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Foreword to National Strategic Plan for the Prevention and Control of HIV 2008-2013

This National Strategic Plan is the by-product of two years of brain-storming with our widest stakeholders, gathering evidence from the ground, utilizing the input of five consultants and then extensive editing prior to validation and re-validation with our stakeholders.

During the first five years of this multi-sectoral, expanded programme, Government took the then unprecedented move for small island developing nations to assure widespread provision of anti-retroviral drugs with impressive results.

At this juncture in our National AIDS Programme, the time is ripe for equally fearless commitment to and investment in, prevention strategies.

This Strategic Plan looks at the range of key populations at highest risk and addresses specific behaviours and vulnerabilities in promoting the adoption of wide-ranging, innovative and fearless behaviour change campaigns. These campaigns are based on relevant and current surveys to be rolled out where our at risk populations congregate.

It envisages a move towards widespread national sero-prevalence studies so as to better gauge the epidemic as well as significantly enhancing the uptake of voluntary counselling and testing utilizing provider-initiated testing across the public health spectrum.

We continue to commit to and build on the fundamental principles of the greater involvement of people living with HIV (GIPA) while ensuring that our programme is strongly rights-based and gender-focused.

It is the intention of all who were involved in the production of this document that it be a vital, widely-utilized document which will serve as a guide towards the achievement of Universal Access to prevention, treatment, support and care services by 2010 and subsequently to the dramatic reduction in incidence of HIV so as to ensure sustainability of this programme.

Dr. Carol Jacobs, BCH, GA
Chairman
National HIV/AIDS Commission
2001-2008

Acronyms & Abbreviations

AIDS	Acquired immunodeficiency syndrome
AID Inc.	Associates for International Development Incorporated
ART	Antiretroviral therapy
ARV	Antiretroviral (drugs)
AZT	Azido-deoxythymidine
BCC	Behaviour Change Communication
BCD	Barbados Council for the Disabled
BCI	Behaviour Change Information
BDS	Barbados Drug Service
BHTA	Barbados Hotel and Tourism Association
CARE	Comfort, Assist, Reach out and Educate (NGO representing PLHIV)
CAREC	Caribbean Epidemiology Centre
CAFRA	Caribbean Association for Feminist Research and Action
CARICOM	Caribbean Community
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
CGDS	Centre for Gender and Development Studies
CHART	Caribbean HIV/AIDS Regional Training
CRIS	Caribbean Regional Information System
CSME	Caribbean Single Market and Economy
CSOs	Civil Society Organisations
CTUSAB	Congress of Trade Unions and Staff Associations of Barbados
DFID	Department for International Development
FBO	Faith-based Organisations
GDP	Gross Domestic Product
GIS	Government Information Service
GNP	Gross National Product
GOB	Government of Barbados
HAART	Highly active antiretroviral therapy
HASSER	Health and Social Services Evaluation and Review
HASSUS	Health and Social Services Utilisation Study
HDI	Human Development Index
HFLE	Health and Family Life Education
HIV	Human immunodeficiency virus
HRM	Human Resource Management
IEC	Information, Education and Communication
ILO	International Labour Organisation
IOM	International Organisation for Migration
KAPB	Knowledge, Attitudes, Practices and Behaviour
LRU	Ladymeade Reference Unit
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MESA	Men's Educational Support Association
MES	Ministry of Education, Youth Affairs and Sports
MH	Ministry of Health
MHA	Ministry of Home Affairs
MPT	Ministry of Public Works and Transport
MSM	Men who have sex with men
MST	Ministry of Social Transformation
MTCT	Mother-to-child (HIV) transmission
NAP	National AIDS Programme
NHAC	National HIV/AIDS Commission

NGO	Non-governmental organisation
NOW	National Organisation of Women
NSP	National Strategic Plan
NSCA	National Council on Substance Abuse
NUPW	National Union of Public Workers
OI	Opportunistic infections
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organization
PLHIV	People living with HIV/AIDS
PWD	Persons with Disabilities
QEH	Queen Elizabeth Hospital
QoL	Quality of Life
RBPF	Royal Barbados Police Force
SHIP	Sexual Health Information Programme
SUDW	Single, Unemployed Dependent Women
STI	Sexually transmitted Infections
SW	Sex worker
UGLAAB	United Gays and Lesbians against AIDS, Barbados (NGO representing Gays and Lesbians)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNIFEM	United Nations Development Fund for Women
US	United States
USAID	US Agency for International Development
UWI	University of the West Indies
UWI HARP	University of the West Indies HIV/AIDS Response Programme
VCT	Voluntary counselling and testing
WHO	World Health Organisation

"For there to be any hope of success in the fight against HIV/AIDS, the world must join together in a great global alliance".

Kofi Annan, former UN Secretary General

EXECUTIVE SUMMARY

As Barbados responds to the changing face of the HIV and AIDS epidemic, the NHAC has designed fresh approaches for improved results in the National Strategic Plan for HIV Prevention and Control 2008-2013. The NSP will therefore build and improve on the achievements of the NAP to date.

Guided by Goal three of ***The National Strategic Plan of Barbados 2005-2025*****,** the current Strategic Plan is framed within the context of other national, regional and global priority development goals. This all encompassing developmental approach was used to ensure that the economic and social fabric of the country remains strong and dynamic.

The Barbados epidemic has evolved over the past quarter of a century from being mainly concentrated and driven by sexual networks of men who have sex with men (1984 to early 1990s) to rapidly increasing incidence in self-reported heterosexual males and in females of child bearing age (feminization of the epidemic). Current figures on reported cases show that females of child bearing age represent 50 % of new AIDS cases in 2006. The challenge has been in characterizing the nature of the epidemic, and accurately documenting the changing trends that result from changes in transmission dynamics.

With vertical transmission of HIV virtually eliminated and no reported cases of HIV being transmitted via blood transfusions, the primary mode of transmission of the virus, therefore, is through unprotected sexual contact.

Among the new approaches required in fighting HIV and AIDS in Barbados, is an openness and honesty about sexuality and a supportive, enabling and non-judgemental environment. This will also be reflected in the nature and content of safer sex education and staff training resources, effectively targeted at HIV risk and the social and sexual realities experienced by the population. The NHAC has been established to articulate the national strategy and ensure sustainability of the NAP.

Barbados is ready to move beyond educating its population about the facts on HIV to effecting changes in attitudes and behaviour focusing particularly on boys, girls, adolescents, young men and women between the ages of 10-29 years. Statistics show that children between the ages of 5 and 14 represent fewest infections and cases of AIDS. In the NAP 2008-2013, activities targeting this population group would allow for timely interventions for these children who will be taught to protect themselves from HIV infection before they become sexually active and hopefully remain free of HIV. However, efforts will still be maintained to identify and address apparent knowledge gaps and inconsistent condom use in the 40-49 age groups and males aged over 55.

The National Strategic Plan for HIV/AIDS, 2008–2013 outlines a logical flow of actions from priority areas through strategic objectives to the overall developmental goal for the NAP.

Developmental Goal

The Developmental Goal of the NAP as outlined in the NSP for HIV/AIDS, 2008-2013 is:

Mitigation of the social and economic impact of HIV and AIDS on the population thereby reducing new cases (incidence) and ensuring the sustainable development of our nation.

This goal is in line with the objectives of Goal 3 in ***The National Strategic Plan of Barbados 2005-2025*** - "Strength and unity: Building Social Capital".

Priority Programme Areas for Action

The following programme areas have been identified as priorities for the period 2007 to 2012:

1. Prevention and Control of HIV transmission
2. Diagnosis, Treatment and Care of PLHIV
3. Support for PLHIV
4. Programme Management and Institutional Performance
5. Surveillance, Monitoring & Evaluation and Research

Cross-Cutting Themes

Three areas of focus have been introduced to ensure a more comprehensive response strategy and are highlighted as cross-cutting and are considered to be key to achieving success and sustainability. They are:

- Gender power relations and dynamics and HIV/AIDS
- Human resource management
- Human rights policy and legislation

Expected Outcomes

It is expected that the NSP for HIV/AIDS, 2008-2013 will promote sustainable and effective multi-sectoral responses through the:

- Establishment of a logical sequence for scaling up towards Universal Access to prevention, care, treatment and support services over the period 2008-2013 and
- Development of fully costed, annual operations plans with support from Government's Estimates and external financing.

In addition, the Plan has adopted a two-tiered approach, with an initial decision-support strategy which will focus on filling key data gaps and strengthening surveillance and scaling–up interventions already know to be essential (for example - prevention among MSM and sex workers; ensuring high ART adherence). Once the epidemic is better understood, key populations at higher risk will be

targetted during the second part of the strategy period. An effective decision-support strategy will be able to measure the success of the Programme by tracking the indicators below.

Indicators

During the period 2007-2012, it is expected that the following targets will be attained:

- At least 85% of diagnosed PLHIV who require HAART accessing treatment by 2008;
- At least 10% annual increase in access to care and support (including psycho-social support services) by vulnerable groups of men and women by 2010;
- At least 20% annual increase in the number of men and women consenting to HIV testing by 2010 and returning for their results;
- At least 20% increase in membership of PLHIV associations by 2010;
- All relevant legislation reviewed and revised to support new policy developments by end of 2011;
- Improved monitoring, evaluation and operational research conducted according to national guidelines to identify vulnerable groups of men and women and to facilitate policy development and efficient planning of targeted interventions on an annual basis until 2012;
- Biennial improvement of the quality of life scores of PLHIV, vulnerable and high risk groups by 2012;
- A 33% annual increase in community-based outreach programmes targeting key populations at higher risk by 2012 and
- A annual increase in resources (people, funds and materials) available to civil society organisations to effectively deliver well-coordinated and sustained interventions to key populations at higher risk.

Baseline data does not exists for all of the above indicators. Once baselines have been established through the Tier 1 decision-support strategy, there may be a need to revise some of these targets.

Primary Beneficiaries of the NSP 2008-2013

It is envisaged that the NSP for HIV/AIDS, 2008-2013 will have a positive impact on the following population groups directly - youth, women, sex workers, bisexual men, beach boys and indirectly on government, civil society and the private sector.

Children and youth (boys and girls between the ages of 3-9, young men and women between the ages of 10-29)

The programmes and activities of the NSP 2008-2013 will enable this group ultimately to make positive life choices and adopt behaviours (such as informed decision-making and changes in high risk activity including delaying initial sexual activity) that will reduce the spread of HIV. The NSP will also recommend interventions to improve the educational and economic opportunities of young girls and “boys on the block” through targeted outreach interventions.

Key populations which include, in addition to youth, sex workers (SW), single, unemployed dependent women (SUDW), men who have sex with men (MSM), persons with disabilities (PWD),

bisexual men, beach boys, drug and alcohol abusers will benefit from the programme and activities of the NSP 2008-2013. This will be achieved through targeted Behaviour Change Communication and Behaviour Change Information; access to psycho-social support systems and needed supplies; development of employable skills; and development of group support programmes involving peer educators and counsellors.

PLHIV and affected households which include orphans and their families will benefit from the programme and activities of the NSP 2008-2013 through continued care provided by improved public and private health care services, the NGOs and the CBOs; protection of their human rights; longer involvement in the workforce; and enhanced psycho-social services.

OVC at risk of HIV but not associated with PLHIV, will benefit through strategies to promote their welfare, protection from child abuse and other factors that would otherwise contribute to their growth into vulnerable adults.

At the **national level**, the macro-economic impact of improved productivity of the nation will be enhanced by implementing a number of interventions outlined in the NSP. The country will benefit from the cost effectiveness brought about by the reduction in duplication and overlap of services and the synergies to be derived from greater coordination and collaboration among stakeholders (public, private and civil society).

Key determinants of HIV in Barbados

- Stigma and discrimination including attitudes toward key populations at higher risk
- Tourism (highest foreign exchange earner) and migration
- Gender inequalities and insufficient open dialogue on sexuality between partners. As a result of gender relations, males and females experience different kinds of vulnerabilities which can be attributed to factors that are biological, social and cultural, economic, legal and political
- Insufficient translation of HIV prevention and transmission knowledge to safer sexual practices.

Cost and Resource Mobilisation

It has been broadly estimated that it will cost BDS $180 million to finance the programmes and activities under the NSP 2008-2013.

Given the rating by the World Bank as a high-income country, the Government will have to provide the majority of financing for the NSP 2008-2013 from its Consolidated Fund while seeking to attract additional funding from the international community.

Conclusion

It is expected that the new Strategic Framework for HIV/AIDS 2008-2013 will find the balance needed for prevention, treatment, care and support of PLHIV through modification of behaviour, attitudes and cultural practices of the Barbadian society; while identifying realistic targets for change. These changes could be measured annually during the five year period among the general population but particularly among the vulnerable and high-risk behaviour groups. Concurrently, it will develop a strategy and action plans to strengthen the human resource management systems required to support the NAP.

To achieve this objective, there will be a need to involve "agents of change" in the expanded response to the epidemic. These agents of change include political leadership at the highest level of the society; NHAC as an empowered, committed national authority to coordinate, motivate and guide the activities of stakeholders in implementing the NAP and specialist agents (HIV/AIDS coordinators and educators/trainers) appointed to work in Ministries and influence the work force and the wider community.

Successful implementation of this new Strategic Framework will move the country even closer to attaining universal access to prevention, care, treatment and support services by 2010 as well as the attainment of the Millennium Developmental Goal Number Six to halt and reverse the spread of HIV by 2015.

The following matrix provides a summary of Results Framework for the NSP 2008-2013, outlining a logical flow of actions from levels of objectives and strategies to programme goals and ultimately the overall developmental goal for the NAP.

The HIV/AIDS response, 2008-2013: Results Framework

GOAL: ***Mitigation of the social and economic impact of HIV and AIDS on the population thereby reducing new cases (incidence) and ensuring the sustainable development of our nation.***

Strategic Objectives (Expected Outcomes)

SO1 - To increase HIV and STI awareness
SO2 - To effect positive behaviour change to reduce spread of HIV/STIs
SO3 - To strengthen treatment, care and support services for PLHIV, OVC, and vulnerable and high-risk groups
SO4 - To boost the educational and economic opportunities of PLHIV and of *the most at risk*
SO5 - To build capacity, strengthen institutional and management structures across private sector, civil society and government to deliver effective and sustainable programmes
SO6 - To strengthen institutional structures that will enable successful scale up and execution of monitoring and evaluation of programmes to allow for evidence-based decision-making.

Intermediate results (IR)

IR: Increased Access to service and improve availability (distribution)

IR: Improved Service Quality* - improved outcomes in prevention, treatment, care and support services

IR: Sustainable financing of all activities and interventions

IR: Increased demand for services by key populations

IR: Improved enabling environment

Strategies/activities

- Service information and outlets increased
- Increase provider skills and knowledge to increase performance
- Improve Health system policies and configurations to improve productive efficiency
- Improve attitudes to seeking health, information and support; as well as to provider attitudes to equitable service
- Develop national policies on stigma
- Implement institutional polices and guidelines to improve equity of access to services
- Deliver appropriate training and effective management and coordination and design of programmes
- Introduce Health care financing and cost recovery strategies
- Increase client's knowledge on prevention, transmission and symptoms of HIV and STI
- Increase knowledge on workplace policies and implement these in particular the informal sector
- Information systems development and implementation. Increase Operational research and research into contextual factors
- Increase private sector activities, collaboration, resource support and sharing
- Increase Community mobilisation – to increase support and involvement and acceptance of key populations
- Initiate Research into existing policies and their impact

***** Dimensions of quality are defined as appropriate to need, available, responsive, effective and accessible

MATRIX – PROGRAMME AREAS BY TARGET GROUPS BEING ADDRESSED

PRIORITY PROGRAMME AREAS	TARGET GROUPS													
	1.Boys, girls, young men and women	2.Sex Workers (formal and informal) including the "beach boys" and their clients	3.MSM and Bisexual men	4.Workers in the tourism industry	5.PLHIV	6.Women – SDW	7.Orphans and vulnerable children (OVC)	8. Prisoners	9. Migrants (Non-Barbadians) and CSM&F	10. Persons with Disabilities (PWD)	11. General Population especially those people who are in constant contact with the rest of the population.	12. Security Forces – Prisons, RBPF and the Defence Force	13. Staff of the NHAC and Ministries	14. Men and women 50 years and older
Prevention and Control of HIV transmission	x	x	x	x	x	x	x	x	x	x	x	x		x
Treatment and Care of PLHIV					x				x	x				
Support for PLHIV					x		x		x					
Programme Mgmt. & Institutional Performance					x						x	x	x	
Monitoring & Evaluation and Research	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Schedule of Activities 2008-2013

Target groups	Year					
	2008	2009	2010	2011	2012	2013
Boys, girls, young men and women	x	x	x	x	x	x
Sex workers+	Prevention research	x	x	x	x	x
MSM and Bisexual men	Prevention research	x	x	x	x	x
Tourism employees	Existing programme with DFID			x	x	x
PLHIV	Outcomes and impact evaluation	x	x	x	x	x
Women – SUDW	Research to be initiated		x	x	x	x
OVC	x	x	x	x	x	x
Prisoners	Research initiated			x	x	x
PWD	Current report	x	x	x	x	x
Population*	Research initiated by unions & employers			x	x	x
Security forces				x	x	x
Staff – public sector employees	x	x	x	x	x	x
Men and women 50 years and older			x	x	x	x

x – New initiatives
+ - Formal and informal sex workers including "beach boys"
***** - People in the world of work especially those in constant contact with the population

INTRODUCTION

The observed decline in AIDS deaths (Figure 1) clearly highlights that increasing HIV prevalence is the resulting trend. Figure 2 shows the estimated prevalence with and without HAART interventions with increasing prevalence from 1.5 to 1.7% as a result of treatment. This underscores **the importance of achieving a significant reduction in incidence in order to minimize the treatment cost of increasing HIV prevalence as well as effective data collection systems to determine HIV incidence**.

Figure 1: Summary Profile of reported AIDS and HIV Cases 1984 to 2006

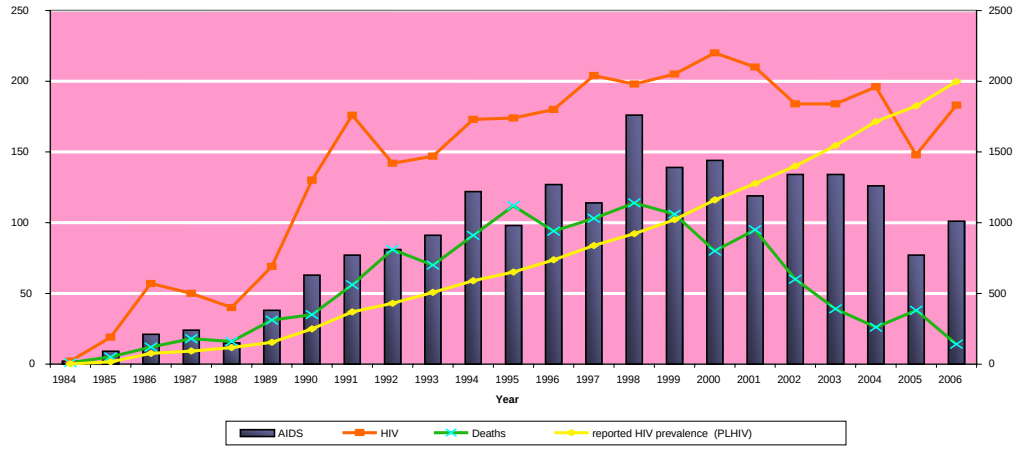
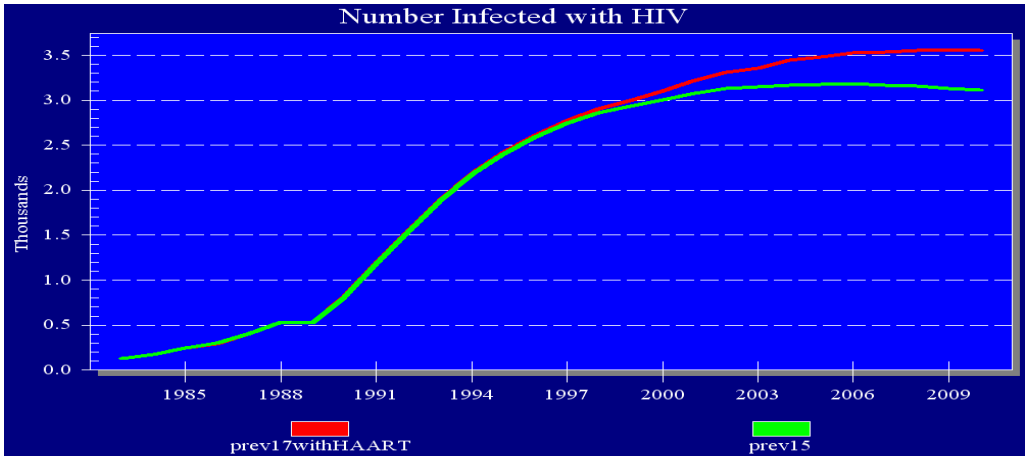


Figure 2: Magnitude of HIV in Barbados with and without HAART

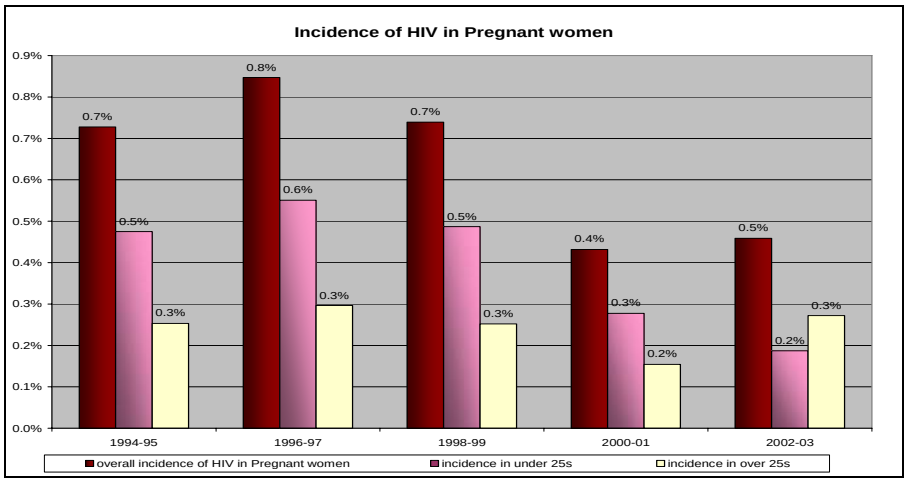


Antenatal case surveillance forms the most representative data for the general population and, hence, provides the basis for generating national prevalence estimates for generalised epidemics.

Analysis of reported antenatal cases for 2006 reveals that antenatal prevalence rates are fluctuating, having declined from 1.1% in 1999 to 0.8% in 2000 and 0.5% in 2005 and to

rise again in 2006 to 1.5 %. Incidence of new cases in pregnant women[1] declined from 0.7% to 0.4 % between 1999 and 2003. In the past 3 years since 2004, reliable antenatal data required for the modelling has not been available in the public domain or comprehensively collected under any HIV surveillance system. This has created delays in updating national prevalence estimates.

Figure 3: Incidence of HIV in Pregnant Women



The fall in incidence is most significant in the under 25 years age group declining from 0.5% in 1998 to 0.2% in 2002-2003 (see Figure 3 above), while incidence in the over 25 years age group appears to have risen between 2002 and 2003, consistent with self reports of poor condom use in this group of older women compared with increasing awareness in youth. In order to fully establish transmission patterns across age bands, there is an urgent need to standardise data collection processes and flows of antenatal HIV cases from all VCT service points on island. This standardisation needs to occur prior to further scaling up of VCT services.

Improving access to HIV testing services to increase the early detection of HIV is paramount to controlling spread and prolonging the lives of those found to be positive. Hence, the key goal of any effective, scaled up VCT programme should be to reduce the number of simultaneous and delayed diagnoses (AIDS within 12 months of HIV diagnosis) and to increase the number of deferred diagnoses of AIDS (AIDS onset is more than one year after HIV diagnosis).

In terms of prevention and support, once diagnosed, the PLHIV is able to access welfare and other social services including psychosocial support and other programmes aimed at reducing secondary transmission of HIV from diagnosed PLHIV.

Since the start of the Programme, the pattern of males accessing VCT services later than females has been maintained. A sign of slow yet steady success of the VCT programme has

[1] Antenatal screening rates have been high in Barbados (up to 93% in 2000 and 83% in 2006) and hence sero-prevalence rates, statistically adjusted for the un-screened population (extrapolation factor) are a valid source of data to support prevalence projection modelling.

been the rise in the proportion of males whose AIDS diagnoses have been deferred. There has also been a concomitant decline in the proportion of males diagnosed with HIV and AIDS simultaneously.

KAPB surveys now indicate that the age at which approximately 40% of youth become sexually active ranges between 10-14 years. This data presents a compelling case for the strategic directions of the NAP 2008-2013, to focus on key populations, particularly children younger than age 11 with special attention being given to modelling positive behaviours which will redound to their benefit for years to come. There is an urgent need to address the specific behaviours and vulnerabilities of our young people and to delve deeper into issues associated with risky sexual practices of the other population groups; while identifying structural, socio-economic and environmental variables that contribute to the dynamics of the HIV epidemic in Barbados.

In the past, the most at risk groups have been defined as the youth, MSM and sex workers as a result of their self-reported sexual practices. However, recent sexual practice surveys indicate that the epidemic may not be driven solely by these HIV-vulnerable groups, but also by risky sexual practices in the general population as a result of key gaps in knowledge and inconsistent condom use. The survey data for 2004, 2005 and 2007 also indicates that self reported risky practices within the perceived most at risk groups has decreased during the last five years of the programme (MSM and sex workers studies). The current trend linked to behavioural survey findings point to a mixed epidemic, i.e. increasing generalisation of the epidemic with concentrations of HIV prevalence in selected higher risk groups.

A key challenge for the NAP, therefore, is to scale up BCC moving from basic IEC strategies to more tailored approaches that will result in sustained safe behaviours in the population. A five-year behaviour change communication (BCC) strategy (at Appendix 5) has been developed to reduce HIV infection rates; increase survival rates for PLHIV; and influence HIV/STI trends to realise a shift in behaviour that is required for a change in the progress of the epidemics.

The NHAC, having recognised the need for this paradigm shift, engaged five (5) consultants to assist them in developing the National Strategic Plan for HIV/AIDS 2008-2013. Based on their Terms of Reference (see Appendix 1), they conducted interviews with public and private sector stakeholders, civil society (NGOs, FBOs, the media) as well as regional and international agencies involved in the response to HIV. From those interviews they were able to:

- Assess achievements of the NAP during the period 2001-2006;
- Identify challenges and gaps of the NAP during the period 2001-2006;
- Assess skills levels and capacity gaps in the NHAC Secretariat and in the mainline Ministries;
- Set priorities, goals, objectives and targets for the period 2008-2013; and
- Recommend new strategic directions for the period 2008-2013

This informed the approach for creating a new response to the HIV epidemic for the period 2008-2013.

Initially (2008-2010), activities of the NSP will be directed to the following key populations at higher risk:

- Boys, girls, young men and women between the ages of 10-29 years
- Sex Workers including the “beach boys”
- MSM and bisexual men
- PLHIV
- Women (single heads of households, low income earners and unemployed women) – SUDW; women in long standing relationships and women who want to get pregnant.
- Orphans and vulnerable children (OVC)

In the remaining 3 years of the Plan (2011-2013), strategies will target the following key populations:

- Workers in the tourism sector – Hotel workers, visitors, support staff, transport sector, golf caddies, vendors, massage therapists, water sports personnel)
- Prisoners
- Non-Barbadians particularly with the introduction of CSME
- Persons with Disabilities (PWD)
- People who are in constant contact with the rest of the population – Sanitation Service Authority workers, Port messengers, Workers with the Transport Board.
- Security Forces (Prisons, Royal Barbados Police Force and the Defence Force), workers in the Immigration and Customs departments.
- Men and women 50 years and older.

The Plan will address HIV by tackling the root causes of the epidemic which include:

- Insufficient information base for planning and decision-making
- A paucity of legislation related to HIV
- Deep seated socio-culturally driven practices
- Stigma and discrimination
- Poverty and unmet needs

The 2008-2013 Plan will identify its strategic imperatives, outline the contextual framework on which the Plan is based given the evolution of the epidemic in Barbados over the period 1984-2006, chronicle Barbados’ response to the epidemic in its strategic plan for the period 2001-2006 in order to identify emerging gaps that need to be addressed to provide the strategic directions required for the next five years.

SECTION 2: STRATEGIC IMPERATIVES: NAP 2008-2013

Rationale for the NAP 2008-2013

HIV/AIDS is a national priority for the Government of Barbados. The "*Action Plan for a Comprehensive Programme for the Management, Prevention and Control of HIV/AIDS, 2001-2006"* formed the basis of HIV/AIDS-related policy decisions and programming actions for that period.

Progress has been uneven across institutions and a number of shortcomings have emerged that test the long-term sustainability of the programme. For example, while there is considerable knowledge about HIV and AIDS among young men and women, there is still evidence of early sexual initiation; multiple sex partners; and inconsistent use of condoms (2001, 2003-2004 and 2005-2006 KABP studies) that reflect a failure to apply that knowledge to behaviour change.

Equally, the socio-cultural contributors to at risk behaviours have escalated to such an extent that they now must be examined more deeply to effect the change needed to transform the course of the epidemic. **An important strategic imperative for the new plan is, therefore, behaviour change communication**.

In order to accomplish the desired results, the NHAC will also require institutional strengthening based on the new competencies identified to embark upon the innovative thrust in leading and managing this process (cf. Appendix 3).

Major Contextual Factors

There are several factors that wittingly or unwittingly contribute to the dynamics of this epidemic. Among them are the **socio-economic circumstances that create poverty and unmet needs** and can influence the nature and extent of sex work, especially by those in unstable employment who undertake periodic sex work to supplement their income in order to meet the basic needs of their household.

Other **key obstacles are stigma and discrimination** which drive the epidemic underground. Surveys and focus groups in the Adults Sexual Behaviour Study, 2004-2005 and the more recent 2007 Men's Lifestyle Study have shown that as a result of stigma and discrimination towards sexually active youth and other sub groups, the health and social support for 15 to 19 year olds at risk of HIV infection, sex workers and MSM are hindered. This results in poor engagement of health and social support resources and unwillingness to reintegrate into society. HASSUS findings also revealed that up to 35% PLHIV left work not because of physical ill health, but as a result of poor mental health due to stigma and it resulted in discrimination and their dependence on the government for periods longer than two years before requiring ARV drugs. Thirteen per cent (13%) of PLHIV were dismissed from their jobs with no explanation from their employers. This, together with breaches of confidentiality and increasing PLHIV self-stigma (internal stigma) contribute to all forms of community withdrawal, social exclusion and subsequent economic hardship.

Labour Migration through the Caribbean Single Market and Economy (CSME) is another variable that has the potential to exacerbate Barbados' vulnerability to the spread of HIV and AIDS. Recent studies and reviews of migration by IOM (2004) have shown considerable movement of sex workers, tourists, business travellers, petty traders and casual labourers between Caribbean countries. In this environment, the region's epidemic can become indistinct between countries promoting unchecked transmission of HIV in the absence of adequate surveillance, health system revisions and appropriate prevention programmes.

In a 2005 ILO HIV assessment on selected economic sectors in Barbados, informal sex work (sex for gifts or favours) was shown to "be acceptable" and prevalent among non-professional workers both within and external to the tourism sector. The constant contact of workers in the tourism industry with clientele increases their susceptibility to engaging in unsafe sexual practices. These contributing factors must also be seen against emerging evidence that **sex tourism and informal sex work have expanded** to include single and married women and men in addition to the established and mobile commercial sex workers. Other population groups involved in commercial and/or transactional sex include children, schoolgirls, housewives and professional workers. There is also evidence of growth of a more formalised sex tourism operation across the Caribbean as revealed though key informant interviews.

There has been a growing recognition that HIV initiatives must consider the linkages of the intricate issues underlying sex work beyond the obvious commercial sex setting. It is important to understand the diverse nature of sex work and the attitudes, behaviour patterns and contextual factors involved, as the interplay of these dynamics intensifies the risk of STI/HIV transmission.

These contextual factors cannot be ignored and clearly show that despite widespread dissemination of information on HIV transmission and prevention, risky practices among youth and adults still prevails.

Goals and Objectives

The **Developmental Goal** of the NSP, 2008-2013 is:
Mitigation of the social and economic impact of HIV and AIDS on the population thereby reducing new cases (incidence) and ensuring the sustainable development of our nation.

This Goal is in keeping with the objectives of Goal 3 in ***The National Strategic Plan of Barbados 2005-2025*** - "Strength and unity: Building Social Capital". This goal "places people at the heart of the development process" and acknowledges that "people, (social capital) are critical to economic development" and also states that "The key to unlocking the productive potential of Barbadians is a continuous revolution in education from nursery to tertiary level …" One aim is to improve the health of all Barbadians so that they will enjoy a good quality of life and have access to a health system that guarantees an equitable provision of quality care.

Objectives of the NSP

The programme areas and cross-cutting themes translate to the following strategic objectives and are outlined in the Table 1 below.

Table 1: Programme Areas and Strategic Objectives

Programme Areas	Strategic Objective
1. **Prevention and Control of HIV transmission** Reduction of the spread of HIV and STIs with particular focus on BCC towards identified key population (youth, MSM, Sex workers, SDW, OVC) through scaling up and ensuring the availability of universal access to preventive and supportive services (including HIV testing) for all target groups.	***NSP SO1.*** To increase awareness and knowledge on the transmission and prevention of STIs/HIV and include concepts of human sexuality, gender relations and life skills in the school curricula, thereby increasing uptake of HIV testing including targeted VCT, pMTCT, STI management and psycho-social support services.
	NSP SO2. To effect positive changes in attitudes and sexual practices among key populations as well as within the employment sectors.
2. **Diagnosis, Treatment and Care of PLHIV** Ensuring Universal Access to comprehensive treatment, care and support services for all PLHIV, including ARV provision and support, treatment monitoring, support for adherence, coping and prevention of HIV transmission.	***NSP SO3.*** To strengthen Treatment, Care and Support services for PLHIV, OVC and vulnerable as well as high risk groups, thereby promoting healthy and prolonged lives for these persons.
3. **Impact mitigation and Support for PLHIV** Promotion of economic and social productivity of PLHIV and the most at risk members of key populations at higher risk, accelerating poverty reduction and community support strategies (such as programmes for personal development and welfare support) that improve the quality of life and reduce vulnerabilities to HIV in key populations at higher risk particularly OVC, PLHIV and SUDW, thereby contributing to a reduction in primary and secondary transmission of HIV.	***NSP SO4.*** To boost the educational and economic opportunities of PLHIV and of *the most at risk* including vulnerable young girls and boys on the block through targeted interventions.
4. **Programme Management and Institutional Performance** Placing greater focus on sustainability through better programme coordination and management; well informed programme design; and through the cost-efficient allocation of goods and services directed towards strengthening the national capacity for implementing and coordinating a multi sectoral response. This includes the exploration of approaches to shared care to ensure equity of access to HIV care within the public and private health services for all community groups.	***NSP SO5.*** To build capacity and strengthen institutional and management structures across private sector, civil society and government to deliver effective and sustainable programmes to boys, girls, young men and women between the ages of 3-29 years, vulnerable, high risk and hard to reach groups including vulnerable employment sectors.
5. **Surveillance, Monitoring, Evaluation and Research** Ensuring the integration of monitoring and evaluation into all components of the National AIDS Programme; providing appropriate training to build partners' monitoring and evaluation capacity in an effort to develop a monitoring and evaluation culture. This should be supported by the formulation of a comprehensive research agenda designed to fill the data gaps which if ignored would undermine programme efforts and reverse programme achievements. This includes the development of a fully functional surveillance system.	***NSP SO6.*** To build skills and human resources capacity and strengthen institutional structures that will enable successful scale up and execution of monitoring and evaluation of programmes, a comprehensive third generation surveillance system and operations research for implementation design and evaluation across government, private sector, civil society.

The cross-cutting themes are:

1. Human Rights, policy and legislation (especially in the area of AIDS-related stigma and discrimination)
2. Human Resource Management including capacity building
3. Gender relations and dynamics (integrating gender into all components of the NSP) – see Appendix 4.

Critical assumptions

- That all stakeholders will buy in to the developmental goal of this Strategic Plan and are committed to the drive for sustainability. This ensures that each player seeks to avoid wastage and bases decision-making on rational judgment and collective viewpoints underpinned by sound information.
- That the NHAC will be strengthened to manage and coordinate effectively the response, in particular as activities and service coverage move to decentralisation of varying degrees and configurations.
- That the Strategic Plan is translated into action in a timely manner.

These strategic imperatives must be viewed in the context of over two decades of initiatives to address this pandemic in Barbados. That historical framework provides invaluable insights into what has been achieved and what is still needed to thwart the exponential spread of HIV in Barbados.

SECTION 3: THE HIV/AIDS SITUATION IN BARBADOS, 1984 TO 2006

Evolution of the HIV/AIDS Epidemic 1984 to 2006

Magnitude and Distribution

Since the early 1990s, AIDS has been among the leading causes of death in the age group 15-49 years and the data indicates that since 2005, men and women are equally affected, except in the age group 15-29 years. In 2001, it was estimated (using both SPECTRUM, AIDSProj with AIDS case surveillance data and antenatal sentinel surveillance data[2]) that 1.9% (approx 3810 adults) of the adult population is living with HIV/AIDS[3]. Further, more recent updates using more current and larger data sets (cleaned up to remove duplicates) provided an estimate of 1.5% (approximately 3180[4] adults) in the absence of treatment and rising to 1.7% (approx. 3500) with HAART treatment. In 2000, there were an estimated 210 orphans due to AIDS deaths and this number has increased to an estimated 244 in 2006 using Spectrum (cf. Figure 2 on p.1).

Reported Cases

The first AIDS case was reported in December 1984, and by 1996 the cumulative total of reported cases was 762, increasing to 2032 by December 2006 in a population of approximately 270,000 persons. By that date also, the cumulative total of persons who had tested positive for HIV was 3,295 and the number of persons who had died of AIDS was 1, 297. Reported AIDS, HIV and Deaths have been declining steadily since the initiation of the expanded response in 2001. Despite the overall declines observed, there are spikes and troughs within various age groups that may indicate changing transmission dynamics within these groups and, thus, changing priorities for re-focusing of prevention efforts.

Overall, annual incidence of AIDS cases have fallen by 46%, concomitantly with the 85% decline in deaths that have been observed between 2001 and 2006 (cf. Figure 1 on p.1). These declines have been attributed to the success of the HAART programme initiated since 2002.

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[2] Antenatal services users are the only sentinel population that has been monitored since the early 90s with high screening rates, despite the existing gaps in surveillance of this group, projection estimates have been derived.

[3] National estimates of HIV prevalence are based on data generated by surveillance systems that focus on pregnant women who attend a selected number of sentinel antenatal clinics, and in an increasing number of countries on nationally representative sero-surveys. This data is entered into the AIDSPROJ Package (By Futures Constella) which is used to estimate and project adult HIV prevalence from surveillance data from various years, showing HIV prevalence among pregnant women. AIDSPROJ, like the EPP by UNIADS, is used to fit a simple epidemic model to the surveillance to produce an adult prevalence curve. Along with national population estimates and epidemiological assumptions, prevalence is then entered into the SPECTRUM software program which considers other demographic variables such migration rate, crude death rate, treatment coverage, survival etc so as to calculate the number of people infected, new infections and deaths.

[4] During the expanded response (2001 to 2006) the progression from HIV to AIDS has slowed with over 70% of patients on ARVs achieving undetectable viral load and survival rates are increasing while progression to AIDS has slowed significantly for patients attending for care. These clinical outcomes due to ARV treatment have altered the transmission dynamics of HIV.

The reported AIDS cases represent the visible part of the epidemic. However, there is much more to the epidemic than the number of reported cases. This is just the tip of the iceberg as the number of visible AIDS cases translates into an even larger number of undiagnosed HIV cases, early AIDS cases and hidden diagnosed cases. Of concern is the fact that 6 years since the start of the expanded multi-sectoral programme, the general population is not accessing VCT services significantly. Behavioural surveys 2004, 2005 and 2007 show that many have taken a test (46%) at one time or the other in their lifetime for reasons such as insurance, loans, travel, pregnancy, but less than 10% of those who practice inconsistent condom use and have multiple partners seek tests for the purpose of their health maintenance.

As a result of poor health seeking practices in particular among males (Males lifestyle survey 2007), the true number of AIDS cases since the beginning of the epidemic is not known.

Reported HIV cases - Age distribution

As vertical transmission of HIV from mother to child is maintained below 5%, the portion of newly diagnosed cases in those under age 15 is less than 1% since 2005, while the fastest growing age range of HIV diagnosis is in persons aged 50 and over. Between 2005 and 2006, there was a 12.3% drop in newly diagnosed HIV cases falling in persons aged 15-49 while there was a rise of 79% in t newly diagnosed cases in persons aged 50 and over (Table 2).

Table 2: Age Distribution of HIV cases

Year of HIV	0 to 4 yrs	5 to 14 yrs	15 to 49 yrs	50 and over
1990	1.5%	0.8%	65.4%	6.2%
1991	3.4%	0.6%	65.9%	8.0%
1992	2.8%	0.0%	74.6%	12.7%
1993	5.4%	0.7%	72.1%	12.2%
1994	5.2%	1.2%	80.9%	8.1%
1995	4.6%	0.0%	69.5%	13.2%
1996	2.8%	0.0%	78.3%	14.4%
1997	3.4%	0.5%	76.5%	11.8%
1998	1.0%	0.0%	69.2%	14.6%
1999	1.0%	0.5%	73.7%	13.7%
2000	2.3%	0.0%	73.2%	13.6%
2001	1.9%	1.0%	76.7%	9.5%
2002	0.5%	0.5%	78.3%	12.5%
2003	0.0%	0.0%	75.5%	16.8%
2004	2.6%	1.5%	77.6%	14.3%
2005	0.0%	0.0%	87.2%	10.1%
2006	0.5%	0.0%	76.5%	18.0%

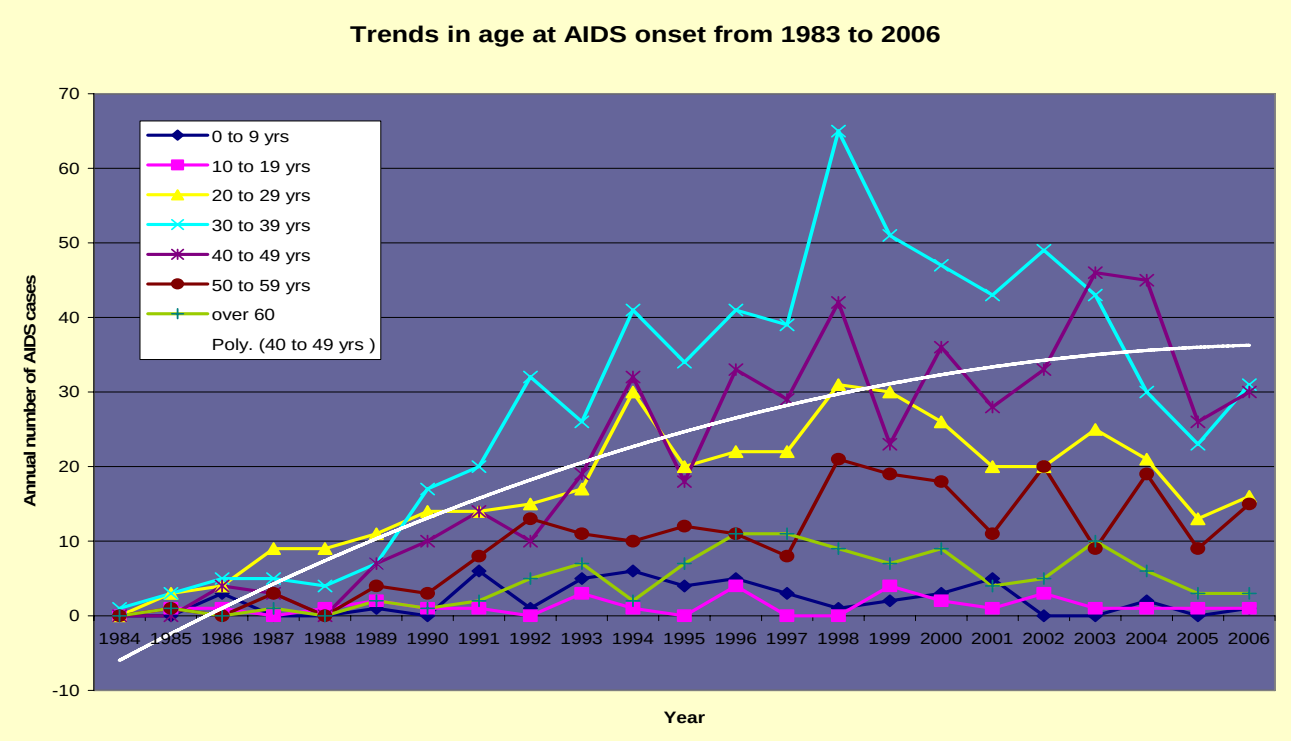
Although the overall proportion of the over 50s newly diagnosed with HIV remains lower than the 15 to 49, group, this rising trend indicates either continued risky sexual practices or delayed HIV testing patterns within specific population sub groups that are transitioning into their 50s.

Reported AIDS cases - Age distribution

In 2006, over 75 percent of reported infections occurred within the age group of 15 to 49 years and overall this group comprises 77% of all reported cases since 1983. The AIDS diagnoses rose in the 30 to 39 years age group until 2004, after which the 40 to 49 age group represented the highest number of AIDS diagnosis until the end of 2005. Since 1991, the onset of AIDS has declined in all age groups except for the 40 to 49 age group where the general trend is upwards.

The median age at HIV and AIDS diagnosis has risen overall. Median age of AIDS has risen from 35 years since 2001 to 39 in 2006 (28 in 1990 to 38 in 2006 in females and from 31 to 42 in males).

Figure 4: Trends in Age at AIDS Onset from 1983 to 2006



Nature of the epidemic and emerging issues around key populations

Current figures on reported cases show that females of child bearing age represented 50% of new AIDS cases in 2006. The challenge has been in characterising the nature of the epidemic, and accurately documenting the changing trends that result from changes in transmission dynamics.

The current trends linked to behavioural survey findings point to a mixed epidemic - that is, increasing generalisation of the epidemic with concentrations of HIV prevalence in selected key populations at higher risk. The general perception based on interviews and anecdotal evidence is that the most at risk groups are MSM, CSW, prisoners, informal sex workers (who report as being part of the general population) and youth. However, the sound validation of this assumption is hindered by weak surveillance systems which prevent identification and classification of these groups. Thus, the total estimated prevalence in the most at risk groups has not been fully estimated.

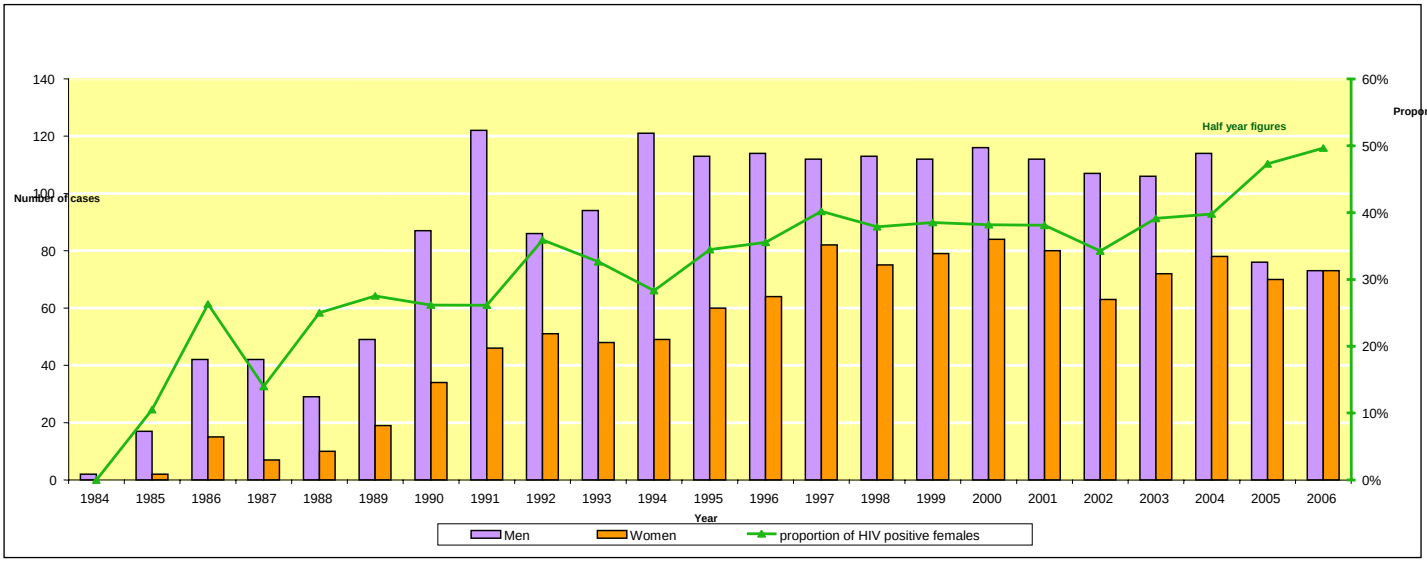
Recent sexual practice surveys indicate that the epidemic may not be driven solely by these HIV-vulnerable groups, but also by risky sexual practices in the general population, including networks of informal and unidentified sex workers – in which sexual activity begins young - as evidenced by the self reported age at first sex - and extends widely throughout society. The survey data also indicates that self-reported risky sexual practices within the most at risk groups has decreased during the last five years of the programme (Barbados Sex workers interventional study 2006 and the Barbados Men's Lifestyle Survey 2007). Hence, sub-epidemics presenting with different patterns of transmission dynamics and resulting incidence over time are likely and newly emerging sub-groups need to be better identified and closely monitored.

(a) Women in the general population

i) Rapidly increasing feminisation – an urgent need to focus on gender specific prevention

In 2006, the male to female ratio of HIV cases was 1:1 and women accounted for almost 40% of reported AIDS cases. The change in the ratio from 2:1 in AIDS cases reflects the lag in the epidemic as it transitioned from being driven by MSM activity to heterosexual intercourse.

Figure 5: HIV cases reported by year of diagnosis and gender, 1984-2006



The increasing trend of feminisation of the epidemic ***signifies that various sub-groups of women may require more tailored prevention approaches to promoting safer sexual practices.*** The need for producing more effective behaviour change is further supported by documented evidence on self-reported sexual practices within this sub-group.

ii) **Single, Unemployed and Dependent Women (SUDW)**

This group includes women who are single heads of households, low income earners and unemployed; women in long-standing relationships (whether married or single); and women who want to get pregnant. While data on gender distribution based on reported cases is available in Barbados, the actual understanding of the gender dimension and design of an appropriate response has not been fully realised. This is particularly important considering that age at first sex in youth continues to decline representing early exposure to HIV risk. Interventions do not generally address the uneven power relationships between men and women. Consequently, research is required into the impact of such relationships on HIV transmission.

(b) MSM

The 2007 Men's Lifestyle Survey revealed that 65% of MSM had more than one partner compared with 90% in 2004 and compared with 32 % the non-MSM male population. It is highly likely that this change in the statistics is an under-estimation due to under-reporting resulting from the cultural taboos, stigma and discrimination against MSM and bisexual men.

However, consistent with the feminisation of the epidemic is the documented rise in condom use in MSM between 2004 and 2007 whereas there was no increased condom use in females in the general population between 2004 and 2005. Of those MSM with multiple

partners, 50% reported inconsistent or no condom use in 2007, compared with 80% in 2004. 50% reported that they always used a condom.

Despite positive changes in their sexual practices, this group (MSM) has expressed that they find it difficult to access health services, (including sexual health, prevention services including the diagnosis and treatment of STIs) in settings where there is provider stigma and discrimination. Those who can afford it, therefore, go elsewhere or to local private non-stigmatising physicians.

As a result of reported stigma against MSM, the rights of this group are often compromised. In the survey undertaken between 2004 and 2005, data showed that gay men under the guise of heterosexuality are more likely to report seeking the services of a male sex worker. In addition, in a study on the impact of HIV on PLHIV receiving care, six out of eight young HIV positive MSM in focus groups sessions reported being victimised (being raped and sexually abused at nights) by men known to them and who present as heterosexual in the daytime. In all cases, condoms were not used. Despite an obvious need, none of the men reported these incidents to the law enforcement or sought the support of health services. The result being that they "go underground" and their risky behaviours go "unchecked" because they do not access prevention services.

(c) Males over 15 years

Comparison of the 2004 Adult sexual behaviour survey with the 2007 Barbados Men's Lifestyle Survey revealed that males appear to be changing their perceptions about what they feel is a regular partner despite the formal definition remaining the same (regular: a relationship that lasts or is expected to last more than 1 year). For instance, in 2004 86% had a regular partner or spouse, whereas in 2007 only 46% saw their partner as regular.

However, 70% of the 25-29 year olds cite having a regular partner compared with all other age groups. Boys aged 15 to 19 years had the least number of partners. Partner reduction approaches that identify the "influencing factors" of multiple partnering in young men and promote the maintenance low partner turnover rates as boys transition to men is indicated.

On the issue of violence against women, 23% of survey respondents stated that they had been violent, 9.3% in self defence while 22% have come close to violence. Programmers will need to explore the use of BCC interventions for couples such as tailored couples counselling and workshops to deal with means of expressing sexual needs and anger management.

Health seeking practices remain poor in males. Only 16.5% males have a doctor that they see on a regular basis, while 68.5% only go when it is perceived that there is a serious problem and 15% never see a doctor. As expected, the under 25 year old males were least likely to see a doctor on a regular basis. This observation calls for a scale up of health promotion and awareness-raising with regards to sexual health of males under 25 years and their heightened risk of STIs and other communicable diseases compared with older age groups. The confounding factor promoting poor attendance is the fact that this group

compared with the over 30s is less likely to seek comprehensive health checks as a result of their youth and their reduced risk of acquiring more prevalent non-communicable diseases.

(d) Youth (15-24 yrs)

Prevention programmes over the past five years have used general IEC to target the population and directly targeted youth, using approaches other than IEC. This positive start may be the result of existing infrastructure within government (Division of Youth Affairs and the Community Development Department) to directly assess and address the needs of young people.

In 2003, a retrospective assessment by the Barbados HIV Impact project of polyclinic STI clinical diagnosis and linked behavioural data demonstrated that **56% of pregnant mothers accessing antenatal services were between the ages of 15 and 19 years**. Their partner turnover rate was 3 times higher than women over 20. This trend may be slowing, as antenatal HIV data demonstrates that the incidence may be falling in the 15 to 24 age group (cf. Figure 3).

Yet, the most recent KAPB youth survey (2005–2006) revealed that 29.4% of youth (age 15 to 24), had more than one sexual partner in a four month period with 7% unable to remember how many partners they had in the last four months. However, by comparison, single adults had more multiple partners than youth in 2004-2005 (58% of single females and 55% of single males). Although the number of partners is rising in youth, condom use also appears to be increasing. In 2001, 53 % of these youth reported inconsistent condom use with non-regular partners compared with 30.2% in 2006[5]. This suggests that **condom use is higher in youth than in adults over 29 years based on the data in the 2004/5 adult survey**.

(e) Sex-workers

This group includes formal and informal, male and female sex workers including "beach boys. Studies by Kempadoo and by IOM in 2004 assessed the extent of sex work in countries of the Caribbean and noted that Barbados is a receiving country for sex workers from Guyana, Dominican Republic, Antigua and Barbuda, Belize, Haiti, Grenada, St. Lucia, St. Vincent & Grenadines and Trinidad and Tobago.

(f) Orphans and vulnerable children including neglected children[6]

In Barbados school attendance of vulnerable children of single HIV positive mothers is 35% less than other non-vulnerable children (HASSUS 2005).

[5] The 2006 youth survey was conducted with slightly different questions compared to the 2001 baseline survey and the maximum age in the 2005/6 survey was 24 years compared with 29 years in the 2001 survey. Hence only broad assumptions can be drawn without access to the raw data.

[6] Orphans and vulnerable children refer to children affected by HIV/AIDS; children who have lost at least one parent to HIV/AIDS; children who are left vulnerable by AIDS, including those who live with HIV positive parents who are chronically ill and those who live in households that have taken in AIDS orphans.

As a result of poor self esteem, OVC are more likely than other non-vulnerable children to be less educated, poor and unemployed. Absent role models or parents combined with a low sense of self-worth predispose these children to sexual abuse. Prevailing stigma and discrimination are the key reasons for preventing the reporting of these occurrences to public authorities such as the Child Care Board.

It is vital that BCC approaches are employed to make use of the window period between ages 3-14 by ensuring that this group of children develops positively, with sound values and a sense of self worth that is so necessary for making informed decisions, resisting early sexual encounters or sex work.

(g) Prisoners

Incarceration as a risk factor for HIV transmission is reported to be linked to violent, unprotected sex. Interventions for risk reduction should include expanded VCT, easier access to prison health services, providing recourse to action for rape victims and reviewing institutional and national policies that promote inaccessibility to health protection services.

(h) PLHIV

The HASSUS studies for 2004-2005 and 2006-2007 of PLHIV receiving treatment, care and support reveals that PLHIV continue to be marginalised from the workplace and from comprehensive health and supportive services as a result of self-stigma (internal stigma) and to a lesser extent, enacted stigma (discrimination). In the era of life-prolonging ARV therapy, while many PLHIV can work, stigma and discrimination experiences prevent them from seeking jobs.

With regards to sexual practices of PLHIV, the sexual practices surveys of PLHIV component within HASSUS undertaken in 2002 and 2004-2005 and 2006-2007 demonstrate that PLHIV partner turnover rates after diagnosis are no different from the general population sexual practices. However, incidence of STI 12 months prior to HIV diagnosis was relatively high in PLHIV (33% of males and 22%of females had an STI).

Health-related quality of life of PLHIV is monitored through the HASSUS study every 2 years. Overall QoL was observed to rise by 16% overall in the first 18 months of their treatment. However, despite increasing physical health scores, overall scores (combined components of physical and mental health outcomes) have begun to stagnate as a result of low vitality and mental health scores in particular within specific PLHIV sub-groups.

The disparity is greatest in PLHIV that have not been able to find means of sustaining economic or social productivity and in those who are not receiving counselling. MSM PLHIV demonstrated higher QoL scores overall than heterosexual males and they have attributed this to their ongoing exposure to psychosocial support and membership of their grass roots organisation (UGLAAB). Conversely, heterosexual males were least likely to seek psychosocial support and demonstrated lowest QoL scores.

Support services and the availability of vulnerable group organisations (not just PLHIV NGOs) are key to the reintegration of PLHIV from various sub-groups back into self-perceived productive existence after HIV diagnosis.

Other Un-defined Key Population Groups

Recent anecdotal information points to other groups that may be driving the epidemic and thus may require tailored prevention efforts. However, adequate information into risk behaviour, HIV prevalence and incidence in emerging groups such as migrants, prisoners, drug users and informal sex workers does not exist for planners to effectively make inferences regarding the extent to which each of the emerging groups impacts on the HIV spread.

There is a general consensus that the challenges with which these undefined key populations live and the way in which services are provided, place them at greater risk than defined key populations at higher risk. However, the exact nature of these challenges must be identified through further contextual research to better inform generalised prevention efforts.

(a) Informal sex workers

Sex work may be formal or informal. In some instances, sex work is only a temporary informal activity. Women and men who have occasional commercial sexual transactions or where sex is exchanged for food, shelter or protection (survival sex) would not consider themselves to be linked with formal sex work. Occasional sex work takes place where sex is exchanged for basic, short-term economic needs and this is less likely to be a formal, full-time occupation. Commercial sex work may be conducted in formally organised settings from sites such as brothels, nightclubs, and massage parlours; or more informally by commercial sex workers who are street-based or self-employed. The context in which the transactions occur has implications for accessing those at risk and for information on behaviour change programmes.

In the 2007 Males Lifestyle Survey, 15% of males reported exchanging sexual acts for money, drugs or gifts compared to 11% in 2005. The 2005 rate for females was 7% (no comparison for 2007 for females). Focus group discussions further revealed that this trend is under-reported in particular in females.

In light of this increasing trend, it is important for programmers to better characterise the target groups who tend to have higher numbers of multiple and casual partners for the purpose of sex exchange so as to appropriately design interventions that can promote safe practices, reduce multiple partners and create and sustain behaviours and attitudes that provide other alternatives to income generation. Therefore, it is necessary to identify the age groups most likely to request gifts etc for sex, the key factors that drive this behaviour and define the indicators that can classify informal sex-work since they do not self-identify.

(b) Migrants

These include non-Barbadians comprising sex workers (SW), petty vendors, hustlers, informal commercial petty traders, agricultural, construction and tourism workers. As irregular migrants, Kempadoo (2004) and Adomakoh (2007) found that sex workers were often exploited and subjected to violence and abuse at the hand of their pimps as well as clients, and in certain cases there were un-documented reports of exploitation by figures in authority as well. Migrants experience greater obstacles in accessing care and support if they are living with HIV. The circumstances of movement (e.g. whether voluntary or involuntary, whether legal or "clandestine") directly affect the potential risk of HIV infection for migrants.

> "*Of note in the region is the fact that the major migration streams (into the region, within it, and away from it) are increasingly dominated by females, a feature that differs significantly from historical patterns of Caribbean migration. The predominance of one sex in a migration stream indicates that immigrants are not moving with spouses or families. This presents opportunities for high risk behaviours, such as multiple sexual partners, the likelihood of engaging in or purchasing commercial sex, and increased use of alcohol and drugs, the abuse of which can impair judgment and free up inhibitions that otherwise might offer protection from undue HIV risk*." (**The Caribbean Regional Strategic Framework for HIV/AIDS 2002 to 2006**)

Migrant workers that move about under CSME rules are more likely to have access to medication, service and formal workplace support. Such regular migrant workers are likely to be targeted through the preventions efforts focused on population groups according to the behaviour and lifestyle demographics that they display. However, the role that irregular migrants play in fuelling the epidemic is not clear, as this group is usually hidden from authorities and hard to reach. Therefore, before any comprehensive efforts can be initiated more information must be gathered.

(c) Drug users

The users of mind altering substances (from excessive alcohol intake to hard drugs) are extremely vulnerable to engaging in actions that expose them to HIV. Recognising the link between substance abuse and HIV, there is need to increase vigilance and surveillance of the use of illegal drugs including intravenous drug abuse and monitor the drug abuse patterns of young people. The National Council on Substance Abuse has already begun to conduct research into this area with the launch of its March 2005 report entitled "Report on the relationship between drug use and sexual behaviour".

(d) Persons with Disabilities (PWD)[7]

PWD have wide ranging abilities and can be found in every strata of society. Stakeholder views state that these groups should be integrated into the development of policies, plans,

[7] PWD include persons with physical and intellectual impairment as well as learning challenges and comprise 5% of the population and therefore they have the same rights as any other citizen.

programmes and the provision of services in the country. Factors that increase the vulnerability of PWD to HIV are essentially the same as those that affect persons without disabilities.

Surveillance Gaps

In the past, impact mitigation programme priorities focused on preventing the loss of lives due to AIDS and, therefore, surveillance efforts were not cost-effective, mainly paper based and centred on reducing AIDS cases and deaths. Basic surveillance was able to provide information required to track first level improvements in treatments and to estimate national prevalence and incidence rates including future projections.

Due in part to lack of trend data for identifying and addressing sub-groups and subsequent sub-epidemics, targeted approaches directed at women and men have not been developed.

The implementation of a fully functional third generation surveillance system is fragmented and under-resourced particularly with regards to routine laboratory and clinical surveillance of cases. There are general population behavioural surveys undertaken at 1 to 2 year intervals. However, sentinel surveillance in the most at risk groups is almost non-existent. Sero-prevalence surveys have not been undertaken in Barbados and this is currently undergoing an ethical review and policy analysis. As such, characterisation of the epidemic within population sub groups is not comprehensively undertaken.

Mixed epidemics, as in Barbados, in which infection is driven both by HIV-vulnerable groups and the general population to different extents and for different reasons require a careful balance of the distribution of effort and investment between targeted and general population. This balance must be determined by assessment of local transmission patterns, underlying drivers of behaviour and sources of infection which will enable closer matching of appropriate interventions for specific high risk target groups.

Contextual and regulatory factors fuelling the HIV epidemic

Political, economical, socio-cultural, behavioural and bio-medical determinants fuel transmission of HIV in Barbados to varying extents. The proximate determinants such as partner turnover rates, sexual mixing, concurrency of sexual contact and biological determinants such as exposure to infected, viral load of the infected and type of risky sex are directly linked to HIV transmission. Meanwhile the contextual or regulatory factors such as existing HIV prevalence, poverty and unmet needs, stigma, health service coverage, effects of current interventions, the cultural milieu are contextual issues that seemingly underlie the behavioural and biological factors that contribute to HIV spread. These are summarised in the Table 3 on the next page.

Table 3: Contextual and Regulatory Factor fuelling the HIV Epidemic

Economic and development determinants	Social, Cultural and Behavioural determinants[8]	Legal and Political environment
1. Unmet Needs which can result in informal and commercial sex work 2. Unemployment - leading to unmet needs and unequal income distribution, and dependencies on the more economically able 3. Lack of skills and poor socialisation in lower SES leading to unstable employment; and 4. *Labour Migration including sex work that ensues in those that are unable to find secure employment in their local environment.*	Evidence of cultural beliefs attitudes and practices that drive HIV risk behaviour are anecdotal and to a limited degree are supported by survey findings[9], however this area required more in-depth analyses. Drivers include; 1. Cultural and religious taboos such as the avoidance of discussions on sexual relations, needs and experiences 2. Discrimination and stigmatisation against PLHIV from pre-existing cultural attitudes that isolate those with alternative lifestyles - young sexually active females, teenage mothers and MSM (MSM PLHIV 8% reported raped and 11% were sexually abused as a child) 3. Stigma that also exists as a result of fear of contracting HIV, as myths regarding modes of transmission are perpetuated in a small proportion of the population and is more pronounced within specific employment sectors. 4. Culturally driven promotion of multiple partners (the *village Ram* mindset) as Masculinity and manhood being defined and associated with high sexual desire, frequent sexual activity; having multiple partners is widely tolerated and that men should have more sexual experience and dominate in sexual relationships with women; 5. Unequal power balance between men and women including the existence of unreported sexual assault (approx 20% of females with HIV reported being sexually abused and 18% were physically assaulted, 13% lived in abusive homes) 6. The practice of irregular or infrequent health seeking behaviour among men; 7. Inability and lack of skills among women to satisfactorily negotiate sexual relationships and safe sex practices; 8. Condom stigma, insufficient condom use the negative ideas and taboos about their use and decreased sexual pleasure; 9. Reduction in the age of first sex and the emergence of the young females in sexual expression, sex for favours and combined with inconsistent condom use	1. Lack of access to reproductive health services by key populations e.g. males and females under 18 years without parental approval; 2. Absence of institutional policies (or failure to enforce existing ones) within small and medium sized firms and the informal sector that recognise the rights of HIV positive workers 3. The absence of a rights-based approach to reproductive health. 4. Stigmatising and discriminatory laws (criminalisation) of sex work and buggery

[8] Key findings of the Adults Sexual Behaviour Study, 2004-2005

[9] From HASSUS study 2002 to 2005 on PLHIV – 1.stigma 2. sexual practices of PLHIV

SECTION 4: THE BARBADOS RESPONSE – NAP 2001-2006

Achievements of the NAP 2001-2006

The achievements and progress made in the NAP are buoyed by the continuing commitment at the highest political level in the GOB. Within the Public Sector, there are 18 Government Ministries with 50% of them having a functional HIV core group and each Ministry having an annual Action Plan for which they receive financing as part of the annual budgetary process.

The GOB has also fully supported and empowered the NHAC and its Secretariat to initiate and develop programmes, coordinate and manage activities, monitor and evaluate the contribution of other agencies.

In short, the principal short-term objectives of the 2001-2006 NAP have been achieved as demonstrated by:

- Stabilisation of incidence at 0.1%;
- Reduction in the recorded deaths from AIDS-related causes by 75% between 2001 and 2005;
- A significant reduction in the mother to child transmission of HIV – from 34.9% (1990-1995) to 5.8% (1996-2000) to 3.3% (2000-2006);
- Decentralisation of care from the QEH to outpatient settings and the community; and
- Significant improvement in the quality of life of PLHIV.

A more detailed review of the achievements is presented below under the following headings:

1. Programme management and institutional performance
2. Prevention and control of HIV transmission
3. Diagnosis, treatment, care and support
4. Monitoring and Evaluation
5. Stakeholder Engagement

1. Programme Management and Institutional Performance

The NHAC has successfully mobilised the line Ministries of Government to mainstream HIV/AIDS in the Public Sector; engaged a range of stakeholders; brokered a model partnership with the Trade Unions; and redoubled its efforts to mobilise the private sector into tangible and meaningful action.

The NHAC has demonstrated success in the following areas:

- Establishing the NAP as a national priority;
- Facilitating capacity building, providing technical assistance and creating linkages between institutions and organisations in the prevention and control of HIV/AIDS;
- Engaging and encouraging faith-based organisations and religious groups to stamp their perspective on HIV messages;

- Spearheading of two innovative programmes namely the Champions Programme and the Speak Sister Campaign.

2. Prevention and control of HIV transmission

Significant achievements in the area of prevention include:

- Increased public awareness and knowledge about HIV/AIDS through ongoing IEC campaigns;
- Involvement of key line Ministries in the design and implementation of prevention and control activities;
- A trend towards declining incidence;
- A high degree of acceptance by pregnant women (>95%) to volunteer for HIV testing (approximately 3,000 pregnant women are screened for HIV per year and an average of 36 persons are HIV positive);
- A successful prevention of MTCT programme with a reduction in the mother to child transmission of HIV after Zidovudine therapy (27.1% to 5.5%)[10]. Statistics from the Paediatric department at the QEH reveal that prior to the Zidovudine protocol, the rate of MTCT of HIV in Barbados was 34.9% (1990-1995). This subsequently fell to 5.8% (1996-2000) after the introduction of the Zidovudine protocol and has further fallen to 3.1% (2004) subsequent to the availability of HAART at the national level.
- Expansion and strengthening of VCT services with the number of permanent VCT sites increasing from eight (8) to eleven (11) sites resulting in more persons becoming aware of their HIV status. The proportion of females tested exceeds that of males. In 2005, approximately 24,465 tests for HIV were conducted at community events, in routine testing, for the blood bank and for US immigration purposes;
- Increase in condom use;
- Increase in numbers who delay early age of first sexual encounter;
- An HIV-free blood supply has been maintained since 1985 when HIV screening of blood for transfusion was introduced. There have been no reported cases of HIV infection through blood transfusions.

3. Diagnosis, Treatment, Care and Support

There have been dramatic improvements in the programme for the treatment, care and support of PLHIV. Improvements have been gained by meeting their clinical and emotional needs, reducing opportunistic infections, reducing work disability, and improving their quality of life and life expectancy. Through treatment PLHIV are living longer and more productive lives.

The establishment of the LRU and the introduction of the fully subsidised HAART programme in 2002 resulted in the provision of comprehensive high quality care to meet the needs of PLHIV at all stages of the disease process. In the LRU, medical interventions focus on disease management and the HAART; VCT, supportive counselling and counselling to

[10] St. John MA, Kumar A, Cave CT. Reduction in perinatal transmission and mortality from human immunodeficiency virus after intervention with zidovudine in Barbados. Pediatric. Infect. Dis. J 2003; 22:422-5

promote adherence to ART medications; nutritional services; in-house pharmacy services and community outreach and domiciliary care activities.

Fully subsidised Anti-Retroviral Therapy was introduced in 2002 and is provided free of charge to Barbadians who qualify through the public health system. The satellite pharmacy of the Barbados Drug Service (BDS) which operates out of the LRU for PLHIV, facilitates swift dispensing practices, monitors patient adherence, disseminates patient information and permits better tracking as well as accountability within the pharmacy service. A high level of client adherence to medication regime has been achieved - 95% adherence in 80% of the patients (Adomakoh, et al, 2003).

The ARV drugs are procured by the Barbados Drug Service (BDS) and through the BDS, the GOB has advocated for and worked with drug manufacturers and suppliers for reduced prices of ARV drugs, resulting in the reduction of the triple therapy regime from US $4,500 - $9,500 per year to US $1,000 per patient per year.

Preventing secondary transmission of HIV from diagnosed PLHIV through psychosocial support must form a key focus area of treatment and care interventions of the NSP, 2007 to 2012 in order to ensure greater returns on treatment and care investments. Scaling up BCC, psycho-social support and personal development (including building skills) of PLHIV can be the cornerstone of the strategy for alleviating situations of mental stress, poor coping skills, poverty and economic dependencies that are likely to promote risky sexual practices.

Since the successful scaling up of treatment and care, prevalence rates are on the rise as a consequence of a combination of successfully increasing life expectancy of PLHIV receiving ARV therapy and new cases of HIV in the context of reducing incidence. This trend provides a strong impetus to ensure that treatment resulting in increased lifespan of PLHIV is perfectly balanced with prevention of new cases of HIV.

From Dying to Living - Success in HIV to AIDS Survival and AIDS to Death

Issues	Successful Outcomes
Deaths	**Reduced by 75% between 2001 and 2005 – supported by** • **key stakeholders and by cost-effective studies of the NAP;** • **the introduction of HAART, care and support services delivered through the centralised clinic services at the LRU;** • **increased availability of drugs to private sector patients.**
Median Survival Rates	• **A steady increase with 81% of those enrolled between 2002 and 2006 still alive by the end of 2006.** • **One year AIDS survival has risen from 65% in 2000 to 95% by the end of 2006. By the end of 2006, 65% of those diagnosed with AIDS over the years are still alive.**

Community-based services and home care

Community-based services for PLHIV have become more accessible and uptake has improved. Homelessness among PLHIV continues to be addressed through the establishment of the Elroy Phillips Centre which accommodates ten (10) residents and is manned by ten (10) staff members headed by a Supervisor.

4. Monitoring and Evaluation and Research

Since 2001, outcomes studies in the form of surveys and economic and clinical evaluations have been conducted and reported in the areas of:

1. Adult and youth Sexual practices
2. Survival
3. Cost effectiveness of PMTCT
4. Cost and sustainability aspects of treatment in the HAART era
5. The contextual causes and consequences of HIV stigma and discrimination
6. Male social and health needs assessment – lifestyle survey
7. Impact of HIV on PLHIV including QoL, unmet needs and coping.
8. STI prevalence
9. Epidemiological models

5. Stakeholders Involvement

Trade Unions and the NAP

In 2001, the BWU spearheaded the development of a tripartite policy on HIV/AIDS and other life threatening illnesses in the workplace among government, trade unions and the private sector. This document was approved by Cabinet and the Social Partners. The Unions continue to work closely with the private sector, the Barbados Chamber of Commerce and Industry (BCCI), the Barbados Employers Confederation (BEC), the ILO/US Department of Labour HIV Workplace Education Project and the AIDS Foundation of Barbados (AFOB) to address the private sector response to HIV.

Established partnerships between the Trade Unions, the private sector and several government Ministries are outlined in Appendix 2. Despite widespread dissemination of the Social Partnership Policy Document, the policy environment across both public and private sector agencies now needs to move to a stage where it can be described as enabling.

In summary, there can be no doubt that the NAP 2001-2006 has been a major success. With the following strategic initiatives at the macro level converging with specific targeted initiatives outlined earlier, it has enabled meaningful progress towards noteworthy achievements for Barbados:

- The appointment of a Project Coordinator for a proposed stigma and discrimination unit.

- National public debates between key stakeholders on legal, ethical, socio-economic issues relevant to HIV to stimulate discussion in order to effect change in social norms, related to stigma and discrimination.
- Development of a policy document inclusive of advocacy components to reduce HIV incidence within a human rights framework.
- The allocation of an Entrepreneurship fund of BDS $1m for start up to support micro-enterprises for PLHIV.
- A National campaign highlighting the public health and human rights issues surrounding access to employment, shelter, education and health for positive persons.

GAP ANALYSIS AND RESOURCE NEEDS

Notwithstanding these achievements, the NHAC has been faced with challenges associated with sustainability of these achievements. On one level, the bigger question confronting Barbados must be whether the institutional arrangements currently in place can prevent re-emergence of the epidemic to pre-programme levels.

Issues and challenges which need to be addressed include:

- Sustainable financing channels;
- Scale up of the M&E, operations research and impact assessment that commenced in 2002 to further meet the growing demands of an expanded response
- Coordination and support for Ministries, the private sector and NGOs to work more cohesively and in genuine partnership;
- The uneven progress across collaborating institutions;
- Effective and comprehensive participation of civil society in leading the response
- Scaling up prevention including reducing incidence in those over 25 years;
- The lack of significant demonstrable change in attitudes and behaviour among vulnerable groups which has resulted from an insufficient translation of knowledge into sustained behaviour change.

The NAP 2008-2013 must be informed by the gap analysis and resource needs identified through careful scrutiny of the NAP 2001-2006 and its outcomes.

SUMMARY OF EVIDENCE AND RECOMMENDATIONS FOR ACTION

COMPETENCIES NEEDED FOR NAP 2008-2013

NHAC

The National Strategic Plan for HIV/AIDS, 2007–2012 identifies the NHAC as the agency that will not only articulate the national strategies, but will also coordinate, manage and sustain those strategies. This means that the NHAC must manage the changing environment while ensuring stability.

This mandate necessitates the consolidation of existing competencies and acquisition of new competencies and skills. Some of the new competencies identified after examination of the organisational structure and job descriptions can be seen in the box on the following page. For a more complete description, please see Appendix 3.

New Competencies for the National HIV/AIDS Commission

- Donor Coordination
  - Harmonised donor input
  - Alignment of Reporting
  - Ensuring accountability
- Risk Management
  - Managing Organisation Image
  - The need for detail in the absence of data
- Change Management
  - Desire to be innovative and flexible

Table 4 summarises the current status of available evidence as a result of the situation and response analyses with regards to HIV and related behavioural, attitudinal and socio-cultural trends in known key populations.

To implement activities during the strategic plan period 2008-2013, a scaled, two-tiered strategic response will be adopted. This response will consist of:

Tier 1:- Years 1 and 2

(A) Implementing a strategy which will comprise a prioritised list of the gaps and information needs as well as a decision-support strategy and actions focused on information gathering and designed to build up a further evidence base as part of the response strategy.

(B) Designing programmes that are informed by existing evidence and stakeholder interviews as documented in this NSP.

Tier 2 Years 3 to 5 - having identified priority issues and groups develop:

(a) A list of the identified issues, proposed strategies, targets and timelines for the years 3 to 5 and

(b) Evaluate the existing year 1 and 2 strategies and re-programme where indicated.

Table 4: Summary of Evidence and Recommendations for Action

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
1. Information • Weak surveillance due to insufficient capacity. This results in an inability to effectively plan, monitor and evaluate of interventions • Requires strengthening of: – data collection and disseminatio n policies; – skills building; and – financial resources for retaining skilled staff. • Weak M&E due	• Surveillance gaps on transmission risk factors, laboratory and resistance monitoring • No sero-prevalence undertaken	• Low number of KAPB surveys of most at risk groups e.g. sex workers, MSM, adults with multiple partners (including unidentified informal sex workers, migrants).	• Inconsistency in the production of clinical audits for public dissemination. • Gaps in M&E skills within NGOs , community groups etc • Limited funding for operational research. • Inconsistent information flows.	**Tier 1:** Strengthen surveillance to third generation processes involving comprehensive behavioural surveillance and clinical and lab. monitoring Improve the national HIV/AIDS and STI information management system and implement reporting policies and procedures at all relevant agencies under national mandates including national emergencies. **Tier 1:** Scale up focus from PLHIV outcome monitoring to M&E skills required for planning and evaluating BCC programmes **Tier 1:** Conduct M&E needs assessment **Tiers 1 and 2:** Build M&E capacity in Gov't partners and CSOs **Tiers 1 and 2:** Scale up Operations research and formative assessment to:	• Surveillance systems which act as early warning systems must be able to: – detect, identify and characterise the extent of HIV prevalence in key populations perceived to be most at risk; and – identify transmission dynamics within these groups and mixing patterns and bridging gaps between those at risk and the general population. • Comprehensive third generation surveillance should enable the NAP to be more responsive to changing epidemic patterns that may arise from ongoing programme interventions and structural factors

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
to lack of skills and underdeveloped systems: – Standardised and routine reporting; – M&E training to build skills and develop M&E culture				• improve existing BCC programmes; and • design appropriate BCC interventions	(key determinants).
2. Gender: Feminisation of the epidemic and inadequate behaviour change in females over 25 years of age.	• In 2006, surveillance data showed that 50% of new cases were females. • Incidence rates are higher in females than in males.	• In 2005, an increase in multiple partners among single females.		**Tier 1:** Update Adult Behavioural Survey to assess the extent of behaviour change in females compared to 2004 and 2005 surveys. **Tier 1:** Develop and pilot priority action plans from the Men's Lifestyle Study (2007) Emerging priorities: • Men's health promotion and social education • BCC within Relationships • Explore the nature and drivers of informal and transactional sex work	• Economic, social, cultural and religious beliefs and practices promote gender inequities and create different vulnerabilities in males and females. • Programmes must be tailored to identified needs and articulated drivers of vulnerabilities.

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
3a. BCC Interventions BCC prevention interventions are limited			• NGO involvement in prevention programmes is limited as a result of: – Insufficient capacity, financial and technical support and – Effective partnerships • Service distribution outside of urban areas is low	**Late Tier 1 and into Tier 2:** From research and evaluation results in Tier 1, scale up targeted training and capacity building in BCC prevention approaches for all participating civil society organisations. **Tier 1:** Strengthen partnerships, commitments and understanding between local agencies as well as international and regional units to promote skills sharing and technical assistance.	• Increased service distribution would permit individuals from one area to attend services in another area in order to "feel comfortable" about preserving their privacy. • Decentralising services though increased participation of NGOs and community organisations across all parishes would enable less costly roll out and coverage of services.
3b. Prevention BCC: • Increased condom use in youth. • Low rate of HIV testing in youth although they express a willingness to do so.	• A steady decline in the incidence of HIV in young girls under 24 years (since 2000 – based on antenatal tests) indicates reduced HIV transmission in	Surveys show: • Increased condom use between 2004 and 2007; • 80% of youth say that they would test if they could. • Pregnant women are tested through antenatal	• Reviews and focus groups of service delivery (HASSER) with staff highlight that staff unavailability, and existing polices on access for youth hinder the attendance of youth to the	**Tier 1:** A rapid need assessment should be undertaken on STI clinic attendees. The new comprehensive STI programme should be tailored to the findings. **Tier 1:** A testing campaign targeted at general population and identified vulnerable groups	

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
• No real reduction of partner turnover.	this group.	services (this rate can be improved if those in non-public health sector are recorded)	polyclinic services. • Surveys on stigma (HASSUS) show that young girls are stigmatised at the point of care. • HASSER revealed that use of non-Public health trained staff can result in reduced understanding of and response to needs of young STI clinic attendees.	using findings from: • Men's study (2007), • STI needs assessment, • Adult and youth KAP survey, focus groups and formative assessments. Priority groups include- • Youth • STI clinic attendees • Antenatal clinic attendees • Men • Self perceived low risk women Improve procurement practice and stocks for laboratory monitoring Introduce resistance monitoring	
4. HIV testing; clinical prevention Inadequate uptake of HIV testing services, STI testing and referral for HIV tests (through STI services) among vulnerable groups	Surveillance and epi-models show that more than one third of the population do not know that they are positive.	2005 KAP survey revealed: • 45% of males had ever taken a test. • The majority of tests were for pregnancy, insurance, immigration, sickness, or medicals. • Approx. 14% of those who tested did so because of high risk behaviour, or in	• Discussions revealed that there are gaps in provision of STI diagnostics in both private and public sectors (Chlamydia, HSV-2 HPV); • Technical skills are limited and • Resistance monitoring is not yet being done on all PLHIV.		Improving access to VCT to increase the early detection of HIV is paramount to controlling its spread and prolonging the lives of those who are HIV positive. An important and effective goal of any scaled up VCT programme should be to: • Reduce the number of simultaneous and delayed diagnoses of AIDS (within 12 months of HIV

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
		a new relationship. • Many people do no test for STIs unless they have symptoms. A 2003 Survey showed that of 15 to 19 years olds receiving routine antenatal STI screening tests, 56% were positive for an asymptomatic STI			diagnosis) and • Increase the amount of deferred diagnoses of AIDS (AIDS onset is more than on year after HIV diagnosis).
5a. Access to Health and Social services Poor health and social services-seeking practices by males (poorer in young males and females)		The 2007 Men's Study demonstrates that • Not many men (16.5%) have a physician that they visit and • Many (68.5%) feel that they only need to present for health checks when it is perceived that there is a serious problem • 15% never see a physician.	• Youth, in particular have little knowledge about their own sexual health	**Tier 1:** Recommendations from recent policy reviews and evaluation need to be acted upon to re-define policies that will increase access to health and social services by vulnerable groups. **Tier 1:** Developing BCC interventions with public as well as private health and social services providers to increase their leadership role in promoting a non-stigmatising community environment. Improving access to health and social services by youth, sex	Health awareness and promotion campaigns need to be better targeted to determine the reasons why males and females of different age groups do not present for health care checks and to gauge the setting that is most appropriate to their sexual health needs.

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
5b: HIV services Poor uptake of HIV services by HIV positive males due to either stigma of HIV and/or poor referral systems	Need to maintain or reduce hospital admission of PLHIV	Men's Survey (2007) revealed that • 25% of males would be comfortable at the AIDS clinic; • 28% would not be comfortable; • 17% do not know and • 28% do not know about the clinic	Interviews supported by HASSER survey revealed: • Insufficient number of staff operating between primary, secondary and tertiary care services. • Weak links between private physicians and public services in maintaining continuity of care	workers and irregular migrants Increasing condom distribution outlets and tailoring venues and costs to the specific and articulated requirement (including a willingness to pay) of vulnerable groups. Scaling up of condom distribution outlets in youth centres, hotels, bars, rum shops and other places where various risk groups congregate. Up-to-date information on male hospital admission is required. **Tiers 1 and 2:** To improve health seeking behaviour of youth, it is necessary not only to address prohibitive policies and enacted stigma, (mentioned above). Using the findings of a Youth Health Needs assessment to design and introduce youth friendly services for persons (single, married and sex workers) between 15 and 24 years e.g. • "hip" campaigns • Sensitisation of parents	A key step in seeking financial sustainability and an effective response for generations to come is to avoid un-necessary spending through wastage and inefficiencies by: • Preventing un-planned and preventable admissions; • Maximizing skills and human resources capacity to attain the ideal staff to patient ratio; and • Strengthening the response to care through improved and expanded referral networks as well as the provision of community-based care (out of hospital).
6. Condom use (MSM) Increased condom use in MSM, but stigma is still a problem and		• 2007 survey data compared with that of 2005 demonstrate a rise in condom use	• MSM will only see specific doctors and/or nurses. If these personnel are not available, MSM miss their		• The need to scale up anti-stigma programmes that focus on developing stigma-free service

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
hinders service accessibility			appointments, visits or referrals	• Inclusion and training of youth in service delivery (peer education, counselling etc) • Improving prevention services in schools, youth centres and family planning clinics • Scaling up training of parents and teachers for their involvement in life skills delivery as well as youth self-esteem programmes.	outlets and communities.
7. Condom use (Youth) Increased condom use in sexually active youth. An increase in multiple partners also on the rise. (The need to maintain condom use and HIV testing in this group.		• Youth survey data show that persons under 24 years continue to have more partners than those 25yrs and over. • 2006 survey data compared with 2005 survey data show an increase in condom use in this group. • An increase in condom use in MSM and in youth, but is not observed in females over 25 years.	• Discussions indicate that condom distribution for youth and MSM needs to be scaled up to enable access through outlets other than clinics and retail outlets.		• Policies to ensure that counselling, reproductive health services and HIV testing services are accessible especially to sexually active youth.
8. Sex work Increased commercial sex work but is not visible			• Interviews with coordinators of the Sex Worker Interventional study. • Programmers and researchers cannot assess needs adequately or educate sex workers because of stigmatising	• Identify specific practices and determinants of transactional sex work (persons who do not self -identify and have sex multiple long term partners, casual partners, visiting partners and/or one night stands).	• The need for a more enabling environment in which sex workers can feel free to come forward and be heard as well as assist in designing programmes that address their health and social needs.

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
			legislation		• In the absence of policy changes, novel approaches for recruiting and identifying sex workers in the study must be explored.
9. Young males Young males demonstrate a positive attitude towards marriage between 15 and 29years but after 29 years they are more likely to be averse to marriage and one partner relationships. Despite this feeling, males are having shorter and less regular relationships.		• Male survey (2007) reveals that 70% of males under 29 years think marriage is for them. • Compared with the 2005 survey, a significant proportion of males are reporting non-regular relationship (more causal and visiting partners).		**Tier 1:** Need to explore further and to identify the root causes of this shift in relationship preference in moving from the 2nd decade of life to the 3rd decade. Gender dynamics need to be explored in terms of the local situation and the impact of current trends. **Tier 1:** Implement pilot programmes which are based on key findings and evaluate the outcomes. **Tier 2:** Scale up BCC interventions which focus on developing and sustaining relationships between consenting couples.	• Interventions need to be tailored to underlying causes in order to give the desired effect. i.e. What is the root cause in the relationship dynamics between males and females that leads to males having shorter relationships or cause them to view their longer relationships differently?
10. CSME and HIV spread Existing knowledge gaps			• Stakeholder discussions and documents indicate	**Tier 1:** A study is required to map migrant workers (Sex workers, Agricultural workers, petty vendors, construction	In order for public health providers and private health insurers to plan

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
on the impact of CSME on HIV spread between Caribbean countries and the financing of care of HIV positive mobile workers. Gaps in knowledge of HIV in irregular migrants and appropriate disease control/health care access policies in this population			– A dearth of information about migrant workers – the envisaged impact of CSME on HIV spread through positive migrant workers (both regular and irregular).	workers, tourism workers, professionals in regional firms), and define their vulnerabilities so that community-based programmes that address their needs in an unthreatening manner can be developed. This would involve: – Surveys at street level by other involved migrant workers, and – Development of group solidarity to strengthen peer counselling interventions. **Tier 1:** Explore and pilot health and wellness screening programmes for migrant workers in partnership with private and public sector agencies **Tier 2:** Implement health package for migrants with assistance from local and regional public and private sector health insurance as well as health and social agencies.	for shared regional migrant health care programmes, an effective decision-support strategy needs to generate an evidence base that will determine: – The flow of migrants – HIV prevalence and KAP in mobile populations and – The impact of "open borders" HIV incidence rates.
11. Prisoners Gaps in knowledge of true point prevalence in prison population				**Tier 1:** Decision support strategy should seek to estimate the point prevalence of HIV in prisoners and to ensure that treatment and care is accessible by all who are positive.	• Former prisoners are highly mobile. • The potential for HIV transmission is high

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
Gaps in knowledge on follow up of rape cases.				**Tier 1:** Harm reduction strategies must be scaled up and human rights of prisoners upheld. Interventions for risk and harm reduction should include: • Expanded VCT • Easier access to prison health services • Providing recourse for action for rape victims and • Reviewing institutional and national policies that encourage inaccessibility to health protection services **Tier 2:** New services should be implemented and tailored to ensure that all programmes are available to former HIV positive prisoners as they reintegrate into the community.	• Tailored interventions need to be developed for this group both within prison and following re-entry into society.
12. Prevention and Impact mitigation through psycho-social support Services tailored to specific needs and sensitivities of vulnerable			• Members of vulnerable populations revealed (through specific focus groups) that confidentiality is a problem.	**Tier 1:** Data from existing, current and planned needs assessments of key vulnerable groups is required to develop a profile of social needs, service gaps and mental health issues.	

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
groups are insufficient.			• Responsiveness of follow up and referral is inadequate in that members of vulnerable populations often do not know where to go to gain long-term assistance, especially in situations where their needs are changing over time.	**Tier 1:** Training of staff to undertake their own needs assessment and to evaluate current services in partnership with external technical assistance **Tier 1:** Rapid evaluation of existing programmes in terms of service quality (appropriateness, accessibility, responsiveness, effectiveness, reliability), is urgently required for these to be appropriately scaled up. **Tier 2:** Programmes addressing underlying factors of alternative sexual orientation, poverty, and drug abuse which contribute to the risk profile of these individuals need to be considered so as to provide more effectively supportive and empowering environments.	
13. Window of Hope Lack of adequate comprehensive interventions in the ages between 5 and 15 years.				**Tier 1:** A secondary schools survey as a follow-up to the baseline survey is required. **Tier 1:** A needs assessment survey should be considered to explore the design and integration of youth development initiatives (such as self esteem building, visioning)	• Children between the ages of 5 and 14 years represent fewest HIV infections and cases of AIDS. • It is clear that this is the window period – the "Window of Hope"

Issue / problem	Level 1 Evidence base description	Level 2 Evidence base description	Level 3 Evidence base description	Priority Programme Actions	Comments and implications for programming
Description	**Epidemiological**	**Behavioural surveys**	**Other sources e.g. observations, stakeholder interviews, document reviews, etc.**		
				into BCC interventions. • In order to develop tailored programmes from needs assessment, parents of children under 15years across all socio-economic groups should be targeted to identify parenting struggles and support needs	whereby these children can be taught to protect themselves from HIV infection before they become sexually active. • Urgent action must be taken to invest in behaviour change and foundation building as their propensity for undertaking risky practices in the absence of appropriate teaching and communication will increase as the children reach ages 15 to 19 years.

Informing the Way Forward

Table 4 above provides key evidence on the dynamics HIV in Barbados. However, the evidence is fraught with gaps as a result of weak third generation surveillance systems. Recommendations for scaling up surveillance of HIV and AIDS have been presented.

In order to move into an era of sustainable responses and to meet the targets set for universal access to prevention, care, treatment and support services during the Plan period, the overall strategy must be prioritised, tailored to and guided by identified needs. ***Prioritisation must be based on the ability of the country to design effective solutions to address a defined need or problem.*** By knowing the dynamics (baseline or current) and issues which underpin HIV risk, realistic targets can be set and outcomes measured.

Further evidence was derived through document reviews and stakeholder interviews that were conducted as part of the situation and response analyses. These interviews highlight the qualitative aspects of operations and management of the programme, service quality (efficiency of services delivery) and policy issues. These findings will guide the policy framework, determine the intensity of scaling up interventions within the strategy and identify resource needs.

Limitations of resources and ineligibility for international funding assistance, dictate prioritisation among competing needs in the operationalisation of the National Strategic Plan 2008-2013. It is essential that resource allocation occur in a strategic manner taking into account programme strengths (HAART Programme), and weaknesses (poor surveillance, monitoring and evaluation) while capitalising on opportunities (strong prevention programme and BCC strategy) and neutralising threats (added costs of rising prevalence).

The National AIDS Programme will ensure that strategic decisions are made based on programme needs, the potential to effect change, capacity and skill levels and an adequate information base for sound decision-making. In a situation of limited external support, efforts must be made to build expertise and strengthen information flows to ensure that programme choices are made on the basis of real rather than perceived needs. These real needs are identified as follows:

- Strengthen surveillance to encompass third generation and special studies
- Develop a testing campaign targeting identified population sub-groups
- Adopt recommendations from policy reviews and evaluations,
- Improve health-seeking behaviour of young people, in particular males, and
- Develop a decision support strategy for estimating point prevalence and baselines.

Appendix 7 outlines the priority areas and proposed strategies that will underpin the six (6) Strategic Objectives that define this NSP 2008-2013.

SECTION 5: MONITORING AND EVALUATION

The NHAC recognises that effective monitoring and evaluation are critical for the success of the NSP for HIV and AIDS, 2008-2013 (see Appendix 6). The national M&E Framework and Operational Plan developed in 2005 and refined in 2007 will track the overall performance and impact of the NAP. All partners involved in the implementation of the NSP will be required to report on progress in their specific areas and receive feedback on the progress of the NAP within the framework set out by the national M&E system.

The goal of the M&E framework and system is to guide the collection, analysis, use and provision of information that enables tracking of progress made in response to HIV/AIDS and enhance decision making. The framework articulates the linkages, reporting relationship, indicators used at different levels to measure inputs, outputs, outcomes and impact of interventions.

The specific objectives of the M&E results framework which extend from the overall M&E system[11] are to:

1. Define a set of core indicators (based on the key programme areas defined in the NSP) for monitoring the status of the epidemic and tracking national progress in the most critical areas of the NAP for 2008 to 2013.
2. Provide an outline of the strategy for data collection; M&E instruments; and recommend additional instruments that may be required to improve the monitoring and evaluation of the NAP.
3. Provide guidance and parameters for reporting to national and international partners e.g. World Bank, UNAIDS.
4. Establish the value and importance of M&E in all HIV/AIDS interventions at all levels so that the efficiency and effectiveness of interventions can be documented and reported.
5. Guide the upgrade and operationalisation of the national HIV/AIDS data bank (within the NHAC) for tracking and reporting on activities of the NAP.

The Results Framework is a summary of the core indicators for all programme areas and these indicators will be used for monitoring and evaluating the NAP. It comprises the following three levels of interlinked indicators:

1. Indicators that will be used to measure the overall impact of the NSP.
2. Indicators that measure the effectiveness of programme outcomes (outcome indicators).
3. Indicators that measure key intermediate results and (key interventions) of all seven programme areas.

The measurement and evaluation process will be the key factor in determining the effectiveness of the approach implemented in the NAP 2008-2013.

[11] National Monitoring and Evaluation System for Barbados - Operations Manual and also the Results Framework 2007.

SECTION 6: COSTINGS

The cost of implementing the activities under the priority programme areas outlined in this Strategic Plan over the five year period 2008-2013 has been calculated at approximately BDS $180 million (US $90 million).

Table 5 below presents a breakdown of preliminary costs by year by the priority programme area:

Table 5: Preliminary cost by priority Programme Area by year

	Prevention	Treatment	Care & Support	Programme Mgmt & Institutional performance	Monitoring and Evaluation	TOTAL
2008-2009	4 958 117	10 258 574	2 796 735	4 961 560	688 472	23 663 458
2009-2010	5 679 519	15 432 861	3 340 233	5 666 533	728 311	30 847 457
2010-2011	6 816 543	19 291 076	4 175 299	5 991 260	813 471	37 087 649
2011-2012	7 497 298	21 267 411	4 801 585	6 188 982	978 472	40 733 748
2012-2013	8 246 808	26 584 264	5 281 744	6 541 401	1 013 471	47 667 688
TOTAL	33 198 285	92 834 186	20 395 596	29 349 736	4 222 197	**180 000 000**

SECTION 7: RESOURCE MOBILISATION

The Government of Barbados, in recognising the devastating developmental impact of HIV, continues to commit available resources to and to serve as the primary financier of the National AIDS Programme.

Barbados' classification by the World Bank as a high-income country makes it difficult for the National AIDS Programme to attract funding from external sources. For the first five years of the national multisectoral expanded response to the epidemic, secondary resource support for the National AIDS Programme was derived from the World Bank. This has been supplemented by UN agencies through the provision of small grants to support "one-off" projects.

Beyond seeking external funding support, the country needs to look at internal resource mobilisation beyond that provided by the Government. There is a need to mobilise private sector support and encourage increased self-sufficiency of CSOs/NGOs working in the field of HIV and AIDS. However, successful resource mobilisation within these two entities requires a move beyond the traditional thinking of the 'welfare-state' paradigm. It is, therefore, critical that in accordance with its mandate the National HIV/AIDS Commission plans and coordinates future resource mobilisation in a harmonised and comprehensive manner which will ensure programme sustainability.

The need to ensure sustainability can only be reinforced by the avoidance of wastage that arises as a result of **duplication**, **poor planning** and **fragmentation of resources**, i.e., the Programme will need to aim at reaching large numbers with the greatest impact in the most cost-effective manner.

It is this challenge to avoid wastage that the UNAIDS Three Ones principles are specifically designed to address. Built on lessons learned over the past two decades, the Three Ones have been designed to held improve the ability of donors and developing countries to work more effectively together, on a country-by-country basis.