008 and 94.7% in 2009. Table E1 and E2 show the HIV situation among pregnant women accessing ANC services at the government polyclinics in 2005, 2006, 2007, 2008 and 2009.

Table E1: HIV among antenatal clients from 2005 to 2007

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

Source: Ministry of Health

Table E2: HIV among antenatal clients from 2008 to 2009

Age (years)	2008		2009	
	Tested	HIV+	Tested	HIV+
15-19	419	1	423	2
20-24	495	0	485	2
15-24	914	1	908	4
HIV prevalence				
15-19		0.24		0.47
20-24		0.00		0.41
15-24		0.11		0.44

Source: Ministry of Health

The results indicate very low levels of HIV infection among pregnant women seen at ANC in government polyclinics, 6 per thousand in 2006 and less than 4 per thousand in 2007. Based on the data collected prevalence rates among pregnant women ages 15-24 was about 1 per thousand in 2008 and 4 per thousand in 2009. These figures are believed to reflect the general situation among pregnant women since those who use private ANC services are unlikely to change the values because they are believed to be very few. There is also good correlation between the antenatal data and the prevalence derived from numbers of persons living with HIV (numerator) and the population census data for that age range (denominator) which estimates the prevalence at 3 per thousand in females between 15-24 years.

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

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

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

Improvement in the survival of patients on ART has been discussed in reference to case-specific mortality. Over 90% of adults on antiretroviral therapy are surviving for more than a year. There are no survival differences between male and female patients (Tables E3 to E6). The decline in the survival rate in 2008 might be possibly explained by a cohort effect where the survivors were from two different cohorts carrying different characteristics which would significantly alter their survival.

Table E3: 12-month survival of patients on ART in 2006

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

Table E4: 12-month survival of patients on ART in 2007

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

Table E5: 12-month survival of patients on ART in 2008

2008									
	Male			**Female**			**Total**		
	Survivors	*Enrolled*	*% survival*	*Survivors*	*Enrolled*	*% survival*	*Survivors*	*Enrolled*	*% survival*
Children	5	5	100	5	5	100	10	10	100
Adults	32	37	86.5	32	41	78.0	64	78	82.1
All	37	42	88.1	37	46	80.4	74	88	84.1

Table E6: 12-month survival of patients on ART in 2009

2009									
	Male			Female			Total		
	Survivors	*Enrolled*	*% survival*	*Survivors*	*Enrolled*	*% survival*	*Survivors*	*Enrolled*	*% survival*
Children	5	5	100.0	5	5	100.0	10	10	100.0
Adults	49	56	87.5	42	48	87.5	91	104	87.5
All	54	61	88.5	47	53	88.7	101	114	88.6

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

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

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

According to Table E7, the proportion of HIV positive infants born to HIV positive mothers is extremely low with minimal variations occurring between 2004 and 2006. In 2006, of the thirty-eight (38) children born only one (1) was diagnosed HIV positive. These low figures attest to the success of the Prevention of Mother-to-Child Transmission (PMTCT) programme. In 2008 this trend was maintained and from the preliminary data available in 2009 it seems that it will continue.

Table E7: Infants born to HIV-infected Mothers

2004		2005		2006		2007		2008	
Freq.	*%*	*Freq.*	*%*	*Freq.*	*%*	*Freq.*	*%*	*Freq.*	*%*
$^{2}/_{19}$	10.5	$^{0}/_{16}$	0.0	$^{1}/_{39}$	2.6	0/22	0.0	0/35	0.0

IV. Best Practices

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

Multisectoral Coordination

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

In 2008, the Government of Barbados expressed an intention *"...to developing a Barbados based on families that are independent, hardworking, and socially responsible... and ...able to enjoy all ... [the] support necessary for wholesome and useful lives.*

This overarching vision was manifested in the shift in ministerial responsibility for HIV from Prime Minister's Office to the newly created Ministry of Family, Youth, Sports and Environment, now retooled the Ministry of Youth, Family and Sports. This truly reflects Government's understanding that HIV has moved from being perceived as only a health concern to a developmental issue.

The NHAC is coordinating a national response through the successful harmonisation of partners within the NAP in a very systematic way by:

- Ongoing training in programme planning, implementation, monitoring and evaluation and behavioural change communication to build capacity to enable strategic partners to engage in programming activities.
- The standardisation of reporting protocols and training for strategic partners in their use. This effort has been supported by regular M&E Training Workshops, resulting in the increase in the number of partners consistently reporting on their programme activities.
- Monthly government, private and civil society HIV Coordinators' meetings with over fifty partners which create a forum for idea and information sharing, programme planning and coordination, problem resolution and general NAP feedback.

Political Commitment

Political commitment has been shown at the highest level through the discussion and ratification by Parliament of policies. This led to the development of the National Strategic Plan for HIV Prevention and Control 2008-2013 and a Monitoring and Evaluation Framework and Operational Plan for HIV Prevention and Control 2008-2013 being

nationally recognized, approved and adopted.

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

- the location of the NHAC within the Ministry of Youth, Family and Sports;
- the allocation of financial resources to line ministries;
- the conduct of M&E assessments to guide the implementation of the national Monitoring and Evaluation System;
- the implementation of BCC strategy and Communication Plan to transform knowledge into responsible behavior; and
- the development of a comprehensive Training Plan.

Treatment and care for PLHIV

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

Diagnosis

During the last reporting period the NAP has made great strides in expanding its VCT programme especially in the community where the numbers tested doubled within the last 2 years, without compromising the quality of the process.

It must be also mentioned that although historically females have had a higher uptake of these services, it was found that within the polyclinic system males and females access the service equally. This seems to be strongly linked with the vibrant men's health programmes throughout the polyclinics which encourage men to be more proactive in seeking health checks. This strategy must be studied and refined further but the initial results are promising.

Treatment and Care

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

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

- An improved and strengthened VCT programme in polyclinics;
- The provision of comprehensive clinical, laboratory and pharmacy services at the LRU by a multi-disciplinary team;

- The provision of ARV drugs free to all Barbadian residents who meet the clinical criteria for care;
- The reduction of mother to child HIV transmission has resulted from Government's policy to provide Nevirapine to all pregnant women who were HIV positive.
- An increase in the survival of people on treatment for AIDS;
- A reduced demand for hospital services indicated by a decrease in hospital admissions and total hospital days;
- An increase in outpatient visits and a decline in deaths from AIDS-related causes.

Creating a Supportive Environment for PLHIV

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

- Orientation workshops to disseminate workplace policies on HIV;
- The national efforts to effect change in social norms related to stigma and discrimination. These include public debates, meetings and seminars on PLHIV; empowerment, human rights, ethical as well as socio-economic issues relevant to HIV
- the introduction of the Policy and Code of Practice on HIV and AIDS and other life threatening illness in the Public Sector;
- the opening of the HIV Food Bank and Personal Development Centre, which is aimed at putting a number of support services at one location to improve access and to enhance the supportive environment;
- new emphasis on OVC
- creation of a platform for appropriate advocacy; and
- formulation of a supportive research agenda.

V. Major Challenges and Remedial Actions

The Monitoring and Evaluation (M&E) of the National AIDS Programme remains problematic despite significant improvements made since the preparation of the 2008 UNGASS Report. Although not being fully operational, much progress has been made with the implementation of the system. To date, a National M&E Framework and Operational Plan for HIV Prevention and Control was developed and ratified in conjunction with strategic partners; reviewed by partners on January 30 and February 27, 2008; and approved by the Cabinet of Barbados on March 27, 2008. This document covers a five year period (2008-2013) and guides the rollout of the M&E System. To date:

- a set of indicators was reviewed and ratified by partners in 2008
- data sources have been identified for use in the national programme and every effort is being made to fill data gaps and ensure routine data collection where feasible, as well as the construction of an evidence base with which to guide programming especially among key populations at higher risk. For instance,
    - the Ministry of Health is currently conducting a survey among key populations at higher risk such as Sex Workers and Men who have Sex with Men;
    - the Ministry of Tourism in conjunction with the Ministry of Health is conducting research on the attitudes and sexual behaviours of tourists while on vacation in Barbados;
    - the National HIV/AIDS Commission in partnership with the University of the West Indies is conducting a study on transactional and inter-generational sex among females ages 15-19 years; and
    - the Youth Department, Ministry of Youth, Family and Sports conducted a survey on knowledge, attitudes, beliefs and sexual practices in 2009.

  The collection of this data will guide the implementation of the Prevention Plan once it is finalized.
- the Health Ministry is also seeking to conduct a Health Facility Assessment with assistance from the Pan American Health Organization;
- in 2008, an assessment of M&E was conducted among strategic partners and used to refine the M&E Training Plan and Curriculum. The latter was rolled out in June 2008 and implementation continued in 2009 resulting in improvements in M&E capacity and practice among partners. The purpose of the Plan and Curriculum is to build capacity among partners in government, private sector and civil society to conduct M&E. Training assistance was provided by the Caribbean HIV/AIDS Alliance (CHAA);
- data reporting tools have been standardized and shared with partners. The transition to use of these tools has been smoother with the conducting of M&E training
- data management efforts intensified during the period under review with the Ministry of Health cleaning its National Surveillance Database using data triangulation. This would ensure greater accuracy of information; and a reduction in the turnaround time between data collection, report preparation and dissemination. The Ministry with assistance from the Centers for Disease Control and Prevention (CDC) continues to strengthen HIV surveillance.

There is some evidence to suggest that the educational messages designed to reach particular target groups have not been effective in motivating behavioural change as is seen by

relatively low percentage of respondents who were able to show complete knowledge in the five questions as well as the fact that there is still a relatively large percentage of persons who still practice high-risk behaviours. This information is by no means complete and there is still a void of M&E information among certain risk populations. Traditionally, prevention programmes within the NAP have focused on IEC. With the realisation that this methodology is no longer adequate, the NHAC has realigned the NAP to focus on Behaviour Change and Prevention by continuing the rollout of the BCC Strategy through the conducting of BCC workshops among strategic partners across all sectors. Although strategic partners have been trained in BCC principles, theories and intervention development, the actual implementation of BCC interventions has progressed slowly with only one partner to date successfully developing and implementing an intervention. A Prevention Plan, targeting key populations and inclusive of appropriate indicators, is being developed. This, in conjunction with data collection among the key populations will guide future interventions and programmes targeting these groups.

Although Barbados is has made significant strides, there are still some programme challenges which must be addressed, particularly the allocation of significant financial resources will be required to ensure the implementation of programmes.[3]

According to the Inter-American Development Bank (IADB) finding the necessary financial resources to fund effective prevention, care and treatment programmes are an immediate challenge for governments and donors.[4] In Barbados, this challenge is all the more exacerbated by its World Bank classification as a high income[5] country and its concurrent classification as a Small Island Developing State (SIDS)[6] by the United Nations Commission on Sustainable Development (CSD).

For Barbados, the first classification means that due to its high per capita income, some difficulty has been experienced raising the requisite resources on the international lending market for its NAP. In instances where the country is eligible for funding assistance, the country's position in the global economy makes loan procurement impractical due to unfavourable lending conditions. In spite of productivity in monetary terms and economic growth in real terms, the country is still a SIDS facing the same limitations as its sister island states that have substantially lower GDPs and per capital incomes.

Like other SIDS, Barbados faces challenges of:

- fragility of an open economy;
- reliance on one industry (tourism);
- food dependency (high food imports);
- difficulty adapting to the global trade environment;
- relative poverty
- scarcity of skilled manpower / brain drain
- vulnerability to natural disasters (hurricanes);
- an extremely narrow resource base;
- unsustainable high external debt;

[3] Ibid.

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

[5] Based on the World Bank ranking as of July 2009, High income is classified as $11, 906 or more.

[6] The United Nations Department of Economic and Social Affairs identifies fifty-one SIDS located in three regions – Africa; Asia & the Pacific; and Latin America & the Caribbean. Of these fifty-one, twenty are located within the Caribbean region.

- the over-exploitation of marine resources; and
- intra-regional mobility.

Developmental efforts by SIDS, like Barbados, have been pursued within the constraints of limited financial resources which have been further exacerbated by the current global financial crisis. This included an overall decline in official development assistance (ODA) to these countries. The issue of health has been identified as a major determinant of sustainable development, one which requires further action by the SIDS with essential support from the international community if effective control of the HIV epidemic is to be realised. This includes a need to:

- strengthen the health management and financing systems of SIDS;
- provide bilateral or multilateral technical assistance to facilitate access to funds;
- continue to improve accessibility to effective pharmaceuticals at reasonable prices;
- actively implement public policy and effective prevention programmes vis-à-vis sexual and reproductive health, and health education;
- develop and implement effective surveillance initiatives at local, national and regional levels; and
- enhance data collection on demographic and epidemiological trends.[7]

Denial of access to funding assistance based on global comparisons and categorizations essentially ignores the dynamics of the epidemic within the local context, compromises the efficacy of the NAP and condemns the country to fighting a losing battle with real costs in human and economic terms.

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

Despite the numerous achievements of the national programme, the single greatest gap in the HIV and AIDS and STI program is the M&E system which is not fully functional. This may be the result of inadequate information sharing on the "Three Ones Principles." The importance of One Coordinating Body, One Strategic Plan and One M&E Framework has not been internalized and adopted by all partners who continue to work with a disconnect from the NHAC. Many of the UNGASS indicators that should have been easily and routinely reported could not be reported because the data is either not available or is not in a form that is usable specifically for the computation of the indicators.

Some progress has been made in the area of M&E, since the 2008 UNGASS Report but there are still many challenges. Most of these relate to the organizational culture of Government and Private sector in the region, where for the most part programmes are not driven by M&E,

[7] The Mauritius Strategy

but more on political will and administrative habit. Therefore many persons throughout the various levels of the organization resist change and progress.

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

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 Financial Support for HIV

Source	2008	Focus area of Support	2009	Focus area of Support
CHAI	20,000	Prevention	33,466.80	Prevention- key populations at higher risk
DfID/UK	28,410	Prevention	41,787	Prevention- key populations at higher risk
PAHO	-		138,820.87	Prevention – key populations at higher risk (UGLAAB & CARE)
UNAIDS	-		33,200	BCC workshop – Regional faith-based partners
UNICEF	389,616	Prevention (life skill)	168,000	Prevention (life skill) - MEHR
World Bank	-		7,400,000	Prevention, Care and Support, Treatment, Management, Institutional Strengthening
Total BDS	438,026		7,785,274.67	

Source: NHAC Accounts

Table A2 shows the major sources of the money spent in 2008 and 2009 on NAP activities. 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.

The Inter-American Development Bank has argued that finding the necessary financial resources to fund effective prevention, care and treatment programmes are an immediate challenge for governments and donors.[8] Developmental efforts by SIDS like Barbados have

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

been pursued within the constraints of limited financial resources including an overall decline in official development assistance (ODA). The health issue has been acknowledged as a major determinant of sustainable development, one which requires further action by the SIDS with much needed support from the international community if effective control of diseases such as HIV is to be realised.

UNAIDS, UNICEF and PAHO have provided financial and technical support to NAP. Other partners – UNIFEM, UNDP, WHO/PAHO, Caribbean HIV/AIDS Alliance (CHAA) and the Centers for Disease Control and Prevention (CDC) are primarily providing technical assistance.

Apart from financial support from the limited number of developmental partners such as the World Bank, UNAIDS and a few others, Barbados has formed alliances with several regional and international governments and agencies in the management and coordination of the NAP. (The list of regional and international partners is shown in Box-1.) NHAC is working with these partners to increase their contributions to the national effort particularly in connection with:

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

Box-1 Listing of Regional & International Partners

Regional Partners	**International Partners**	
CCAS	Brazil	UNESCO
CCNAPC	CDC	UNFPA
CDRC	CHAI	UNICEF
CHART	COMSEC	UNIFEM
CHAA	DfID/UK	UNAIDS
CHRC	IBRD	USAID
CRN+	ILO	WHO
PAHO	PEPFAR	
PANCAP	PSI	
UWI / UWIHARP	UNDP	

VII. Monitoring and Evaluation Environment

Current M&E Status

In Barbados, HIV monitoring and evaluation is not governed by a comprehensive M&E system. At present, seven ministries (MSCURD, MEHR, MLI, MT, MYFS, MII and MH) engage in various M&E activities either internally or through arrangements with external service providers. In terms of M&E staffing allocations, NHAC has only one national M&E officer; the MH has a programme unit but no assigned M&E officers, and the Ministries of Education and Youth each have a Research Officer. Submissions have been made for additional human resources. Innovative means are being considered to meet these practices such as short-term consultancies and collaborative efforts.

Ministries and government departments submit detailed costed HIV Work Plans with M&E components to the NHAC. At present, approximately twelve (12) out of twenty ministries and departments submit work plans to the Commission in the approved format which is still encouraging. In terms of reporting on programme results, 12 out of 20 ministries report, representing a figure of 60.0%. The decline in the proportion reporting from 87.5% in 2008 to 60.0% can be attributed to the reshuffling of Ministries resulting in an increase in the number of ministries and the concentration of agencies which report routinely under one umbrella. Despite the improvement in M&E reporting, the NAP still lacks a robust M&E culture due in part to lack of skills, resources (physical, financial and human) and bureaucratic barriers. Another contributing factor is the rapid turnover and delays in designating HIV Focal Points in the ministries and departments.

With respect to civil society organizations, a lack of capacity continues to be the primary reason for poor M&E practices. With the advent of intensive training and partnerships with government agencies, this situation has however, improved. Seven (7) and eight (8) civil society organizations reported on their HIV programme in 2008 and 2009 respectively in comparison with one (1) and two (2) in 2007 and 2008.

Challenges for a comprehensive M&E

The challenges to the development and sustainability of a comprehensive M&E system can be summed up in one phrase – **lack of critical resources**. HIV Programmes within government ministries and departments lack the human resources (that is, HIV Focal Points) necessary to fulfill the M&E function. These human resource constraints include not only manpower but skills (technical resources) needed to execute M&E tasks effectively. Where these are available, funding is sometimes absent. HIV Focal Points often do not have the time or skills necessary to execute M&E and other HIV programme responsibilities given that HIV is often an unremunerated adjunct to their regular responsibilities.

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

Remedial Actions

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

- developing a national M&E framework with core indicators
    - tracking the overall performance and impact of the NAP
    - Guiding the collection, analysis, use and provision of information that enables tracking of progress made in response to HIV and enhanced decision-making

  As the framework is being used by partners, challenges are being noted with a view to revision to make it more user friendly
- using the M&E and BCC workshops to facilitate the development of an enabling environment for M&E
- continuing to roll out and revise the M&E training plan and curriculum
- seeking assistance from external partners in building M&E capacity and sourcing additional technical assistance

M&E Technical Assistance

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

- Research Methods
- IT Training, for example CRIS3, MS Access and MS Excel
- SPSS or Statistical Software
- Setting up a M&E Programme within an organisation

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

Additional support is required with the development of a Management Information System for the NHAC to facilitate the management, updating and reporting within and beyond NAP requirements. This support entails the sourcing of qualified IT specialist(s) to develop, pilot and refine periodically the MIS system. Assistance has been sought from the Data Processing Department with either the development or identification of a suitable MIS system.

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

i. Which institutions/entities were responsible for filling out the indicator forms?

1.	NAC or equivalent	Yes✓	No
2.	NAP	Yes	No✓
3.	Others	Yes✓	No
	(please specify) Ministry of Health		

ii. With inputs from

Ministries:

Education	Yes✓	No
Health	Yes✓	No
Labour	Yes✓	No
Foreign Affairs	Yes	No✓
Others	Yes✓	No

(please specify) Ministry of Social Care, Constituency Empowerment, Urban and Rural Development; Ministry of Tourism; and Ministry of Housing and Lands

Civil society organizations	Yes✓	No
People living with HIV	Yes✓	No
Private sector	Yes	No✓
United Nations organizations	Yes✓	No
Bilaterals	Yes	No✓
International NGOs	Yes	No✓
Others	Yes✓	No

(please specify) Barbados Evangelical Association
Family CARE Support Group
AIDS Society of Barbados
AIDS Care Education and Training
United Gays and Lesbians Against AIDS Barbados
St. John HIV/AIDS Committee

iii.	Was the report discussed in a large forum?	Yes✓	No
iv.	Are the survey results stored centrally?	Yes	No✓
v.	Are the data available for public consultation?	Yes✓	No

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

Name / title: Dr. Anton Best, Senior Medical Officer of Health (Communicable Diseases) / Nicole Drakes, Assistant Director

Date: 19 March 2010

Signature:

Address: Ministry of Health, Jemmotts Lane, St. Michael / National HIV/AIDS Commission, 2nd Floor East, Warrens Office Complex, Warrens, St. Michael BB12001, Barbados

Email: anton.best@barbados.gov.bb / ndrakes@hiv-aids.gov.bb

Telephone: 246-467-9439 / 246-310-1000

ANNEX 2: National Composite Policy Index questionnaire

Data Gathering and Validation Process

- **Describe the process used for NCPI data gathering and validation:**

  Part A – direct interviews with respondents and collection of completed questionnaires. Ten (10) questionnaires were completed.
  Part B – stakeholder consultation to discuss purpose of NCPI, complete questionnaires and address concerns. Twelve (12) persons completed questionnaires.

- **Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:**
  No disagreements

- **Highlight concerns – if any, related to the NCPI data submitted (data quality, potential misinterpretation of questions and the like):**

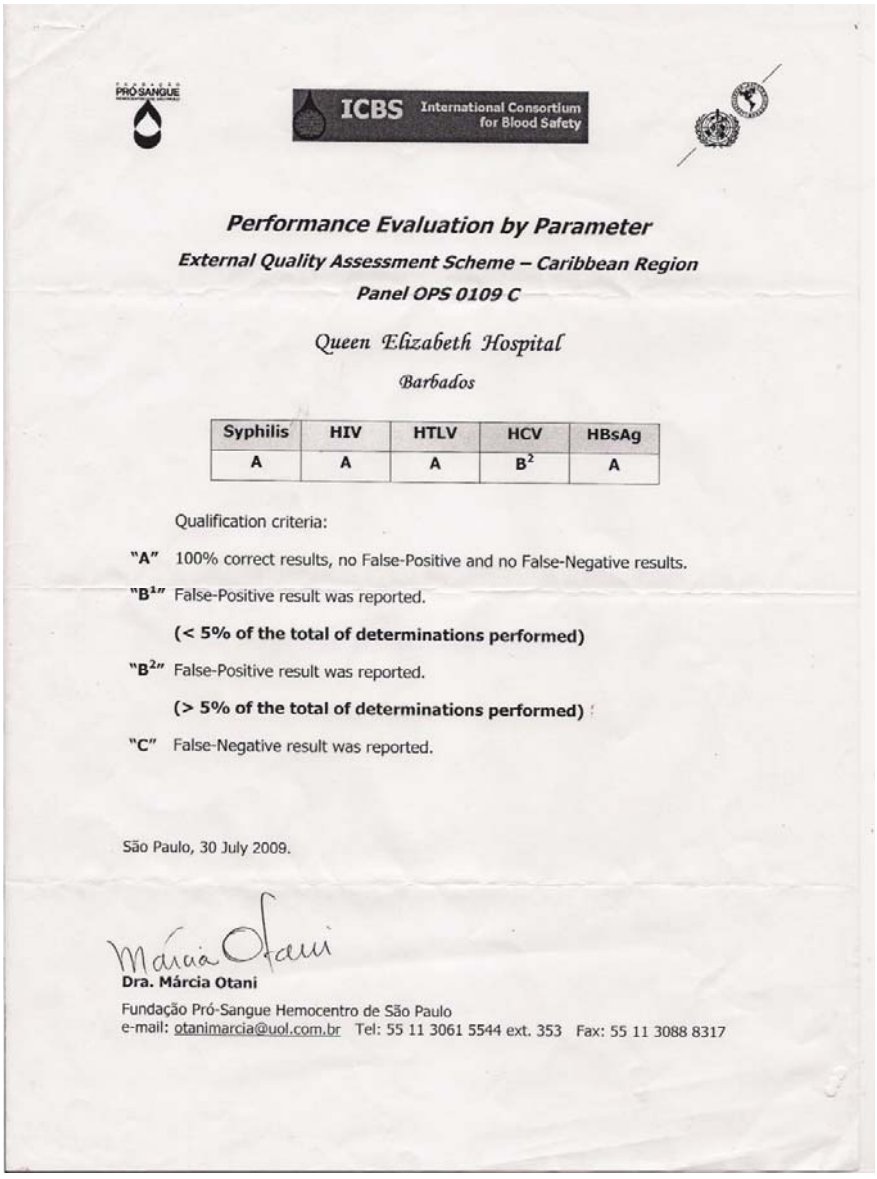
  Segments of questionnaires seemed irrelevant to respondents. Questionnaires were lengthy and tedious to complete. Required substantial amount of information to complete questionnaire and was felt by respondents that this was beyond their purview.

NCPI Respondents

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
National HIV/AIDS Commission	Mrs. Jacqueline Wiltshire Gay, Director	☒	☒	☒	☒	☒
National HIV/AIDS Commission	Ms. Alexis Nurse, Behaviour Change Communication Specialist	☒	☒	☒	☒	☒
National HIV/AIDS Commission	Miss Nicole Drakes, Assistant Director	☒	☒	☒	☒	☒
Ministry of Social Care, Constituency Empowerment, Urban and Rural Development	Mrs. Veronica Belle, HIV Coordinator	☒	☒	☒	☒	☒
Ministry of Tourism	Miss Madge Dalrymple, HIV Coordinator	☒	☒	☒	☒	☒
Ministry of Housing and Lands	Miss Francia Best, HIV Coordinator	☒	☒	☒	☒	☒
Ministry of Labour and Immigration	Ms. Rhonda Boucher, Project Coordinator	☒	☒	☒	☒	☒
International Transport Division	Ms. Angela Brandon-Hall, Senior Research Officer	☒	☒	☒	☒	☒

Organization	Names/Positions	**Respondents to Part B** [Indicate which parts each respondent was queried on]			
		B.I	B.II	B.III	B.IV
Barbados Evangelical Association	Dr. Nigel Taylor, President	☒	☒	☒	☒
St. John HIV/AIDS Committee	Mr. Richard Harris, Chairman	☐	☐	☐	☐
CARE Barbados	Ms. Ingrid Hope, President	☒	☒	☒	☒
CARE Barbados	Mrs. Patricia Phillips, Project Coordinator	☒	☒	☒	☒
Family CARE Support Group	Ms. Judy Archer, President	☐	☐	☐	☐
Family CARE Support Group	Ms. Sonia Arthur, Secretary	☒	☒	☒	☒
AIDS CARE Education and Training	Ms. Lorna Harris, President	☒	☒	☒	☒
AIDS Society of Barbados	Ms. Merlene Blackett, President	☒	☒	☒	☒
Barbados Evangelical Association	Reverend Erskine Branch, Member	☒	☒	☒	☒
Barbados Evangelical Association	Reverend Patrick Drakes, Member	☒	☒	☒	☒
Barbados Evangelical Association	Reverend Stephen Gittens, Member	☒	☒	☒	☒
United Gays and Lesbians Against AIDS Barbados	Ms. Patsy Grannum, Project Coordinator	☒	☒	☒	☒

ANNEX 3: External Quality Assurance Laboratories



ICBS International Consortium for Blood Safety

Performance Evaluation by Parameter

External Quality Assessment Scheme – Caribbean Region

Panel OPS 0109 C

Queen Elizabeth Hospital

Barbados

Syphilis	HIV	HTLV	HCV	HBsAg
A	A	A	B^2	A

Qualification criteria:

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

"B^{1}" False-Positive result was reported.

(< 5% of the total of determinations performed)

"B^{2}" False-Positive result was reported.

(> 5% of the total of determinations performed)

"C" False-Negative result was reported.

São Paulo, 30 July 2009.

Márcia Otani

Dra. Márcia Otani

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