GLOBAL AIDS RESPONSE PROGRESS REPORT Antigua and Barbuda

Reporting period: January 2012-December 2013 Submission date: 28th March 2014.

Table of content

GARPR Target

Indicators……

…….

1.17.5. Percentage of men who have sex with men with active syphilis……

1.17.6. Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months ……..

1.17.7. Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months ……

1.17.8. Number of men reported with gonorrhoea in the past 12 months …..

1.17.9. Number of men reported with urethral discharge in the past 12 months ……

1.17.10. Number of adults reported with genital ulcer disease in the past 12 months……

1.18 . Percentage of pregnant women with a positive syphilis serology whose sexual contacts were identified and treated for syphilis…….

D. Male circumcision……

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

A People who inject drugs ……

2.1. People who inject drugs: prevention programmes ……

2.2. People who inject drugs: condom use……

2.3. People who inject drugs: safe injecting practices ……..

2.4. HIV testing in people who inject drugs …….

2.5. HIV prevalence in people who inject drugs ……..

2.6. Opiate users…….

2.6a. Estimated number of opiate users injectors and non-injectors…….

2.6b. Number of people on opioid substitution therapy…….

2.7. NSP and OST sites……..

2.7a. Number of needle and syringe programme sites ……..

2.7b. Number of opioid substitution therapy (OST) sites……

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

1. Plan and conduct consultation with stakeholders on the 24th June, 2013.
2. Review and collate data for the period under review by the AIDS Secretariat- MOH, HIV Epidemiologist and Health Information Division.
3. Report writing by Mrs. Sonia Cochrane Joseph; Deputy AIDS Programme Manager with inputs from Ms. Delcora Williams, AIDS Programme Manager, Mr. Oswald Hannays, HIV Counsellor/Educator and Mr. Abel Blanco, Epidemiologist. Editing was done by Ms. Maria Pereira, Clinical Care Coordinator.

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

Information for the report was obtained from reviewing relevant documents, interviewing Stakeholders and convening a meeting with stakeholders at the Mount St. John Hospital conference room 24th June, 2013 and subsequently, December, 2013.

Acronyms

AUA	American University of antigua
ARC	Antigua Resilience Collective
ART	Antiretroviral Therapy
ARV	Antiretroviral
APM	AIDS Programme Manager
BCC	Behaviour change Communication
BSS	Behavioural Survey
CMO	Chief Medical Officer
CARICOM	Caribbean Community and Common market
CBMP	Caribbean Broadcasting Media Programming
CDC	Centre of Disease Control
CCC	Clinical Care Coordinator
CHRC	Caribbean Health Research Council
CBO	Community-based Organizations
CBMP	Caribbean Broadcasting Media Programming
CMO	Chief Medical Officer
CARICOM	Caribbean Community and Common Market
DAPM	Deputy AIDS Programme Manager
FBO	Faith-based Organization
FSW	Female Sex Worker
GARPR	Global AIDS Response Progress Report
HID	Health Information Division
HAART	Highly Active Antiretroviral Therapy
HFLE	Health and Family Life Education
IBBS	Integrated Bio-Behavioral survey
ILO	International Labour Organization
KAPB	Knowledge Attitude Practices and Behavior

MARP	Most at Risk Population
MOH	Medical Officer of Health
MoH	Ministry of Health
MOE	Ministry of Education
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
MSJMC	Mount St. John's Medical Centre
NAC	National AIDS Committee
NAP	National AIDS Programme
NGO	Non-Governmental Organisation
OVC	Orphans and Vulnerable Children
OECS	Organization of Eastern Caribbean States
PMTCT	Prevention of Mother to child Transmission
PITCT	Provider Initiated Testing and Counseling
PAHO	Pan American Health Organization
PITC	Provider Initiated Testing and Counseling
PANCAP	Pan Caribbean Partnership Against HIV and AIDS
PEP	Post exposure Prophilaxis
PAHO	Pan American Health Organization
PCP	Pneumocystis carinii pneumonia
PCR	Polymerase chain reaction
PEPFAR	President's Emergency Plan for AIDS Relief
UNDAF	United Nations Development assistance Framework
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WAR	Women against rape

Inclusiveness of stakeholders in the report writing process:

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

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

The MOH recognizes that the Global Response Progress Report reflected new targets. These undoubtedly places each country in a position to set ambitious national HIV & AIDS targets that will reflect the urgent need, to massively scale up HIV prevention, treatment, care and support and move as close as possible to the goal of universal access.

It further accepts the "Three Ones" principles as the appropriate organizational framework for scaling up access to services. These principles aim to achieve the most effective and efficient use of resources and greater harmonization and coordination of the national response through:

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

Government is firmly committed to the Caribbean Cooperation in Health (CCH) as established by the Heads of Government/CARICOM Secretariat and the implementation of the regional health framework for HIV and AIDS through the joint regional actions of PANCAP. As such, the approach to HIV and AIDS intervention in the country; mirrors closely the health framework established in the PANCAP Caribbean Regional Strategic Framework (CRSF) on HIV and AIDS (2008 – 2012). Antigua & Barbuda has adapted the goals of the CRSF, its six priority areas along with their associated strategic objectives and expected results.

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

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

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

Status at a glance

The national response to the HIV epidemic in Antigua and Barbuda continues to be led by the Ministry of Health (MOH). The National AIDS Programme (NAP) remains the focal point for information geared to effecting behavioral change, health promotion and communication strategies. The NAP also continues to coordinate the treatment, care, provision of support, coordination of activities relating to HIV and AIDS and is still the focal point for the collection of and dissemination of most HIV and AIDS related data.

A total of thirty three (33) persons were diagnosed during the period January 2013 to December, 2013 based on data received from the Medical laboratory at MSJMC. Treatment and care has been changed from a public/private partnership to and singularly public oriented service. The Clinical Care Coordinator, a public employee heads the treatment and Care Team and operates within the Out Patient Department (OPD) from the lone public hospital, MSJMC, the lone public hospital.

During the period under review, the health department continues to utilise Voluntary Counselling and Testing (VCT) as an approach to HIV related counselling and testing. In the same time period there was an introduction and expansion of Provider Initiated Testing and Counselling (PITC) through which a wide cross section of personnel were trained in PITC. These included: nurses, doctors, security officers (police, army personnel, NGO, FBO, CBO personnel. Efforts were made to increase uptake of HIV testing, of Mother to Child Transmission free ARV treatment services and a vibrant Prevention (PMTCT), Behavioural Change Communication (BCC) interventions continue in collaboration with regional and local agencies. Collaboration also continues with NGOs to reach the members of the Most at Risk Population (MSM, SWs, transgenders, Youths at risk and persons experiencing domestic violence).

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

The mode of transmission anecdotally, appears to be through hetero-sexual route which makes HIV remain a major developmental challenge. Access to data with regards to the Most-at -Risk Population remains a challenge because persons are unwilling to be identified with that population when they seek care. As a result, there is under-reporting of MSM which may be due to fear of stigma and discrimination.

a. Policy and Programme Response

Antigua and Barbuda remains a signatory to, and compliant with the major international and regional conventions, protocols and agreements dictating the country's response to the HIV

and AIDS epidemic. The country continues to acknowledge the new 2011 Political Declaration on AIDS, which affirms the epidemic as a global emergency and one of the most daunting challenges to human existence and dignity. Further, HIV and AIDS remains a national and developmental issue, thus requiring the continued integration of HIV and AIDS policy and programmes into domestic improvement plans.

The Government subscribes fully to the Millennium Development Goal of fighting disease epidemics such as HIV and AIDS and the specific objective of: "having halted by 2015 and begun to reverse the spread of HIV and AIDS.

Further, the country is committed to meet the Targets and elimination commitments of 2011 UN Political Declaration on HIV and AIDS. To advance this mission, the AIDS Secretariat-Ministry of Health hosted a consultation to examine the achievements towards accomplishing the ten targets on the 24th of June, 2014. Participants came from agencies such as Government, FBO, CBO and NGO, who shared their achievements and constraints.

The MOH remains cognisant of the Global Response Progress Reporting minimal adjustments to targets. These undoubtedly place Antigua and Barbuda in an ambitious position to set achievable national HIV and AIDS targets. This will no doubt enable the country to maintain the scale up process in HIV prevention, treatment, care and support which has begun. Therefore, the realizations of universal access of care, treatment and support will be realised and the country continue to build on those achievements.

It further maintains the acceptance of the "Three Ones" principles as the appropriate organizational framework for scaling up access to services. These principles aim to achieve the most effective and efficient use of resources and greater harmonization and coordination of the national response through:

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

Government remains firmly committed to the Caribbean Cooperation in Health (CCH) as established by the Heads of Government/CARICOM Secretariat and the enactment of the regional health framework for HIV and AIDS by way of the shared regional actions of PANCAP. As a result, the approach to HIV and AIDS intervention in the country was adapted from the health agenda established in the PANCAP Caribbean Regional Strategic Framework (CRSF) on HIV and AIDS (2008 – 2012). This is reflective in the six priority areas along with their associated strategic objectives and expected results outlined in the country's NSP on HIV and AIDS.

Government continues to share the vision articulated by the PANCAP Model Condom Policy which protects 'the rights of all sexually active people in the Caribbean by creating an environment which enables them to acquire information and skills in relation to correct condom acquisition and use as an option to prevent the transmission of STIs, including HIV and undesirable pregnancies.

Recognising that the fulfilment of these objectives demands the involvement of a wide cross section of society, Antigua and Barbuda continues to work closely with Civil Society Organizations, inclusive of FBOs and government. Key stakeholders continue to play an important role in the implementation of HIV programming. This is evidenced by the involvement of relevant stakeholders in the consultative process for the preparation of this report thereby, fulfilling the requirement for a multi-sectoral approach to HIV Prevention and control interventions.

The methodology used in the preparation of this report involved a consultation, discussions with stakeholders and partners directly involved in the national response to AIDS as well as a review of relevant documents. The documents reviewed are attached as Annex 2 and the list of those who participated in the discussions are attached as Annex 3.

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

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

This commitment is evidenced by $135,000.00 CD, over one hundred percent (100%) increase budgetary allocation of subsistence for PLHIVs in the country. In addition, the government continues to play a pivotal role in the empowerment and utilization of the skilled individuals. Two of the individuals previously employed under the Global Fund project remains employed within the within the MOH, while one is retired. They continue to strengthen the capacity of the NAP, thereby improving the government's ability to address Human Rights issues relating to PLHIV and their dependents.

The country has seen a reduction in the number of persons testing positive for HIV infection. Anecdotally, this is thought to be as a result of increased awareness of HIV prevention strategies, collaborative partnership in the prevention efforts and the availability of free ARVs for PLHIV. However, the decrease in donor spending threatens the sustainability of this positive trend in the **HIV response in** Antigua and Barbuda.

During 2011, the National HIV in the Workplace Policy developed by the Labour Department with assistance from the Labour Department was developed with a multispectral approach. The final document has since been presented to Cabinet and is currently awaiting ratification. Provision has also been made by the government within the Office of the Ombudsman to address issues pertaining to workers' rights including those associated with HIV and AIDS.

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

A new National Strategic and Action Plan for HIV and AIDS sponsored by PANCAP with support from MOH was developed in 2011 to cover the period, 2012 to 2016. It focuses on the reduction of HIV infection and aims to decrease in the country. These are identified under the six priority areas outlined below.

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

It was intended to scale up services through strategies designed to achieve the following goals:

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

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

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

The NSP outlines and assigns efforts and resources for the establishment of a governance framework which is geared to ensure policy leadership through multi-sector efforts in order to promote universal access to HIV and AIDS services.

The main cause of HIV transmission remains unprotected sex; therefore much focus remains on prevention. Its main programmatic focus continues to be reduction of unprotected sex and recognizes abstinence as a solution.

The NSP reflects the objective of the Ministry of Health to assume programmatic responsibility for treatment and care of people living with HIV and AIDS in the general primary and secondary

health care services and recommends the gradually relinquishing of the intermediary role of the AIDS Secretariat in the provision of such treatment. The Clinical Care Coordinator continues to take lead role in this activity. Cross training of public and private health workers and staff of NGOs providing who provide HIV and AIDS services has intensified.

To direct the HIV prevention efforts, the Ministry of Health with assistance from HIV Project Unit UWI has formulated a draft HIV Prevention Plan in 2013. The plan examines strategies to be utilized in HIV prevention, responsible persons/organizations and financial allocation for prevention interventions.

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

The collaboration between these organisations continues to enhance the HIV and AIDS advocacy and prevention efforts. The Ministry of Health has collaborated in public-private partnership with different agencies. One such collaboration is between the Ministry of Health, PANCAP, Scotiabank and Caribbean Broadcast Media Partnership (CBMP) to organise Regional Testing Day annually. In 2013, the launch of Regional Testing Day was held in Antigua and Barbuda with partnership between AIDS Secretariat-MOH, Scotiabank and CBMP. Regional testing day became a success with persons accessing HIV testing and counselling over a day period.

III **National Response to the HIV and AIDS epidemic**

The national response to the HIV epidemic in Antigua and Barbuda constitutes a number of interventions. These interventions are targeted on a variety of foci which include vulnerable subgroups within the population. To accomplish this interventions are carried out in school, hospitals, clinics and in community groups' meeting places. See below varying interventions which are carried out and some of the sub-groups which are targeted for the services.

Prevention

Educational Programmes:

Population

Public education and awareness efforts continue to be a major prevention intervention in the spread of HIV infection. There have been intensive behavioural change communication campaigns and trainings facilitated by the NAP, the media, non-governmental organizations, community based organizations and other governmental bodies. Through these efforts the expansion of behavioural change communication across all sub-groups in the community inclusive of the MARPs were facilitated, security personnel and health care workers. During the

period under review, 2012 and 2013, the HIV prevention intervention efforts have targeted a number of strategic areas. These include: MSMs, SWs, in school youths, Youth on the block, men and women the workplace and migrants. In 2013, preparations were started to develop a teaching tool to aid Health and family Life (HFLE) teachers in primary school to deliver HIV related information to primary school children. Subsequently, a workshop was held with HFLE teachers to introduce them to the tool and get their feedback on the information and development process.

There have also been intensive efforts to reach the population of Barbuda with similar programmes as those rolled out in Antigua. In 2013, collaboration with the health care workers, the church, media, the Barbuda Council and the NAP was intensified.

In 2012 education sessions were facilitated by NAPS staff in schools, colleges, other government organizations and FBOs whilst thirty were conducted in 2013. This intervention was further enhanced by the increased capacity of the NAPS through the attendance of its staff to local, regional and international workshops and training sessions.

Staff involvement

In 2013 the staff of the AIDS Secretariat attended twenty-four training sessions and nineteen in 2011. These sessions have improved the capacity of the NAPs to carry out various intervention efforts into the prevention and control of HIV and AIDS. These included short courses on: Monitoring and evaluation, Stigma and Discrimination, Programme Planning, Filing, Leadership and Development.

Condoms Distribution

Condom distribution continues to be a main intervention utilized against the transmission of HIV and AIDS in Antigua and Barbuda. Condoms are issued daily from the NAP to the general population, while in partnership with NGOs and other organizations, condoms are issued to different subgroups within the wider population. Condoms remain available at community outreaches activities conducted by the NAP and other supporting agencies.

The National AIDS Programme (NAP) promotes correct condom use in order to reduce the incidence of HIV, morbidity, sick days and mortality among Persons living with HIV (PLHIVs). To accomplish this persistent condom use, a primary method to facilitate prevention is encouraged by the NAP in Antigua and Barbuda. This requires a sustained supply of male/female condoms and other prevention commodities. This has however been challenging during 2012 and still continues due to financial limitations which rendered the programme incapable of purchasing its own condoms. Most of the condoms distributed by the NAP during the past year were supplied by the Caribbean HIV and AIDS Alliance (CHAA), however; this is far from adequate due to the high demand for assistance to condom access.

Additionally, a number of partners in the HIV prevention intervention in the country exclusively depend on the NAP to maintain their access to condoms. These include; Community Groups, Barber Shops, Mass Bands, bars/clubs, Brothels and Support Groups PLHIV, Sex Workers and MSMs/Trans-genders. Due to the limited supply which was experienced throughout the year, the programme's ability to facilitate this has been impeded. This places the NAP at risk of being rendered incapable of maintaining its prevention effort through targeted distribution of condoms or even to maintain its stock for Office distributions. The AIDS Secretariat-Ministry of Health is therefore requesting the assistance of your organization to help enable our ability to ensure a sustained condom supply.

During the period under review, the NAP has also partnered with Scotiabank to aid in the sustainability of condom supply. However, the contributions from the institution are mainly aimed at ensuring a consistent supply of condom during Regional Testing Day and World AIDS DAY, during their involvement in collaboration with HIV prevention efforts.

Condoms were accessed by the NAP from Caribbean HIV and AIDS Alliance. In 2012 a total of 53,964 pieces of male and 1797 female condoms were issued from the AIDS Secretariat, while in 2013, 59,855 were issued. Condoms distributed are seen in Table: **below.**

Table : Condom Distribution by Type 2012-2013.

	M	F	TOTAL
2012			
2013	**53,855**	**1797**	**55,652**
TOTAL			

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

As seen in the figure 2, there has been a significant reduction in the number of condoms distributed. This reduction is primarily due to resource constraints and dependence on a reduced number of organizations for assistance with condom supply.

Voluntary Counselling and Testing (VCT)

Voluntary Counselling and Testing (VCT) services remain available free of cost at Eight (8) community health centres, the National AIDS Secretariat, Antigua Planned Parenthood, and laboratory of the public hospital in Antigua and Barbuda. By extension, HIV testing services can also be accessed at a cost from medical laboratories and some private physicians' offices. However, there is no certainty that counselling is done at such times. A total of males and females accessed HIV testing in 2012 and in 2013 males and females **(Table).**

Years	15-19		20-24		20-49	
	F	M	F	M	F	M
2012						
2013						

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

During the reporting period, no stock out of HIV Rapid Testing kits have been experienced in the country. Where there were pending shortages, kits were sourced either by the government or supporting local and regional partners.

Antigua and Barbuda continue to utilize the new HIV testing algorithm developed with assistance from CHRC. With the process of decentralization intensifying, increased efforts to train more health care workers in HIV Rapid testing continued throughout the reporting period. This led to more nurses, doctors and NGO partners being trained to perform Rapid Testing.

Efforts have also been intensified to train more persons in Provider Initiated Counselling and Testing (PICT). The most recent of which was 2013 when over eighty community health personnel were trained in PICT.

PMTCT

The PMTCT programme has achieved a 100% uptake of HIV testing services among pregnant women during the last two years (2012 -2014). Surveillance of HIV data from Antenatal Clinic and Maternity Ward continue to show increase in repeat pregnancies among HIV positive women. In addition, HIV-positive mothers are given free infants formula and discouraged from breast-feeding. However, in 203, one mother was tested too late in her pregnancy most likely due to the language barrier which resulted in her transmitting the HIV to her baby.

The total percentage of HIV positive pregnant women was % in 2012 compared to % in 2013 (See Table 4 below). This notable increase was due to high uptake of HIV testing among pregnant women. The higher incidence of HIV infection occurred in the 25 to 34 age group in both years.

Table 4: Pregnant women percentage HIV positive in Antigua and Barbuda, 2012-2013

	2012	2013

Age Group	Tested	HIV +	Tested	HIV +
<15				
15-24				
25-34				
35 +				
TOTAL				
HIV + Percent				

Source: ***Data accessed from Antenatal and Maternity Record MSJMC 2012/2013***

Antiretroviral therapy is given to all pregnant women from the time they are identified and those already on treatments continue their regimen. Infants born to HIV positive women continue to receive Post Exposure Prophylactic and Cotrimoxazole (Bactrim) (PEP) for six weeks after delivery.

All infants were followed-up by the PMTCT representative from the NAP and the Paediatrics clinic to help maintain adherence. A DNA PCR Dry Spot Specimen is collected from the infant six weeks after birth for HIV Testing and an HIV test is done at eighteen (18) months. If the infant is negative with both tests he/she is transferred for follow-up in the District clinic. If positive, the infant continues to be monitored by the paediatrician at the at MSJMC hospital.

Prevention with Positives

Disclosure

Disclosure of HIV status has been encouraged but often resisted by PLHIV. However, the country has observed that partners to whom clients disclosed their HIV statuses are more supportive of HIV positive clients in cases of discordant couples. It has also been observed that these partners are strongly involved in decision making regarding safer sex practices.

Treatment adherence advocacy has played a pivotal role in the prevention of ART resistance in Antigua and Barbuda. In an effort to aid in the achievement of success, one member of staff from the AIDS Secretariat is assigned to carry out the role of case manager at the CCC's office. As part of her duties, she performs adherence counselling for PLHIV in need of the service.

Sustained Condom Use is also encouraged among PLHIV and efforts are made to ensure that they have access to a sustainable supply of condoms. Access to ongoing HIV prevention and control education for PLHIV and their families were increased in 2013.

Workshops

PLHIV were also involved in trainings which are offered in Antigua and Barbuda. Some of these trainings include: BCC, VCT and IBBS research trainings.

Care givers manual

In 2013 a nutrition workshop for PLHIV and their caregivers was facilitated by the NAP-Ministry of health in collaboration with Pan American health Organization (PAHO). Out of that workshop, the request was made by participants for a tool to guide them in offering care to PLHIV. As a result an HIV caregiver's manual is currently being developed for Antigua and Barbuda.

Treatment Care and Support

HIV Care and Treatment remains centralised, however, the service is now completely publicly owned. The Clinical Care Coordinator (CCC) continues to head the Clinical Care Team and works in close collaboration with her clinical care team from the NAPs. During the period under review, a number of doctors were trained in HIV and AIDS management after three of them were assigned to the CCC's office for orientation. Efforts are being made to strengthen surveillance, monitoring and evaluation by the Health Information Division (HID) and programmatic effectiveness of the NAP.

Highly Active Antiretroviral Therapy (HAART) and treatment for opportunistic infection continue to be available from the public hospital pharmacy at no cost to PLHIVs. ARV drugs continue to be provided through PANCAP, under The Global Fund Round 9 Grant. Care and treatment services are provided free of cost regardless of the individuals' immigration status. Some specialist services remain available through the government funding on a needs basis.

Report from the Patient Monitoring System at Health Information Division (HID) indicates that in 2012, there were one hundred and eighty-nine (189) persons with advanced HIV infection and who had ART initiated. At the end of the period, one hundred and sixty three (163) persons were actually on ART. During that period, sixteen (16) persons died while hospitalized due to AIDS related illness, seven (7) persons were lost to follow up and three (3) were transferred out due to migration.

In 2012, there were two hundred and sixteen persons (216) with advanced HIV infection. Of that amount one hundred and eighty six (186) were on ART at the end of 2011. During the same period there were three (3) person deceased and twenty seven (27) persons were lost to follow up (See Table 3). In 2011 there was a slight increase in AIDS related illness cases due to the rise in

the prevalence of HIV. No studies have been done in Antigua and Barbuda during the period under review to determine the impact of the HIV intervention.

Community Outreaches:

Quarterly outreaches involving VCT, PICT, condom distribution and HIV prevention education continues. Strong emphasis has also been placed on Behaviour Change Communication and Sexual and Reproductive Health information during the period under review. Quarterly visits to the sister island of Barbuda by the NAP also included interventions involving HIV prevention education in primary and secondary schools, churches, Hanna Thomas Hospital and the office of the Barbuda Council. These outreaches are conducted with collaboration between the NAP, other governmental organizations, 3H Network, CHAA, HID, MOE and other Civil Society.

Free and confidential HIV counselling and testing are conducted at two locations during these outreach activities. Increased efforts are being made to get the Barbuda population more involved in the HIV prevention and control intervention while at the same time enabling them to take ownership of the HIV intervention in their island.

The NAP is also involved in community outreaches in collaboration with other NGO and governmental organization, 3H Network, CHAA and Health Information Division.

Civil Society Organisations such as CHAA, 3zH Network and ABHAN continue to engage in public education of MARPS. They also engage in prevention efforts usually in collaboration with the Ministry of Health and other NGOs in Antigua and Barbuda. The services and activities conducted by some of these organisations are displayed in Annex 2.

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B. GARPR Target Indicators

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

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

The information for this indicator is a KAPB Survey in six countries of the Organisation of Eastern Caribbean States (OECS) 2011, inclusive of Antigua and Barbuda. The findings of the survey indicate that 48.7% divided by sex male 54.3% and Female 45.7% of the

population aged 15-24 years identified the correct ways of preventing the sexual transmission of HIV and rejected major misconceptions.

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

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

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

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

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

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

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

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

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

The percentage of persons aged 15-24 Years who were infected with HIV in 2013 is 12.12% (4) and 15-49, 70% (23).

Table 1: The estimated projected population in the age group 15-49 years for 2013

AGE GROUP	2012-2013

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

a.

b. ***S***

ource: 2001 Census of Population and Housing

Based on the 2001 Census of Population and Housing, the projected estimated resident population for 2012 and 2013 was 65, 142 persons comprising the age group 15-49 years. This includes 23,018 males and 26,974 females. Of this total there are 6, 964 males and 7,666 females in the 15-24 age group (

For the period 2012-2013, there were twenty seven people testing positive for HIV.

Table 2: HIV Cumulative total 15-49 2013

Age Group	Male	Female	Not stated	Total
15-49	**1**	**1**	**0**	**2**
20-24	**2**	**0**	**0**	**2**
25-29	**2**	**4**	**0**	**6**
30-34	**3**	**2**	**0**	**5**
35- 39	**3**	**0**	**0**	**3**
40 - 44	**2**	**1**	**0**	**3**
45 - 49	**1**	**1**	**0**	**2**

Source: AIDS Secretariat HIV cumulative total

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

Antigua and Barbuda has not conducted any recent surveys with MARPs. The AIDS Secretariat currently targets female sex workers in the wider population. Since this BSS for MARPs has a five year life span, the previous data is resubmitted. To address this situation, the Ministry of Health (MOH) in 2011 made a request and received technical assistance from CHRC, CDC, and University of California San Francisco to conduct a survey to inform the NAP on strategies for prevention interventions with Sex Workers and Men who have sex with men.

Since then a number of meetings and activities have been conducted and a formative assessment has been completed, training has also begun in preparation for the survey. The training included an IBBS training and HIV Rapid Testing training for health care workers and NGOs.

In the interim, the NAP-MOH continues to partner with NGOs, and Civil Society to reach the population. See the summary of activities carried out by CHAA, one of the partners involved Tables 3.

Table 3 Number of most at risk population reached 2013.

Number of MARP reached with individual and of small group level HIV preventive interventions that are based on evidence and or meet the minimum standard required.

	Name	Disaggregation	Q9	Q10	Q11	Total Yr 3	% accomplished
	Total MARP	252	261	104	617	904	68
New	MSM	93	129	61	283	284	100
	SWs	154	124	39	317	533	57
	OVP	5	8	4	17	70	24
Other subgroups reached who are not in the target							
	AVP	0	2	0	2	-	-
1086	SW	55	88	38	181	332	55
332	OVP	110	135	43	288	94	0
	AVP						
Total	MSM	165	223	81	469	1086	43
Condom Distribution	Total	52,474	16,434	19,438	88,880	140,000	63
Sold	Distributed	52,474	16,434	19,972	88,880	140,000	63

	-	-	-	-	-	-	-

Source: CHAA Eastern Caribbean Community Project EC CAP lll March 2013-September, 2013

Table 4: The estimated projected population in the age group 15-49 years for 2013

Table 1: Estimate Resident Population 2010–2013 Antigua and Barbuda.

2010			
Age(1-5-Yr)	**Total**	**Male**	**Female**
TOTAL	**90,801**	**42,642**	**48,159**
0	**1,686**	**839**	**847**
1	**1,685**	**871**	**814**
2	**1,716**	**889**	**827**
3	**1,735**	**917**	**818**
4	**1,738**	**864**	**874**
5-9	**8,724**	**4,350**	**4,374**
10-14	**8,375**	**4.057**	**4,318**
15-19	**7,471**	**3,543**	**3,928**

20-24	**7,159**	**3,421**	**3,738**
25-29	**7,556**	**3,476**	**4,079**
30-34	**8,246**	**3,668**	**4,578**
35-39	**7,896**	**3,566**	**4,330**
40-44	**6,556**	**2,958**	**3,598**
45-49	**5,109**	**2,387**	**2,723**
50-54	**3,859**	**1,820**	**2,040**
55-59	**2,822**	**1,275**	**1,547**
60-64	**2,225**	**1,019**	**1,206**
65-69	**1,865**	**853**	**1,012**
70-74	**1,582**	**694**	**888**
75-79	**1,207**	**556**	**651**
80-84	**859**	**364**	**495**
85-89	**479**	**175**	**304**
90-94	**216**	**71**	**145**

Over 94	**35**	**9**	**26**

Source: National Statistic division-2001 Population and Housing Census

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

For the period 1st January, 2013 to the end of December 2013, the percentage of persons aged 15-24 years who were infected with HIV was 12.12 (4)

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

Data for this indicator are not available because of the challenges experienced with surveys in small at-risk populations and as outlined in the pilot BSS survey among MSM and FSW done in 2006. Currently, with the support of University of California and CDC, work is on-going among the FSWs sub population.

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

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

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

There are no official records containing information on the use of the health services by most-at risk populations as they are included in the general population with respect to health care services

and they will not necessarily identify themselves as part of that population when seeking care. Data for this indicator are not available

Indicators for men who have sex with men

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

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

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

Information on this indicator is not available.

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

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

Information on this indicator is not available.

2012 and 2013, 100% of the women accessing antenatal clinic were tested for syphilis. From the total number of women, three tested positive for syphilis. All women who tested positive for syphilis were treated.

Cases of syphilis among ANC clients in Antigua and Barbuda- 2013

Tested	Number	Positive	% Positive
Number		3	

% Treated	**100%**		

Source: Community Clinic STI Data-HID.

With regards to 1.17.4 and 1.17.5, no data is currently available

1.17.6 In total thirty four (34) persons tested positive for syphilis at the St. Johns Health Centre in 2013. However, there were no data on staging of the infection.

1.17.7 There was one reported case of Congenital Syphilis in 2013.

1.17.8 A total of six men were diagnosed with Gonorrhea in the last twelve months.

1.17.9 During 2013, forty men were diagnosed with urethral discharge at the St. Johns Health Centre

1.17.10 No clients were seen at the St. Johns Health Centre for urethral discharge.

1.18 No data is available for partners of women who test positive for syphilis and accessed treatment.

Table 4: Sexually transmitted infections diagnosed at the ST. Johns Health Centre.

Month	**Syphilis**		**Gonorrhea**		**Urethral discharge**	
Gender	M	F	M	F	M	F

January	2	5	3	0	1	0
February	1	1	0	0	5	0
March	0	1	1	0	3	0
April	0	2	1	0	5	0
May	2	1	0	0	3	0
June	0	3	0	0	2	0
July	0	1	0	0	2	0
August	1	4	0	0	4	0
September	1	2	0	0	2	0
October	1	3	0	0	4	0
November	1	1	1	0	2	0
December	0	1	0	0	7	0
Total	9	25	0	6	40	0

Source: St. John's Health Centre STI Clinic Record-2013

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

Antigua and Barbuda has no data on people who inject drugs because no BSS on injection drug users has ever been done in the country. Therefore no data is available for indicator 2.1 to 2. 5none of these indicators can be answered.

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

3.1 Percentage of HIV-positive pregnant women who receive anti-retro-virals to reduce the risk of mother-to-child transmission

PMTCT Services are provided in conjunction with antenatal, the CCC's office delivery services and the pediatrics' department at the MSJMC. The PMTCT services includes pre-test and post-test counselling, follow-up care for HIV positive pregnant women, antenatal care at high risk clinic, labour and delivery services and pediatrics care for baby after birth. Services also involve Triple therapy ARVs and Bactrim to the HIV-positive mother and their new-born (within 72 hours of birth) and the provision of DNA PCR for the infant one month to six weeks after delivery and surveillance of the family after their discharge from hospital.

During the period 2012 and 2013, eight health facilities, Antigua Planned Parenthood Association, Antenatal Clinic at Mount St. John's Medical Centre (MSJMC) and the Hannah Thomas hospital in Barbuda offered free Voluntary Counseling and Testing services. All pregnant women who test positive for HIV are placed on lifelong ART. Additionally when infants are born, they are also placed on prophylaxis ART and cotrimoxozole; however, breast feeding is not encouraged. Instead, they continue to be supplied with infant formula for the first six months of the baby's life.

3.1 No babies were tested HIV positive in 2012 while one (1) of the four babies born to HIV positive women in 2013, tested positive at six weeks.

3.2 All babies born to HIV positive women have access to a DNAPCR at six weeks of age, however only three (3) had the test done.

Insert Table here

3.4 In 2012, two (2) pregnant women tested positive for HIV during labour and in 2013, two were tested positive during pregnancy and one (1) was tested positive during the post-partum phase.

3.5 In 2012, two (2) pregnant women were informed of their positive HIV status and were informed of their HIV negative status during pregnancy. In 2013, two (2) were informed of their HIV positive status during pregnancy and one (1) during postpartum. During pregnancy one hundred and forty two(142) were informed of their HIV negative status and one hundred and forty two (142) during postpartum.

3.6 In 2012 the two (2) HIV positive women were assessed for ART eligibility and the three HIV positive pregnant women who tested positive for HIV during 2013 were assessed for ART eligibility.

3.7 Seventy five (75) percent of the babies born to HIV pregnant women were assessed for art eligibility.

3.9 All (4) babies born to HIV positive women received clotrimoxozole within two months of birth.

3.10 One baby born to an HIV positive woman in 2012 was breast fed and the other was given formula for six months. The three babies born to HIv positive women in 2013 all received formula for six months.

3.11 In 2012 women attended ANC and in 2013 eight hundred and sixty seven attended.

3.12 In 2012, two children were born to HIV positive women, one was tested negative for HIV in 2012 and one was tested positive for HIV in 2013.

3.13 There is currently no data available relating to injection drug use among pregnant women.

HIV Screening is carried out routinely for women attending antenatal clinics. Additionally, those who did not access an HIV test at ANC receive a test at maternity ward after admission for delivery of their baby. The table 7 below shows the percentage of HIV-positive persons attending antenatal clinics 2012- 2013.

Table **Cumulative HIV test among pregnant women, disaggregated by result and treatment 2012-2013**

PMTCT	**2012**	**2013**
No. of patients seen at ANC	1223	867
No. of women tested for HIV prior to delivery	381	119
No. of patients pre-test counselled for HIV in ANC	202	119
No. of women tested for HIV ANC	202	119
No. of women testing negative for HIV	217	86
No. women tested positive for HIV	4	3
Known HIV cases prior to pregnancy	3	1
No. of mothers on ART	1	3

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

Below in a table reflecting the amount of patients who have been counselled and tested at Maternity Ward at mount St John Medical Centre (See table 18).

Table 5: Number pregnant women tested for HIV at Antenatal and Maternity ward for the period 2012 – 2013.

PMTCT	2012	2013
No. of patients counselled for HIV at	No data available	243
HIV Negative		242
HIV Positive		1

Target 4.

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

The table below shows that in 2012, forty seven (47) persons tested positive for HIV in Antigua and Barbuda. These were dissagregated into twenty seven (27) males and twenty (20) females. Conversely, in 2013 the number of persons who test positive for HIV was thirty three (33), twenty three males and ten females. This indicates that in 2012, males constituted 57.4 % of the newly diagnosed HIV cases in Antigua and Barbuda, while females were 42.6%, showing that males were still being tested HIV positive more frequently than females, however, this lead was by a narrow margin.

On the other hand, in 2013, there were twenty three males who tested positive for HIV and ten females. This reflected a proportion of 70% males to 30% females showing a wider difference

between males and females. Overall, 62% of the persons who tested HIV positive in 2012 and 2013 were males.

This large difference may be the result of increased sensitization to increase early uptake of HIV tests targeting males in 2013. The intervention was necessary since few men were accessing HIV testing and were experiencing a higher morbidity and mortality rate that women.

Number of persons testing positive for HIV in Antigua and Barbuda 2012-2013

Sex/Years	2012	2013	Total
Male	27	23	50
Female	20	10	30
Total	47	33	80

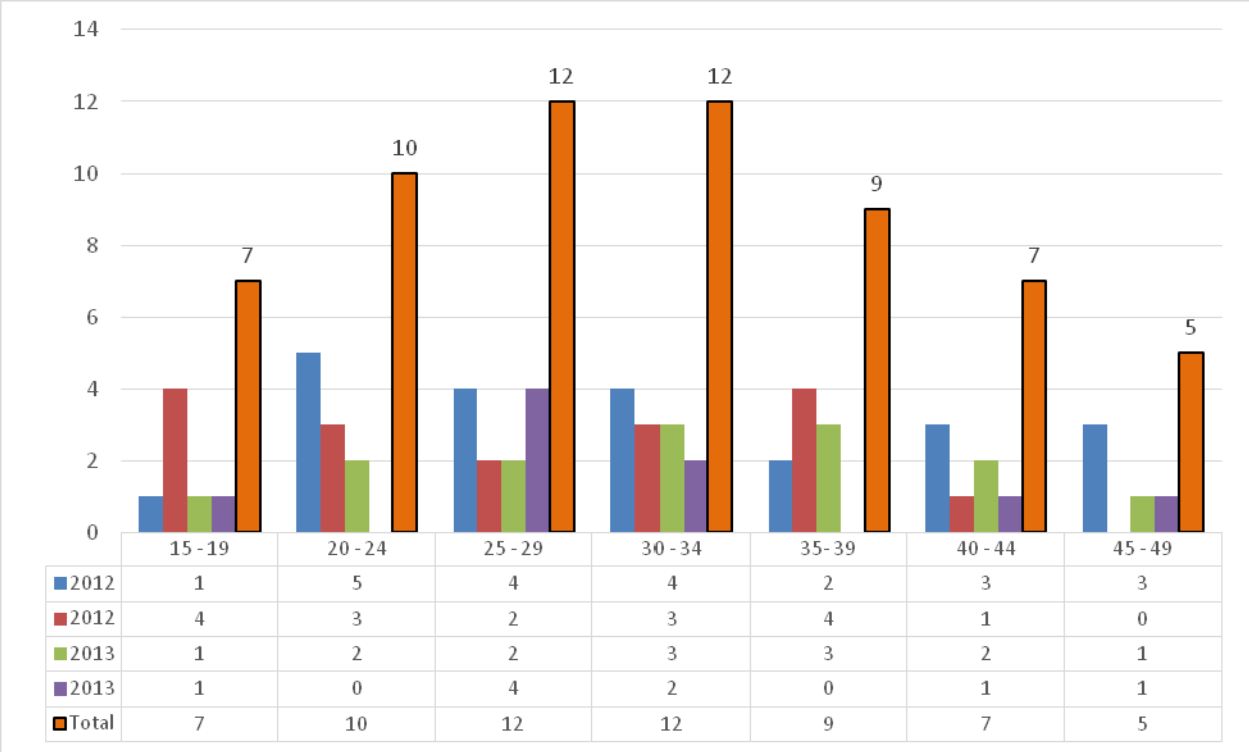
Source: AIDS Secretariat HIV Cumulative Data file

The Table below shows that there was a higher concentration of HIV positive cases in the 25-59 age group.

Table: HIV Positive Persons Diagnosed in Antigua and Barbuda Disaggregated by age and gender 2013.

AGE GROUP	MALE	FEMALE	NOT STATED	TOTAL
0 - 4	**0**	**0**	**0**	**0**
0 - 9	**0**	**0**	**0**	**0**
10 14	**0**	**0**	**0**	**0**
15 - 19	**1**	**1**	**0**	**2**
20 - 24	**2**	**0**	**0**	**2**
25 - 29	**2**	**4**	**0**	**6**
30 - 34	**3**	**2**	**0**	**5**
35- 39	**3**	**0**	**0**	**3**

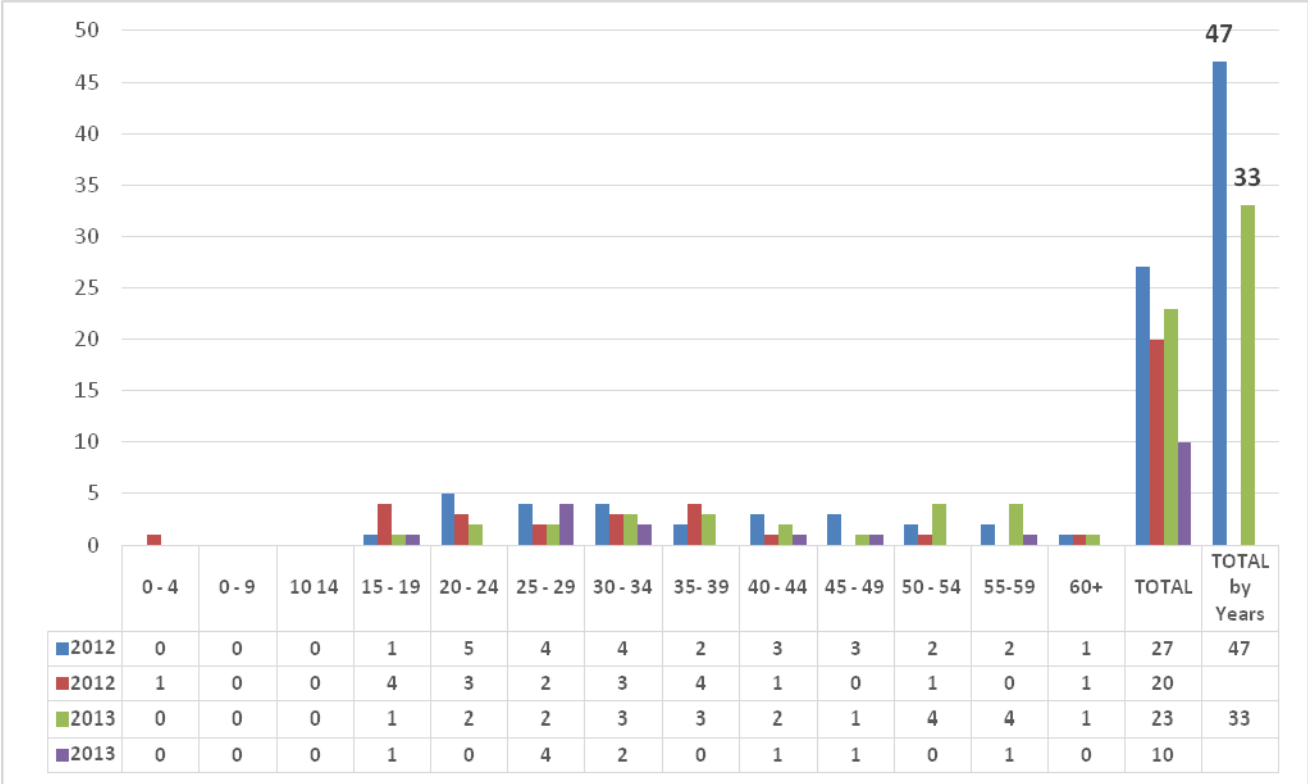
40 - 44	**2**	**1**	**0**	**3**
45 - 49	**1**	**1**	**0**	**2**
50 - 54	**4**	**0**	**0**	**4**
55-59	**4**	**1**	**0**	**5**
60+	**1**	**0**	**0**	**1**
Not Stated	**0**	**0**	**0**	**0**
TOTAL	**23**	**10**	**0**	**33**



	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49
2012	1	5	4	4	2	3	3
2012	4	3	2	3	4	1	0
2013	1	2	2	3	3	2	1
2013	1	0	4	2	0	1	1
Total	7	10	12	12	9	7	5

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

The analysis of figure 6 shows the trend in HIV/AIDS for 2012/2013. There was an aggregated total of 80 reported cases for the period under review.
A total of 58.7 % represents 2012 (47 cases) while 41.2% represents 2013 (33 cases) of the aggregated total for 2012/2013. Further, it was observed that the sexual behavior was a key determinant in the transmission for the 15-49 age groups. The comparison shows that males accounted for 62.5% of the aggregated total while females accounted for 37.5% of aggregate for the period 2012/2013.
Figure 6: HIV/AIDS Desegregate by Age and Sex 2012– 2013.



	0 - 4	0 - 9	10 14	15 - 19	20 - 24	25 - 29	30 - 34	35- 39	40 - 44	45 - 49	50 - 54	55-59	60+	TOTAL	TOTAL by Years
2012	0	0	0	1	5	4	4	2	3	3	2	2	1	27	47
2012	1	0	0	4	3	2	3	4	1	0	1	0	1	20	
2013	0	0	0	1	2	2	3	3	2	1	4	4	1	23	33
2013	0	0	0	1	0	4	2	0	1	1	0	1	0	10	

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

Most of the HIV positive cases were found in the 20 to 24 age group (8 cases) in 2012; in 2013 the age group with the highest infection rate was the 25 – 29 (6 cases). It was widely dispersed within several groups. Of much cause for concern is the increasing incidence in the older age groups which may be suggesting that these individuals maybe engaged in either unprotected or high risk sexual practices or might have been HIV positive over a number of years.

Percentage of eligible adults and children currently receiving antiretroviral therapy*

In Antigua and Barbuda ARV is offered to all HIV infected persons who meet the World Health Organization's criteria for initiation of ART. The Antigua and Barbuda Care and Treatment Guidelines dictates the ART treatment for HIV positive individuals in Antigua and Barbuda. These guidelines are developed based on international standards and were adapted from the Caribbean care and Treatment Guidelines.

4.1 The table below indicates that in 2012 persons accessed ART and were adhering to ARVs, while in 2013, persons accessed ART.

4.2a persons had a twelve month retention on ART treatment in 2012 and in 2013.

4.2b. % of persons were retained on treatment for the last twenty four months.

4.2c. % of persons were retained on ARV treatment for the last sixty months.

4.2.1 No data is available for HIV treatment uptake among drug users. Additionally, HIV positive individuals are not allowed to commence ARV if they are abusing controlled substances such as alcohol or marijuana.

4.3a and 4.3b All ARVs in Antigua and Barbuda are dispensed at the MSJMC Hospital.

4.4 There was no ART stock outs were experienced in 2012 or 2013. In cases of pending stock out of any ARV, it is sourced in another neighboring country before the stock out occurs.

4.5 % of persons had CD4 levels of <200 cells/ul in 2012 and % in 2013.

4.1The table above indicates that persons accessing and adhering to ARV therapy in 2012 and in 2013 . (Table 20).

	2012		2013	
Number of HIV + persons in care				
Advanced HIV				
Number adhering to ART				
No Lost to follow up				
Deaths				

4.6 In 2012 there persons who remained in care while in 2013 persons remained in care.

4.7a. % of persons on ART experienced viral load suppression during 2012 and % in 2013.

4.7b Two hundred and fifty five (255) persons were tested for Viral load in 2013.

4.7 c. % of persons experienced VL suppression in 2012 and % in 2013.

4.7d. % of people on ART tested for VL have achieved VL levels of < 1000 copies/ml after 12 months on ARV therapy.

Insert Table on ARV Coverage

Mortality among HIV positive persons

Table below show a total of twenty deaths () of which fifteen () are of the male sex and five () female, during the year 2012, in 2013 were a total of seven deaths (7) five (5) female and two (2) male, finishing with a percentage of the mortality rate at 0.02% in 2012 and 0.007% in 2013. (See the table 6). We note that the mortality is an increasing trend in general.

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

Antigua and Barbuda remains cognizant of the public health threat which Tuberculosis (TB) has become internationally. Therefore all HIV positive persons are sent for a TB assessment test upon admission to the clinic and thereafter annually.

5.1 During 2012 and 2013 four (4) HIV positive persons tested positive for TB and was treated.

In table below the number and percentage of HIV/TB cases compared to those diagnosed with HIV in 2012 and 2013 is represented. All TB clients and their contacts are screened and they are followed up by the department of the Medical Officer of Health (MOH) and the Nurse Epidemiologist**.**

Table 22: Incidence of TB cases PLHIV 2012- 2013

Distribution of TB CASES IN PEOPLE LIVING WITH HIV.ANTIGUA AND BARBUDA, 2010 – 2013.

	2012	2013
No.TB cases	**1**	**4**
HIV	**47**	**33**

cases		
%	**2.1**	**12.12**

Source: St Johns Health Centre TB Statistics

5.2 ot of percent of adults newly enrolled in HIV care were detected of having TB, while no children

5.3 100% of persons diagnosed with TB received isoniazid therapy.

5.4 % of adults and children enrolled in the CCC's clinic had their TB status assessed and recorded during their last clinic visit to the CCC's clinic.

AIDS related morbidity

The total hospitalization for 2013 was __ cases, with __ deaths resulting in __%. In 2012, __ persons were hospitalized, __ were lost to AIDS related illness with a percentage of __._%. Of this total _____( ) were males who were diagnosed with advanced HIV infection. The Ministry Of Health over the past two years have been focused its attention on strategies to target males with health educational messages. The expected outcome of this strategy is to reduce the negative health-seeking behavior of males (waiting until they are too ill before seeking health care) and increase access VCT services.

Figure 7: HIV/AIDS Mortality Rate 2012 - 2013 Antigua-Barbuda.

	No. Cases	Death		TOTAL	Mortality Rate
		F	M		
2012	47	5	15	20	0.02%
2013	33	2	5	7	0.007
Total	80	7	20	27	0.02

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

Target 6. Close the Global Recourse Gap by 2015

During the financial year 2012 to 2013, the Government of Antigua and Barbuda received technical assistance through PEPFAR, regional and other international donors along with the government allocated budget of 860,032.00 ECD. Contributions from local business entities and fund raisers amounted to ECDs in 25,585.75 ECD in 2012.

On the other hand, in 2013, international and regional contributions increased to USD whereas the government's spending decreased to. 742,820.00. However, government increased its contribution to subsistence for HIV positive individuals one hundred and thirty five thousand dollars (135,000.00). This is over 100% of the contributions to HIV positive individuals in 2012. Contributions from local NGO's amounted to 10, 101.94 ECD.

Antigua and Barbuda continue to examine cutting edge ways of mitigating the shortfall in donor funding. This can further be achieved where financially sustainable programme implementation is practiced.

See below Table and figure 11 Domestic, Regional and International HIV and AIDS expenditure for the period 2012 and 2013.

Table 23: Domestic, Regional and International spending 2010-2011

Heading	2012	2013	Total
State	$ 815,105.23 ECD	742,820.00 ECD	1557,925.23
Local NGOs		10,101.94 ECD	
PEPFAR		941,467.00	
GIZ/EPOS	-	60,537.25 USD	60,537.25 USD

PAHO			
Global Fund/OECS		**65,337.65 USD**	
Total			

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

Government's HIV related expenditure 2012 to 2013

For the period 2012-2013, a review of the Antigua and Barbuda's Estimates indicated that Funds for the NAP were allocated as shown in table 24 below. Information on actual expenditure is not itemized into the categories recommended by UNAIDS. Monies are dispersed by the Ministry of Finance upon request based on budgeted item. Funds are released from the Programme Sub-Head according to the Annual Estimates of the Ministry of Health. A periodic reporting of expenditures of international donor funding were done during the period under review.

Table 24: Government financial commitment for the NAP

Year	Amount allocated/ECD	Amount Spent
2012	815,105.23	815,105.23
2013	742,820.00	742,820.00

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

Target7: Eliminating Gender Inequalities

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

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

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

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

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

Table : gender-based violence statistics.

Type of Abuse	**Number**	**Sex of Victim**		**Sex of perpetrator**	
		M	**F**	**M**	**F**
Rape and Sexual Violence (adult	**1 see police stats for full report**		1	1	
Child rape and sexual violence(under	**Child welfare department**				

18 yrs)					
Physical abuse (adult)	95	3	42	42	3
Psychological and emotional abuse (adult	137	23	114	114	23
Financial abuse	112	-	112	111	1
Sexual abuse in domestic violence	18	-	18	18	-
TOTAL NUMBER OF DV CASES	187	74	107	107	74
Number of rape in adults	1	-	1	1	-
Other Cases , advice, counseling etc	30	6	24		
Human Trafficking					
TOTAL	218	30	137		

NUMBER OF Cases					

Source: Directorate of Gender Affairs

Females:

Age- Range = 12 – 16 = 4, 17 -21,
= 8, 22 -2 6,
= 12 27 - 31
= 22 , 32 – 36 = 29 -,

Age Range = 37 - 41 = 20 42- 46
= 12, 47 - 51
=15 , 52 – 56
=9 , 57 – 61 =6 ,

Age Range = 62 - 66 = 0 , 67 -71,
= 0, 72 – 76
= 0, 77 – 81 = 0 , 82 -86 = 0,

87 – over = 0

Males:

Age- Range = 12 – 16 = 0, 17 -21, = 0, 22 -2 6, = 2 27 - 31 = 22 , 32 – 36 = 10 -,

Age Range = 37 - 41 = 14 42- 46 = 20, 47 - 51 =8 , 52 – 56 =5 , 57 – 61 = 0 ,

Age Range = 62 - 66 = 0 , 67 -71, = ,0 72 – 76 = 0 , 77 – 81 = 0 , 82 -

86 = 0,

87 – over = 0

DIRECTORATE OF GENDER AFFAIRS GENDER - BASED VIOLENCE STATISTICS 2013

Type of Abuse	**TOTAL NUMBER**	**SEX OF VICTIM**		**Sex of PERPETRATOR/ Service User**		
		MALE	**FEMALE**	**Male**	**Female**	
Rape and Sexual Violence (adult	5	-	5	5	-	
Child rape and sexual violence(under 18 yrs)	4			4		
Physical abuse (adult)	109	5	104	107	2	
Psychological and emotional abuse (adult	89	7	82	82	7	
Financial	89	7	82	82	7	

abuse						
Verbal abuse	172	43	129	133	39	
Sexual abuse in domestic violence	58	3	55	58	-	
TOTAL NUMBER OF DV CASES	172	43	129	132	40	
Number of rape in adults	9 See police report					
Other Cases , advice, counseling etc	142	55	87	55	87	
Human Trafficking	1	-	1		1	
TOTAL NUMBER OF Cases	315					

Source: Gender Affairs Division Gender-Based violence stats

To discuss

Females

Age- Range = 12 – 16 = 6, 17 -21, = 19, 22 -26 = 12 , 27 - 31 = 48, 32 – 36 =27,

Age Range = 37 - 41 = 36 42- 46 = 12, 47 - 51 = 34, 52 – 56 = 10, 57 – 61 = 4,

Age Range = 62 - 66 = 00, 67 -71, = 4, 72 – 76 = 2, 77 – 81 = 00 , 82-86 = 0,

87 – over = 00

Males:

Age- Range = 12 – 16 = 0, 17 -21, = 0, 22 -26 = 0 , 27 - 31 = 13, 32 – 36 =21,

Age Range = 37 - 41 = 17 42- 46 = 26, 47 - 51 = 8, 52 – 56 = 10, 57 – 61 = 3,

Age Range = 62 - 66 = 00, 67 -71, = 0, 72 – 76 = 0, 77 – 81 = 00 , 82-86 = 0,

87 – over = 00

Table DIRECTORATE OF GENDER AFFAIRS GENDER - BASED VIOLENCE STATISTICS 2012-2013

Type of abuse	Year	Total	Sex of Victim		Sex of Perpetrator	
		Number	Male	Female	Male	Female
Physical Abuse (Adult)	2012	95	3	42	42	3
Sexual Abuse in (domestic violence)		18	-	18	18	-
Physical Abuse (Adult)	2013	109	5	104	107	2
Sexual Abuse (in domestic violence)		58	3	55	58	3

In Table -- note that there are a greater number of women with sexual abuse in both years, according to the variables to the type of abuse, there are a total of 60 women (53.09%) in 2012 and a total of 159 (95.2%), compared with 2.65% male in 2012 and 4. 79% in this 2013. this corresponding to the global statistics that show more abuse in females than in males comparing the two years, in 2013 there represented more sexual violence in the year 2012.

Target : Eliminating Stigma and Discrimination

8.1 Discriminatory attitudes towards people living with HIV (GARPR)

Target 10: Strengthening HIV integration

10.1 Data received from the Ministry of Education (MoE) revealed that six thousand (6389) children between the ages of 10 and fourteen attended school in 2013. Among those children there are two (2) children orphaned due to AIDS attended school.

10.2 No data is available for the percentage of the poorest household who received economic support. However, a number of agencies in the country continue to offer social services to the marginalized in society. These include, Social security, the Board of guardian and the Petro Caribe. Additionally a number of churches and members of Civil society offer financial services to members of poor households.

In 2012, HIV treatment and care in Antigua and Barbuda was transferred from a public/private partnership to an exclusively public service provision. The CCCs clinic now operates out of the MSJMC hospital. This clinic is currently staffed by the CCC, two case managers and nursing duties are carried out alternately by the APM and DAPM, two nurses assigned to the AIDS Secretariat. The country is preparing for complete decentralization of HIV treatment and care. This is evidenced by the training of eighty two nursing personnel in Provider Initiate Testing and Counselling (PITC) and on-going training of health care workers in in VCT. Additionally, in collaboration with the Community Nursing Department, meetings and training sessions have been held with midwives attached to the department. These included New PMTCT guidelines, VCT, Behaviour Change Communication (BCC)

Some focus has also been placed on empowering the Health and family Life teachers and Counsellors attached to the Ministry of Education to impart HIV related information to students. To help in accomplishing this, a training tool is currently being developed. A workshop was held in 2013 with the target group in collaboration between the PAHO, AIDS Secretariat-Ministry of Health and the Ministry of Education. During this workshop, the teachers and counsellors were introduced to the tool and allowed to make

their input. Currently, there are children between ages ten to fourteen in school. Of that total, there are two (2) children who have been orphaned by HIV.

Security services have also been a focus for HIV prevention.

ll. Overview of the AIDS epidemic

Population of Antigua and Barbuda.

HIV prevalence in Antigua and Barbuda was in 2012 and in 2013 based on data collected by the AIDS Secretariat.

Insert HIV Prevalence table here:

HIV/AIDS PREVALENCE 2010 – 2013, Antigua & Barbuda.

YEARS	**2010**	**2011**	**2012**	**2013**
CASES	684	702	729	755
POPULATION By Age Group (15-49)	49 993	49 993	49 993	49 993
PERCENT PREVALENCE RATE*	1.36	1.40	1.45	1.51

Source: AIDS Secretariat–Ministry of Health

HIV/AIDS PREVALENCE 2010 – 2013, Antigua & Barbuda.

YEARS	**2010**	**2011**	**2012**	**2013**
CASES	685	702	729	755
TOTAL POPULATION	90 801	90 801	90 801	90 801
PERCENT PREVALENCE*	0.7	0.7	0.8	0.8

Source: AIDS Secretariat–Ministry of Health

Linkages between Existing Policy and Programme Response.

The NSP 2012-2016 addresses the need to reduce HIV transmission and stigma and discrimination in several key populations. These include the youths, women, MSM, and SWs. The country has embarked on several interventions to aid in the fulfilment of these directives.

Youths: UN Convention on the Rights of the Child Convention

In 2013, the MoH in collaboration with PAHO embarked on a project to increase the competence of Primary School HFLE teachers to impart HIV prevention information to children 5 to 13. To achieve this, the development of a teaching tool was started and shared with the teachers who gave their input and endorsed the project.

Simultaneously, the AIDS Secretariat-Ministry of Health continues to carry out health promotion exercises in secondary schools based on the school's convenience. The department also continues to conduct similar exercises at youth and community meetings. Efforts to educate youths in HIV preventive and Behaviour Change Strategies also target the football clubs during their seasonal football matches.

Women Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women

The AIDS secretariat-Ministry of health continues to educate women in HIV preventive and sexual and Reproductive Health during a number of interventions in 2012-2013. Women's groups such as Church's Women's groups and Women of Esteem were reached with this knowledge. To increase the programme's ability to reach women, the programme continues to work closely with the Directorate of Gender Affairs and Civil Society.

In collaboration with PANCAP/GIZ/EPOS, Antigua and Barbuda has also embarked on an intervention to increase accessibility of HIV and AIDS services to Migrants. This intervention has incorporated a number of activities. These included four consultancies, trainings and HIV testing services.

MSM and SWs

The HIV response programme is still limited in its ability to unilaterally carry out HIV prevention interventions among the MSM population. Therefore, the programme continues to work closely with Civil Society to reach this target group. Work is still on-going in the country in association with the University of California and CDC to conduct a formative assessment. Nevertheless, due to the close collaboration with Civil Society, more members from the vulnerable population inclusive of the MARP are initiating access to government services such as HIV Counselling and Testing, care, treatment and support services. No recent studies have been conducted to determine behavioural change in the targeted sub-populations.

Antigua Resilience Collective Inc reveal that some work is in progress. Antigua Resilience Collective Inc. (ARC) since its incorporated as a legal registered NGO within Antigua and

Barbuda in 2011 has been providing members of MARPs safer sex commodities (male and female condoms, dental dams, lubricants, IEC materials), one-on-one and group intervention.

These sessions are carried out by a cadre of peer educators that act as foot soldiers for the organization. The Peer Educators of the organization participate in a number of training exercises to prepare them for field work to ensure the best result is achieved. They meet on a bimonthly basis to share information, knowledge, successes and challenges that arise from interacting with clients. Over the years the organization has been able to network not only with local partners such as National AIDS Programme, Women Against Rape Inc. (WAR), Meeting Emotional and Social Need Holistically (MESH), Community Health Care Providers, Directorate of Gender Affairs, Planned Parenthood Affiliation, Caribbean HIV/AIDS Alliance (CHAA) just to name a few but also regional and international organizations.

The organization has also been able to participate in building capacity training for its members and taking part both in the Caribbean and International AIDS Conferences. Please see Table below for data regarding this intervention.

lV. <u>Best Practices.</u>

a. Political support and Leadership

There has been some political leadership in the HIV and AIDS response for Antigua and Barbuda in 2013. The HIV in the Workplace Policy which was developed by the Labour Department with assistance from the ILO was endorsed by Hon; Erol Cort, Minister of National Security and Labour. It was also presented to Cabinet in 2012 and in 2013 reiterated the fact that his department is guided by the policy on more than one occasions.

b. Community Outreaches

The HIV prevention team from the AIDS Secretariat frequently engages in outreach activities which target the communities across the country. This is aimed at taking the public health service on HIV prevention and control to the doorsteps of the community. Services offered during community outreaches include Sexual and Reproductive Health (SRH) information, Behaviour Change Communication (BCC), Condom Distribution and Demonstration, distribution of other HIV prevention commodities, house to house visitation and free and confidential HIV Counselling and testing. Since the intensifying of community outreaches, the programme has seen an exponential increase in the uptake of HIV testing.

c. Collaboration

The country has a strong focus on collaboration in the HIV prevention and control efforts. Activities are implemented partnership between Governmental Organization, Non-Governmental Organization, Faith-based Organization,

Community Groups and Civil Society. Workers Union also play a role in the HIV response in the country. PLHIV are also strongly involved in the support and education aspect of the HIV intervention in the country.

Prior to 2013 the male population were accessing HIV related services at a significantly lower rate than females. Consequently, the HIV related male mortality rate was higher than that of females. To address this issue, the AIDS Secretariat-Ministry of Health in partnership with the media and other collaborative partners in the country, set out on a campaign targeting men for early diagnosis and management of HIV. As a result, the country has seen a significant reduction in morbidity and mortality among HIV positive individuals in 2013. However, since no impact study has been carried out, this may be anecdotal.

d. It has been observed that children are very knowledgeable about sexual intercourse and are becoming involved in experimental sex at a much earlier age. The MOH has observed that there is need for a component to teach HIV prevention from the primary school stage. With this in mind, in 2013, the AIDS Secretariat-Ministry of Health embarked on a project to equip HFLE teachers with the relevant knowledge and skill to deliver age appropriate HIV prevention education to primary school children between the ages of 5 and 12.

e. Capacity building and Decentralization

The AIDS Secretariat-Ministry of Health in collaboration with other regional and international organizations continues to prepare the health care department and other organizations for the eventual complete decentralization of HIV services. Activities include PITC, VCT, BCC, and English as second language training for Migrants (ESL).

The treatment and care component of the HIV management which was once a public/private service is now completely public in its approach. HIV related services which cannot be accessed publicly, are accessed privately at the government's expense.

f. HIV Counselling and Testing Protocol
g. HIV Care and treatment Manual

V. Major Challenges and Remedial Action

The country has seen slight improvements in the approach to HIV intervention during the period under review. Nonetheless, significant challenges still remain. The challenges with incremental changes are displayed in the table below.

INTERVENTION	COMMENTS
Social marketing of condoms	**The NAP continues the social marketing of male and female condoms along with other commodities such as dental dams. However, due to financial constraints, the programme does not have a sustainable supply of condoms. To help alleviate this situation, one partner, Scotiabank has purchased condoms which are used during the Carnival activities and WAD when they partner in the HIV prevention intervention. The excess are distributed as part of the condom stock.**
School-based HIV education for youth	**The NAP continues with it collaboration with the Ministry of Education towards ensuring HIV/AIDS education and life-skills are delivered in all Schools. Additionally, in collaboration with PAHO HIV prevention intervention is targeting the primary schools children.**
Need for retraining and replacement of Voluntary Counselling and Testing	**Training of Health care workers continues and in collaboration with PAHO eighty five community nursing personnel were trained in PITC. Training was also conducted in Rapid Testing during the period under review.**
Need for more programmes to build HIV prevention capacity among sex workers	**In collaboration with CHAA, WAR and the 3H Network MARPs in Antigua and Barbuda continue to be reached with HIV prevention programmes. Work continues in collaboration with University of**
Need for more programmes to build HIV prevention capacity MSM and other most-at-risk populations	**Work continues in collaboration with University of California San Francisco. CDC and Antigua and Barbuda. The Ministry of Health is seeking to develop a suitable methodology to collect data from this subgroup.**

HIV counselling and testing community outreach	**Efforts to intensify efforts in the country continue. There is an increase in the up-take of HIV testing services.**
PMTCT	**PMTCT uptake services remain significant. One baby was tested positive in 2013 as a result of language barrier between mother and health care team. Efforts are being made to get heath care team**
Mechanism to ensure that PLHIV receive appropriate medical care, home care and supportive palliative care	**The NAP continues its work in collaboration with Civil Society to ensure PLHIV receive the required services. Specialist medical services are provided free of charge to the client. These services include Dental Care, Ophthalmology and Dermatological care and women's health services. The services are financed by the government of Antigua and Barbuda for persons who request them.**
Close the Resource Gap: Increasing country ownership of the HIV response	**Donar spending in HIV prevention increased as it related to capacity building. However, as it relates to percurement of HIV related specialist services, their contributions were reduced. This shortfall was taken up by the government increase in spending for HIV related care. Services such as pap smear and laboratory services which were not offered by the**

IV. <u>Major challenges to achieve the GARPR targets</u>

The AIDS response for Antigua and Barbuda identified the following challenges in carrying out the activities of the NAP 2012-2013

CHALLENGES	RECOMMENDATIONS / ACTION

Programme Coordination and Management	Since there has been no Country Coordinating mechanism to give oversight to the intervention, limited coordination exist where the intervention is Civil Society driven. There is also limitation in the country's ability to influence the interventions conducted by Civil society resulting quite often in task duplication and wastage of resources.
There remains limited data on MARPS, especially MSM and SW to conduct effective HIV intervention by the NAP.	Continue to work with other agencies to get imperative data on the population of MARP in Antigua and Barbuda.
The Lack of a monitoring and evaluation officer at the NAP to collect empirical data on the HIV epidemic. Dissemination of data a regular and timely basis to the general public and stakeholders	Finalize the draft monitoring and evaluation plan which has been developed with assistance from CHRC-CARFA. Build human resource capacity in monitoring and evaluation.
Lack of recent, relevant and accurate data to report on the various indicators requested	Urgent need to develop questionnaire for a research and other data collection tools. Create a culture where regular reporting is done and continue to strengthen an efficient data collection system and the coordination of services between partners in the public and private sectors with greater involvement of civil society in the design and implementation of HIV activities with the NAP. Integrate gender issues such as gender equality into the HIV/AIDS policies and programmes (all components of the NAP).

Unavailability of updated policies, guidelines and protocols on HIV and AIDS.	Develop a legislative framework which protects the rights of those vulnerable to HIV by reviewing and or amending existing policies and laws relating to HIV and STI related services. These include: insurance and HIV testing; and the protection of human rights including those of prisoners.
Lack of legislation to address deliberate and reckless transmission of HIV; Age for accessing of health services by youth.	Revise and update the existing Policy Framework on HIV/AIDS and disseminate widely to all stakeholders involved in the response to HIV. Revise policies on access to HIV services among youths A
No enforcement of anti-discriminatory legislation for the protection of PLHIV especially with respect to housing and employment.	Review and revise existing policies and programmes which relate to access to health services by youth; the deliberate and reckless transmission of HIV; access to medicines; and disclosure of HIV status.
Need for Civil Society to agitate for amendment to laws which disempower the vulnerable population from accessing HIV prevention and control services.	Empower Civil Society to lobby for amendment to the beggary and sex work laws.
Understaffed Human rights Desk to focus on all HIV related Human rights issues.	Increase staff at human Rights desk to include legal and social welfare personnel and scrutinizers. Also examine the possibility of transferring the human Rights focus to the Legal department. Increase advocacy for HIV positive individuals and more big sister/ big brother arrangements among PLHIV

Lack of knowledge of Human Rights services among PLHIV.	Inform the population of the human Rights Laws and Conventions which the country has signed. Lobby government for ratification of the conventions which have been signed but remain ungratified in parliament.

HIV Education and Prevention	
Lack of empirical data leading to misconceptions related to drug use and its influence on sexual behaviour such as early sexual experience and multiple partners among illicit drug users.	Develop an evidenced based behaviour change programme for the population through a comprehensive BCC Strategy which aims to bring about lifestyle changes based on evidence from relevant sub-populations.
2. Lack of empirical knowledge about HIV, and its link with substance abuse and sex, and the negative impact it has on personal life and behaviour especially among the youth.	Design and disseminate age-appropriate messages using various art forms; involving target populations and popular artistes (especially in the music industry) in the design of these messages.
Lack of appropriate mechanism to reach out of school/on the block youths and the inability of the programme to collaborate with the sub-population.	Ensure that messages (posters and brochures) are displayed in non-traditional outlets and places frequently used by the target population.
Limited partnerships with role models in society to disseminate HIV prevention and control information.	Target gate keepers of communities, Parent Teachers Associations and other key community members to assist in the intervention.
Limited uptake of the female condom as a barrier method for preventing HIV transmission and other STI among sexually active individuals	Increase the number of sites for the distribution of condoms using non-traditional outlets. Continue to increase the number of condom marketing through increased partnership with NGOs.

7. Limited finance to purchase condoms for distribution to the general public.	Improve collaboration between the agencies involved in the distribution of condoms. Lobby for government to resume the purchase of condoms. Also lobby for the adoption of PANCAP's Condom Policy.
Limited health facilities offering Rapid Testing	Train more health care workers in Rapid Testing and provide more finances to procure Rapid Testing Kits.
1. Fragmented treatment and care services for PLHIV especially in the areas of monitoring and follow-up care.	1. Establish a comprehensive treatment, care and support unit for PLHIV.
Fear of confidentiality breaches acts as a deterrent and causes reduced uptake of HIV testing and treatment services.	Establish a system for follow-up care for PLHIV on ARV drugs in their respective networks. Train other health care personnel in treatment adherence issues.
Lack of youth-friendly services minimise the freedom with which youths access the services. It also reduces the programmes ability to offer services which are relevant to youths. .	Re-establish services for adolescents and youth in a user-friendly environment.
Insufficient testing uptake among men	Provide standardised services for inaccessible vulnerable groups in a more comfortable environment.
Unwillingness of male and female sex workers to attend clinics for VCT services.	Conduct an island-wide assessment of OVC as well as develop and implement policies for the management of OVC.
Lack of knowledge about OVC.	Strengthen and coordinate services for OVC involving relevant agencies e.g. Big Brother/Big-Sister Association and the Child and Family Guidance Centre.
Under-use of VCT services and Care and treatment by nationals.	Develop systems and train staff to ensure high-quality and confidential HIV testing and counselling services.

Limited number of trained staff to provide ART services and a low number of HIV positive clients accessing available services.	8Train HIV counsellors as Treatment Care Advocates
Lack of a Monitoring and Evaluation System which will provide technical assistance to ministries and agencies to maintain applications of Operational and Procedural manuals; as well as provide quality management of information.	Finalize the draft Monitoring and Evaluation manual to track the performance impact of the services offered by the NAP as well as provide evidence-based information to local Stakeholders for decision-making and to international donors for funding.
Lack of a monitoring and evaluation officer assigned to the National programme	Improved M&E skills (capacity building).
Lack of funds to conduct population surveys, BSS and research associated with vulnerable and most at-risk groups including Youth, MSW, orphans and vulnerable children in the population.	Incorporate M and E component in the M and E framework.

VI. Support from Country's Development Partners:

A number of development partners have contributed to the HIV response in Antigua and Barbuda; these include Pan American Health Organization, PANCAP/GIZ/EPOS, PEPFAR and Global Fund. It has, however, been observed that at times there has been duplication of interventions between partners and quite often stakeholders are unaware of this phenomena until interventions have completed or they become knowledgeable if they are contacted on another project.

This can lead to wastage of much needed resources and fatigue of the target group. Consequently, the country's ability to meet some targets may be diminished. To alleviate this problem, strategic planning and collaboration between country and implementing partners is required prior to the start of the fiscal year.

Vll. Monitoring and Evaluation.

Target 10: Strengthening HIV integration

10.1 Data received from the Ministry of education revealed two (2) children orphaned due to AIDS attended school.

10.2 No data is available for the percentage of the poorest household who received economic support. However, a number of agencies in the country continue to offer social services to the marginalised in society. These include, Social security, the Board of guardian and the Petro Caribe. Additionally a number of churches and members of Civil society offer financial services to members of poor households.

In 2012, HIV treatment and care in Antigua and Barbuda was transferred from a public/private partnership to an exclusively public service provision. The CCCs clinic now operates out of the MSJMC hospital. This clinic is currently staffed by the CCC, two case managers and nursing duties are carried out alternately by the APM and DAPM, two nurses assigned to the AIDS Secretariat. The country is preparing for complete decentralization of HIV treatment and care. This is evidenced by the training of eighty two nursing personnel in Provider Initiate Testing and Counselling (PITC) and on-going training of health care workers in in VCT. Additionally, in collaboration with the Community Nursing Department, meetings and training sessions have been held with midwives attached to the department. These included New PMTCT guidelines, VCT, Behaviour Change Communication (BCC)

Focus has also been placed on empowering the Health and family Life teachers and Counsellors attached to the Ministry of Education to impart HIV related information to students. To help in accomplishing this, a training tool is currently being developed. A workshop was held in 2013 with the target group in collaboration between the PAHO, AIDS Secretariat-Ministry of Health and the Ministry of Education. During this workshop, the teachers and counsellors were introduced to the tool and allowed to make their input. Currently, there are children between ages ten to fourteen in school. Of that total, there are two (2) children who have been orphaned by HIV.

Security services have also been a focus for HIV prevention.

ANNEX 1:

List of Participants interviewed:

Names	Designation
Hon. Wilmot Daniel	Minister of Health
Mr. Edson Joseph	Permanent Secretary- Ministry of Health

Mrs. Rhonda Sealey Thomas	Chief Medical officer-ministry of Health
Dr. Oritha Zachariah	Medical Officer of Health
Dr. Maria Periera	Clinical care Coordinator
Dr. Richardson	Peadiatrician-MSJMC
Ms. Delcora Williams	AIDS Programme Manager-AIDS Secretariat
Mrs. Sonia Joseph	Deputy AIDS Programme Manager- AIDS Secretariat
Mrs. Almira Henry	Citizen's Welfare Division
Ms Hawtensia Brookes	Strategic Development Coordinator-Ministry of Finance
Mr. Anthony Spencer	Education officer of Natural Science-Ministry of Education
Miss Andrea Airall	HFLE Coordinator-Ministry of Education
Ms Jose Laurent	Director Legal AID
Ms. Alverna Innis	Programme Officer-Directorate of Gender Affairs
Mr. Colin Okeif	Head of Health Information Division
Mr. Osbert Williams	Statistical Data Coordinator/HIS- Health Information Division
Ms Secora Jarvis	Statistical Offices-DCS/HID
Norma Jeffrey Dorset	Substance Abuse Prevention Division
Mr. Barrios Blanco	Epidemiologist-AIDS Secretariat
Everton Pigott	HIV Counsellor and Educator-AIDS Secretariat
Oswald Hannays	HIV Counsellor and Educator-AIDS Secretariat
Ms Gail Aska	Secretary-AIDS Secretariat
Mrs. Karen Brotherson	Coordinator-Human Rights
Mrs. Alexandrina Wong	Women Against Rape
Mrs. Elenora Frederick	Antigua and Barbuda HIV and AIDS Network
	Antigua Workers Union
Mr. Paulette Ambrose	Ministry of National Security and Labour
Mr. Lyndale Weaver	Executive Director Antigua Planned Parenthood Association
Ms. Melissa Johnson	Senior Programme Officer- CHAA

Craige Rijaard	Antiguan Resilience Collective
Orin Jerick	MESH

b. Documents reviewed

1 Strategic Plan for the National Response to HIV/AIDS, Antigua and Barbuda, 2012-2016.
2 GLOBAL AIDS RESPONSE PROGRESS REPORT Country Report 2010-2011 Antigua and Barbuda.
3 Guidelines on Construction of Core Indicators, 2014 Reporting.
4 KNOWLEDGE Attitude Practice and Behaviour Survey (KAPB) in Six Countries of the Organisation of Eastern Caribbean States (OECS), 2011.
5 Caribbean HIV AIDS Alliance (CHAA) quarterly reports to the AIDS Secretariat.
6 Antigua and Barbuda population Census 2001.
7 Risk reduction forms for HIV testing at the AIDS Secretariat.
8 Living Conditions in Antigua & Barbuda: Poverty in a services economy in Transition (volume 1 August 2007).
9 Patient Monitoring system – Health Information Division.
10 UN Convention on the Rights of the Child [SI 32/1993]
11 Antigua and Barbuda Food and Nutrition Security Policy 2012
12 United Nations Development Assistance Framework (UNDAF) for Barbados and the Organisation of Eastern Caribbean States (OECS) 2012 to 2016
13 Poverty Reduction Strategy

15 Inter-American Convention on the International Return of Children [SI 4/1994].

16. UN Convention and the 1967 Protocol relating to the Status of refugees

17. Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women [SI 27/1995].

18. Inter-American Convention on the Forced Disappearance of persons in 1994 [SI 51/00].

Annex 2:

National Commitments and Policy Instruments (NCPI)

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

Antigua and Barbuda National Strategic Plan (NSP) for HIV and AIDS 2012-2016 focuses on six Priority Areas. These are as follows:

Priority Area 1: Promote an enabling environment that fosters universal access to HIV prevention, treatment, care and support.

Priority area 2: An expanded and coordinated multi-sectoral response to the HIV epidemic

Priority area 3: Prevention of HIV transmission

Priority area 4: treatment, care and support

Priority area 5: Institutional Systems Development.

Priority area 6: Barbuda Development Programme.

Antigua and Barbuda will scale up access to HIV related services through strategies designed to achieve three main goals by 2016.

1. To reduce the estimated number of new HIV infections by 33% of the last three year's average.
2. 2. To reduce mortality due to HIV by 33% of the last three years average.
3. To achieve 100% confidential referrals of all requesting PLHIVs to relevant national social support agencies.

The country has in place a multi-sectoral strategy to addressing HIV and AIDS issues. This strategy includes collaboration in programme interventions between relevant stakeholders. Some stakeholders include MOF, MOE, Ministry of Labour and Justice, Economic Policy.

The activities in this strategy are led by the MOH which has direct responsibility for HIV control and prevention. Other agencies involved in the strategy include: Ministries of Education, Labour, Military/Police and Social Welfare, however, only the Ministry of Health has an earmarked budget for HIV related interventions. Nonetheless, the strategy does not address many of these agencies.

The strategy targets key populations which include: youths, MSMs, SWs, women and girls and the disabled. Cross cutting issues addressed by the strategy include: Stigma and Discriminating, Gender Empowerment and PLHIV involvement.

Political Support and leadership.

In 2012, the HIV and AIDS in the workplace policy for Antigua and Barbuda which was completed in 2011 with assistance from International Labour Organization (ILO) was presented to Cabinet by the Hon; Erol Cort, Minister of National Security and Labour. Since then he has insisted that the policy be used as the guiding principle of the department of labour when addressing HIV and AIDS in the workplace issues.

The stance was reiterated in 2013 when he addresses another function sponsored by the ILO. This function was organized by the labour department to launch a memorandum of understanding between business enterprises and the ILO in 2013. To further enhance the use of the HIV and AIDS in the workplace Policy for Antigua and Barbuda, a consultant was employed to assist these enterprises in formulating their own HIV and AIDS in the Workplace policy.

Human Rights

The Constitution f Antigua and Barbuda guards against denial of the fundamental freedom rights and freedom of individuals. Chapter three speaks to the Rights to Personal Liberty, Chapter twelve to Protection from Discriminating on the grounds of race, sex and of other attributes. These chapters of the Constitution can render some form f protection from discrimination to the population.

The country has also signed on to some international Conventions. These include the UN convention on the Rights of the Child [SI 32/1993] and Inter-American Convention on the International Return of Children [SI 4/1994]. In 1951, the country also signed the UN Convention and the 1967 Protocol relating to the Status of refugees, Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women [SI 27/1995]. Additionally, the country has signed the Inter-American Convention on the Forced Disappearance of persons in 1994 [SI 51/00]. However, many of them have not been ratified in parliament; therefore, they cannot be used to protect anyone in the country.

Additionally, the office of the Ombudsman is an impartial entity with the responsibility to address complaints where person's individual rights have been denied. However, the Ombudsman may refuse to investigate a claim if the subject is frivolous, vexatious, trivial or if the complainant does not have enough interest in the complaint.

Notwithstanding Constitutional Laws, the signing of these Conventions, and the services of the Ombudsman, some subgroups that are most vulnerable to contracting of HIV do not have access

to Human rights protection by virtue of their life styles. These include sex workers, men who have sex with men and drug users. This occurs as a result of the presence of laws against their lifestyles in the same Constitution which protects the Human rights of all persons.

A.IV. Prevention

The Antigua and Barbuda National Strategic Plan for HIV and AIDS does not include an HIV prevention component. However, with the assistance of the University of the West Indies HIV Project Unit, the country has developed a draft HIV prevention Plan.

This draft supports the sharing of IEC which addresses sexual debut, safer sex practices, fight against violence, involvement and acceptance of PLHIV, PMTCT and consistent condom use. Although HIV is not mentioned as a part of the curriculum in schools, it is addressed in the HFLE component along with all STIs. It also includes age appropriate sexual and reproductive health, gender sensitive and reproductive health. Key and vulnerable populations are also addressed in this strategy.

Treatment and care

All persons identified to be HIV positive in Antigua and Barbuda are informed of the treatment services which are available at the MSJMC. This is managed by a Clinical Care Team which is headed by the CCC. The country provides treatment and care services which include ARVs, treatment for OIs, TB treatment and STI management free of cost to the client/patient. Follow-up investigations are carried out at the government's expense. PLHIV also have access to laboratory and radiological services free of cost to them.

Persons who are infected with and affected by HIV are able to receive financial and nutritional support if the need arises. Financial support is received through the Petro Caribe, Social security invalidity benefit and Board of Guardian. Where nutritional support is necessary, Petro Caribe supplies beneficiaries with food vouchers which can be used to redeem food supplies at the Central marketing Cooperation. Otherwise, a number of FBOs and NGOs provide hot meals to vulnerable in the population inclusive of PLHIV and those affected. PLHIV are often reached by other organizations through support groups.

Orphans and Vulnerable children are housed at the Care Project located at the former Holberton Hospital Compound. However, there is need for staff training to deal with specific issues as it relates to HIV and AIDS and other issues relating to Orphans. Programmes also need to be put in place for orphans relating to their eventual release.

Monitoring and Evaluation

Antigua and Barbuda does not currently have a monitoring and evaluation plan. In 2013 a draft Monitoring and Evaluation Plan for Antigua and Barbuda Expanded Response to HIV 2012 to 2016 was completed. This was done with the assistance of CHRC. This plan addresses areas

such as Behavioural surveys, Evaluation and research studies, HIV surveillance, Routine programme monitoring, tools for data collection, data analysis strategy and use strategy,

Although M and E is not carried out systemically, information from some observational strategies are used to help in guiding programme planning. Some observations which have guided programme planning and implementation include: the targeting of men for early HIV identification when men were not seeking HIV testing before the latter part of the disease stage. Additionally, since some primary school children are knowledgeable about sex and there are reports of early sexual experimentation among them, efforts are being made to develop a tool to help HFLE teachers share age appropriate HIV prevention information with these children.

B.I. Civil Society Intervention

Caribbean HIV AIDS Alliance (CHAA)

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

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

Number of MARP reached with individual and of small group level HIV preventive interventions that are based on evidence and or meet the minimum standard required**.**

	Name	Disaggregation	Q9	Q10	Q11	Total Yr 3	% accomplished
	Total MARP	252	261	104	617	904	68
	MSM	93	129	61	283	284	100
	SWs	154	124	39	317	533	57
New	**OVP**	5	8	4	17	70	24
Other subgroups reached who are not in the target							
	AVP	0	2	0	2	-	-

1086	**SW**	55	88	38	181	332	55
332	**OVP**	110	135	43	288	94	0
	AVP						
Total	**MSM**	165	223	81	469	1086	43
Condom Distribution Sold	**Total**	52,474	16,434	19,438	88,880	140,000	63
	Distributed	52,474	16,434	19,972	88,880	140,000	63
	-	-	-	-	-	-	-

Source: CHAA Eastern Caribbean Community Project EC CAP lll March 2013-September, 2013

Output 1: To reduce vulnerabilities to HIV through access to comprehensive prevention services.

	Number of community animators	**Disaggregation**	**Q9**	**Q10**	**Q11**	**Total**	**Target Yr lll**	**%**
Number of individuals who received Testing and counseling services for HIV and received their test results		**Males**	210	220	83	513	600	86
		Females						
		New						
		Repeat						
		Total						
	# of individuals who received T & C services for HIV and received their results. # MARP reporting uptake of services		210	220	83	513	600	86
			18	19	7	44	120	37
		males	160	174	7	341	154	221
		Females	374	242	20	636	232	274
		Gender not reported	0	0	0	0	-	-
	Number of people living with HIV reached with a minimum package of prevention with PLHIV (PwP) interventions	**New**	18	14	6	38	83	-
		Repeat	18	17	5	40	-	-

		Total	534	416	27	977	386	353

Source: CHAA Eastern Caribbean Community Project EC CAP lll March 2013-September, 2013

# of people living with HIV reached with a minimum package of prevention in PLHIV interventions.

EC CAP ll P Yr 3	**Q 9**	**Q 10**	**Q11**	**Total**	**Percentage**
New		**14**	**6**		**-**
PLHIV	18	0	0		
MSM/SW/PLHIV	0	0	0	0	
MSM/PLHIV	0	0	0	0	
SW/PLHIV	0	0	0	0	
Repeat	18	17	5	40	
PLHIV	0	0	0	0	
MSM/SW/PLHIV	0	0	0	0	
MSM/PLHIV					
SW PLHIV					
Total	36	31	11	78	

Source: CHAA Eastern Caribbean Community Project EC CAP lll March 2013-September, 2013

Increased Number of referrals by community animators

		Q9	**Q10**	**Q11**	**Total**
Total	**# of referrals**	210	220	83	513

Source: CHAA Eastern Caribbean Community Project EC CAP lll March 2013-September, 2013

Tabl

Increased number of MARP reporting uptake of HIV and AIDS related services

Distribution of HIV prevention Prophylactic by quarter

	Q9	**Q10**	**Q11**	**Total**
Male Condoms	52,474	16,434	19,972	88,880
Female Condoms	895	1,033	1,183	3,111
Dental Dams	542	435	385	1,342

Lubricant	3,239	1,933	716	5,888

Source: CHAA Eastern Caribbean Community Project EC CAP lll March 2013-September, 2013

3H Network

The Health, Hope & HIV Foundation Inc. (3HN) is a registered non-profit organization, dedicated to the enlightenment and empowerment of persons living with HIV and affected by HIV and key populations at higher risk to HIV infection with a strong advocacy focus. 3HN operates under the following shared values: Empowerment and Accountability

Leadership and Innovation

Self Respect and respect for Others

3HN implements a comprehensive approach to HIV prevention, treatment, care and support using the human-rights base approach to it programming. Reducing the transmission of HIV infection, re-infection and co-infection has propelled the organization to broaden its mandate to include a structured Palliative Care Program, using the WHO definition of Palliative Care. This has resulted in fewer hospitalization of members and other PLHIV referred for HIV Management. A rigorous outreach and prevention program that is peer-based has reinforced the view of positive living with adherence to treatment as a means of prevention of opportunistic infections. Through our various programs, and the impact resulting for the coordinated collaborative partnership of clients, caregivers and other partners the 3H Network is constantly being recognized for its work and worth. Our work in advocacy has been recognized regionally and in 2009 we were the recipient of the PAHO/WHO MISOPLWHA AND PARTNERS – Barbados and Eastern Caribbean award in the category of NGO contribution. *"For our sterling, significant, dedicated, continuous, unselfish and tremendous contributions in advancing development in Barbados and the Eastern Caribbean especially in the area of addressing HIV & AIDS through the eradication of stigma & discrimination against PLHIV".*

The Health, Hope & HIV Network provides a comprehensive basket of services free of cost.

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

Our education as prevention and behaviour change program among Security Officers has been most outstanding and we are humbled by the commitment of this new partnership that we share with the Royal Police Force of Antigua & Barbuda and Her Majesty's Prison. Further, we have extended our services to our sister isle of Barbuda and will be working in collaboration with the Barbuda council, educational institutions and civil society organizations in the areas of Behaviour Change, HIV preventions and case management.

The 3H Network has become an umbrella agency for MSM and Spanish SW and has now extended its program to reach the vulnerable migrants and English speaking SW. Increasing access to HIV prevention education, treatment which will result in adherence, care and support of infected individuals and their families, sexual and reproductive health and its impact on PLHIV and vulnerable groups, stigma & discrimination reduction through a multi-sectoral approach including the expertise of government and civil society has aided in the organization fulfilling its goals and objectives.

As we continue to create positive change we embrace the masses with a sense of optimism and await the outcome of strategic intervention, integration and coordination.

Antigua Resilience Collective:

Antigua Resilience Collective Inc. (ARC) since its incorporated as a legal registered NGO within Antigua and Barbuda in 2011 has been providing members of MARPs safer sex commodities (male and female condoms, dental dams, lubricants, IEC materials), one-on-one and group intervention. These sessions are carried out by a cadre of peer educators that act as foot soldiers for the organization. The Peer Educators of the organization participate in a number of training exercises to prepare them for field work to ensure the best result is achieved. They meet on a bimonthly basis to share information, knowledge, successes and challenges that arise from interacting with clients.

Over the years the organization has been able to network not only with local partners such as National AIDS Programme, Women Against Rape Inc. (WAR), Meeting Emotional and Social Need Holistically (MESH), Community Health Care Providers, Directorate of Gender Affairs, Planned Parenthood Affiliation, Caribbean HIV/AIDS Alliance (CHAA) just to name a few but also regional and international organizations. The organization has also been able to participate in building capacity training for its members and taking part both in the Caribbean and International AIDS Conferences.

During 2013 the organization has been able to reach 75 peer education one-on-one session, of which 47 negatives, 1 positive and 26 unknown. We still have a challenge whereby clients who refuse to use the public health services for testing due to a number of reasons the top one been: lack of confidence in the system. Peer educators continue to encourage such persons to be tested since it is very important to know their status. Not with standing peer educators were able to

distribute 846 male condoms, 136 female condoms, 89 dental dams, 405 lubricants. Peer educations along with other ARC members were able to distribute over 500 of the two MSM specific brochures that we developed and over 1000 other related IEC materials.

Meeting Emotional and Social Needs Holistically (MESH)

During the period under review 2011 through 2013, I am pleased to inform you that MESH has been engaged in several activities. These include the following:
Targeted out reach for MSM
Targeted outreach with Social Partners (WAR and CHAA) by providing information and safer sex commodities to clients. MESH also participated in violence against women in the Orange Day activities, provided capacity building of the organization members through selected topics at monthly meetings and Co- facilitated workshop on human rights violation documentation training of members and social partners. This was funded by Caribbean Vulnerable Communities (CVC) and AIDS Free World.

E. Key Populations

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

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

Although there are reports that there are orphans and vulnerable children (OVC) resulting from the AIDS epidemic in Antigua and Barbuda there are no records or official data to confirm these Reports. Presently there are two children who were orphaned as a result of HIV and AIDS attending school and three in the care of relatives.

Antigua Planned Parenthood Association

In September 2013 Antigua Planned Parenthood Association (APPA) started a youth clinic, this was in response to our observation that the Sexual and Reproductive Health (SRH) needs of our nation youths were largely unmet. At this clinic which is held every Thursday afternoon from 3pm the youths are provided with SRH information to include HIV/STI prevention. A doctor is also available to provide medical care. Youth friendly pamphlets on these topics are also available.
In addition APPA is periodically invited to provide SRH information in schools, both Governments primary and secondary as well as private owned. This is done using both visual and audio presentations.

The Antigua and Barbuda HIV and AIDS Network continue to work in the area of support for those infected and affected with HIV and AIDS. Much of the work is done in collaboration with other Civil Society Organization such as the American University of Antigua with whom they

carry out services to the population they serve. They also facilitate the functioning of a buddy programme for those affected and infected with HIUV and AIDS.

Women against Rape (WAR) also continue to conduct activities among persons who have experienced rape.

ANNEXES 1

The National Consultation on the Monitoring of progress towards the Declaration of Commitment on HIV and AIDS was held on June 24th 2014. Is preparation for this consultation, a number of activities were undertaken.

Firstly, the date for the consultation was determined, after which a venue was secured. Thereafter, participants were invited to the consultation and asked to bring along any HIV related data which were in their possession. During the process, stationary and material for the consultation were procured and consultation materials prepared. Tables and chairs were borrowed from the Nurses association and Lunch and snacks were bought.

On the 24th of June the Consultation was held. Please see the report below.

Minutes for Ministry of Health UNAIDS Consultation
Antigua and Barbuda's Assessment of Target and Elimination Commitments of the 2011 UN General Assembly Political Declaration on HIV and AIDS, 24 June 2013
Mount St John Medical Centre Conference room

The consultation began at 8:45 a.m. with the personal introduction of the Master of Ceremonies, Mr. Oswald Hannays, Counselor Educator of the AIDS Secretariat. The group was then lead in prayers by participant, Mrs. Ambrose of the Ministry of Labour.

Opening Remarks:

Permanent Secretary in the Ministry of Health, Mr. Edson Joseph, presented the Opening Remarks. Mr. Joseph commented that he had committed a great deal of time and resources to the challenge of HIV and AIDS in Antigua and Barbuda and he had attended every important meeting regarding the issue. He remarked that a lot of work needed to be done in the field. He noted that most at risk populations (MARPS) are now more involved in the HIV and AIDS programmes and the attainment of more knowledge of their risk factors. He remarked that the issue of Stigma and Discrimination regarding HIV and AIDS needed to be resolved. Mr. Joseph stated that according to Christian values, there is no discrimination and humans should love and respect everyone. He then wished the participants a productive consultation and hoped that by

2015 Antigua and Barbuda would have attained zero new HIV transmission rates of mother to child and would have attained the Millennium Development Goals.

Master of Ceremonies comments:

Master of Ceremonies, Mr. Oswald Hannays then outlined the goals of the consultation which were:

1. Sexual transmission of HIV to be reduced by half in United Nations designated countries. This he said is the responsibility of all stakeholders including members of the MARPs.
2. Vertical transmission and maternal transmission of HIV be reduced by half and then sustained at zero percent transmission.
3. No new transmission of HIV among intravenous drug users.
4. Decrease tuberculosis related deaths among persons living with HIV (PLHIV) by half.
5. Protect persons living with HIV and AIDS and focus on care and support of infected and affected persons.
6. Zero tolerance for gender based violence as females are mainly affected and a large proportion of violence towards females are unreported

Presentation of findings:

Mrs. Sonia Joseph, Deputy AIDS Programme Manager then made a presentation on the findings and recommendations for the plenary session. The power-point presentation was entitled 'Charting the Course for Achieving Targets against HIV and AIDS 2011-2015.' The talk commenced with an outline of the HIV intervention in Antigua and Barbuda and displayed statistics on HIV in the country.

A background of the response to HIV and AIDS was highlighted revealing the 2001 Declaration of Commitment on HIV and AIDS, the 2006 Political Declaration of commitment against HIV and AID and the 2011 world leaders meeting at their renewed commitment to combat HIV and AIDS at national, regional and international levels.

Other slides reviewed treatment options for HIV, the availability of Anti-retroviral therapy, developing an HIV free generation, the human rights response and financial responsibilities. Political commitments were discussed.

Mrs. Joseph identified that the age group most affected by HIV and AIDS were in the productive and reproductive age range. Significant factors in the fight against HIV and AIDS involved financial, social and productive parameters. Some costs for treatment were covered by

international agencies for which sustainability was questioned since financial assistance from major donors was scheduled to be reduced. There were also current and pending challenges with competing diseases such as non-communicable chronic diseases, new and emerging diseases and the potential threat of cholera and malaria.

The power-point presentation displayed graphics regarding Antigua and Barbuda HIV data. The age and time of diagnosis was examined and the reality that some persons might have unknowingly transmitted the HIV virus was discussed. discussions also surrounded the possibility that the low numbers in some age groups might be due to the members of that group not accessing testing due to age of consent and ideas of invincibility.

Mrs. Joseph explained the intra-country as well as inter-country mobilization of PLHIV can carry a significant public health burden on any country. Although ART is available free of cost to the PLWHIV, reduced capacity to sustain such programmes can lead to other challenges. Therefore the more cases are identified early, the better will be the country's chances of controlling the virus.

Also displayed was HIV data disaggregated by age and gender 2010 to May 2013. Consultants then reviewed the number of tuberculosis cases from 2010 to 2012 in Antigua and Barbuda and the necessity for control in its transmission discussed. The next set of slides reviewed the date on the prevention of mother to child transmission (PMTCT) from 2010 to 2012.

Following Mrs. Joseph's presentation was a panel discussion where some members of the consultation sat as panelists. They were asked to educate the remaining participants of their work, the data which they collect and give an idea of the challenges and successes which they encounter in the conduct of their duties.

Panel Discussion:

The general discussion began with Mrs. Jarvis, supervisor of laboratories at the hospital who expressed concern about the number of pregnant females who were not tested for HIV before being admitted for delivery. She further expressed the need for mothers to have knowledge of their HIV status before that period. This was readily agreed to and the assurance was given to the group that preparation are continuing to remedy this situation.

Nurse Wong suggested that there should be a guideline for the testing of pregnant women and voiced her concerns that no rapid tests for HIV were being done at the community clinics. A senior maternity nurse responded that there is a protocol in place for antenatal testing for HIV. Mrs. Joseph noted the loss of some VCT trained community nurses as a result of attrition which has reduced the capacity of the clinics to perform VCT. This she said will shortly be resolved since the country is actively involved in decentralization of HIV services.

Mr. Hannays noted that since the decentralization of services for HIV commenced and some clinics, involved in Voluntary Testing and Counseling still extract venous blood for HIV testing

which is transported to the lab by the AIDS Secretariat. Another participant voiced concerns regarding the Post Exposure Prophylaxis (PEP) issues and whether the protocol has been disseminated throughout the entire health workforce. This was also explained by a member of the panel and Nurse King, the Infection Control Nurse at the hospital. Nurse King also explained that the post exposure prophylaxis protocol is displayed on the wall or bulletin boards in certain clinics and at the Mount St. John Medical Centre.

Participant Ms. Corbin voiced concerns about the confidentiality of the HIV testing at the community clinics. She inquired of the risk of female to female transmission of HIV in women who have sex with women (WSW) relationships. Mr. Everton Pigott responded that all HIV tests are confidential. Mrs. Brotherson maintained that confidentiality of HIV testing is maintained at all stages. Dr. Maria Periera explained the risk of WSW transmission of HIV.

Other participants voiced concerns about the VCT and the testing of minors for HIV. Mr. Pigott revealed that he performs VCT on minors and all underage (below the age of sixteen) persons should be accompanied by a parent or guardian when accessing HIV testing. A member of the Police force voiced his opinion that the age of consent should be 18 years of age which created an engaging discussion among the participants.

Mrs. Joseph then thanked the participants for their input. This was followed by a coffee break.

During the next session, participants were divided into groups according to their area of expertise. The ten UNAIDS targets were then divided among these groups for discussion and presentation. Groups were instructed to select a leader, a scribe and a presenter from among them and to review their targets according to the sub-heading on the ten by ten matrix. The groups consisted of five to six persons who explored the findings and key recommendations for respective target areas.

Targets examined were:

Reduction of sexually transmitted HIV,

Reduction of HIV transmission among intravenous in drug users

Fifteen Million Accessing treatment

Elimination of vertical transmission of HIV

Reduction of HIV/TB related deaths

Closing resource gaps

Decreasing Gender Inequality

Reducing Stigma and Discrimination

HIV related restrictions,

Strengthening HIV integration in Antigua and Barbuda.

Group discussions were interrupted by a forty five minutes lunch break, after which the groups resumed their discussions. At the end of the discussions, each group presented their findings and recommendations to the wider body.

Closing remarks were presented by Ms. Delcora Williams, National AIDS Programme Manager-Antigua and Barbuda. The meeting ended at 4:20 p.m.

List of Participants and their Designations.

Number	**Name**	**Organization**	**position**
1	Arlea Gregory	MSJMC	Nurse Midwife
2	Sybil Knowles Smith	Community Health Department	Nurse Epidemiologist
3	Orin Jerrick	Police, CHAA	Police, Community Animator
4	Roland Curry	Police	Community Policing
5	Merve Joseph	Probation Unit	Probation Officer
6	Richard Hadeed	Biohealth Medical Lab	Owner-Medical Technologist
7	Catherine Nisbett	Women Against Rape	Partner Volunteer
8	Patricia Galloway	Antigua/Barbuda HIV/AIDS network	Peer Counselor
9	Vonetta Corbin	Health, Hope and HIV	Partner/Volunteer

		Network	
10	Mrs. Karen Brotherson	Health, Hope and HIV Network	
11	Ann-Marie King	MSJMC	Infection Control
12	Abel Barrios Blanco	AIDS Secretariat	Epidemiologist
13	Everton Pigott	AIDS Secretariat	Counselor Educator
14	Condon Jarvis	MSJMC Medical Lab	Chief Medical Technologist
15	Wesley	Immigration Department	Senior Supervisor
16	Paulette Ambrose	Labour Department	Senior Labour Officer
17	Dr. Maria Pereira	MOH	Clinical care Coordinator
18	Keithly Thomas	Immigration Department	Grade V Officer
19	Sherilyn Federick	Antigua and Barbuda HIV/AIDS Network (ABHAN)	Partner
20	Elisha Walker	ABHAN	Peer Counselor
21	Eleanor Frederick	ABHAN	Executive Director
22	Alexandrina Wong	Women Against Rape	President
23	Dave	MSJMC	Pharmacy Manager

	Bridgewater		
24	Sheila Roseau	Directorate of Gender Affairs	Executive Director
25	Paul Joseph	3H Network	Care Giver
26	Lucetta Mc Pherson	AIDS Secretariat	
27	Roxanne Herbert	AIDS Secretariat	Senior Accounts Clerk
28	Annetta Dowe	AIDS Secretariat	Junior Accounts Clerk
29	Delcora Williams	AIDS Secretariat	AIDS Programme Manager
30	Dawn Small	AIDS Secretariat	VCT Provider
31	Alex Prince	3 H Network	3H Network
32	Wendel Robinson	Police	Superintendent of Police
33	Sonia Joseph	Deputy AIDS Programme Manager	Deputy AIDS Programme Manager
34	Kim Martin	Substance Abuse and Prevention Unit	Drug Prevention Educator
35	Ammarilla Henry	ACE and ABHAN	Citizen's Welfare Division
36	Oswald Hannays	AIDS Secretariat	Counselor/Educator
37	Gail Oska	AIDS secretariat	HIV Outreach Coordinator/Secretary
38	Osbert Williams	Health Information	Statistician

		Division	
39	Clairfoster Rogers	AIDS Secretariat	Office Assistant
40	St. Claire Williams	AIDS Secretariat	Receptionist/Office Assistant

Instructions being given to the group

Photo of Group Work Activity:

Group Presentation Photo

Original Sign in Sheet

The AIDS Secretariat - Ministry of Health
One (1) Day UNGA Stakeholders Consultation
Mount St. John's Medical Centre Conference Room
Monday 24th June, 2013

No.	Name	Organization	Position	Contact #	Email Address
1	ROBERT WILLIAMS	HEALTH INFORMATION DIVISION	STATISTICIAN	4045685	rwilliams@health.gov.gy
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The AIDS Secretariat - Ministry of Health
One (1) Day UNGA Stakeholders Consultation
Mount St. John's Medical Centre Conference Room
Monday 24th June, 2013

No.	Name	Organization	Position	Contact #	Email Address
1	Dave Bridgewater	MSJMC	Pharmacy Manager	764-1203	DaBridge26@gmail.c
2	Sheila Rogers	Directorate of Gender Affairs	Executive Director	462 3990	10seaus@hotmail.com
3	PAUL JOSEPH	3H	CARE GIVER	785-7552	
4	Lucetta McPherson	AIDS Secretariat	Messenger	726-8805	
5	Roxanne Herbert	AIDS Secretariat	Senior Clerk	779-0588	queenhenny@hotmail
6	Arnetta Lowe	AIDS Secretariat	Junior Clerk		
7	Delcora Williams	AIDS ~~Programme~~ Secretariat	AIDS Programme Manager		
8	Dawn Small	NAS Secretariat Manager			
9	Alex Prince	3H NETWORK			AlexPrince23@Hotmail.c
10	Wendel Robinson	Police	Supt of Police	764-8796	wendelrobinson@g
11	Delcora Williams	AIDS ~~Programme~~ Secretariat	AIDS Programme Mngr	764-8252	aidssec@antigua.gov.a
12	Kim Martin	Substance Abuse	Drug Educator	784-4955	laurieKimi@hotmail.com
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The AIDS Secretariat - Ministry of Health
One (1) Day UNGA Stakeholders Consultation
Mount St. John's Medical Centre Conference Room
Monday 24th June, 2013

3

No.	Name	Organization	Position	Contact #	Email Address
1	Ammarilla Henry	ACE } ABHAN	Counselor/Educator	773-8518	goallight58@hotmail.c
2	Oswald Hannaway	AIDS Secretariat	Ca-Seller and Education	764-8250	glenfield@live.com
3	Gail Askew.	"	HIV Coordinator / Secretary	778-0227	ladygaddd@yahoo.com
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The AIDS Secretariat - Ministry of Health
One (1) Day UNGA Stakeholders Consultation
Mount St. John's Medical Centre Conference Room
Monday 24th June, 2013

No.	Name	Organization	Position	Contact #	Email Address
1	Arlea Gregory	MSJMC	Nurse Midwife	728-0560	arleas39@yahoo.
2	Sybil Knowles-Smith	Community	Nurse Epidemiologist	461-8497	SYbmksmith@yahoo.com
3	ORIN JERRICK	Police / CHAA	Community Animator/Rhic	7885679	Genderissues with Orin@hs
4	ROLAND CURRY	Police	Community Policing	789-1679	OLIVER@LANDW.ag.
5	MERVE JOSEPH	Probation Unit	Probation Officers	725-3248	Mervejoseph@hotmail.com
6	RICHARD HADEED	BIOHEALTH MEDICAL LAB	OWNER / MEDICAL TECHNOLOGIST	720-3738	INFO@BIOHEALTHLAB.NE
7	CLAUDINE KNISBETT	WOMEN AGAINST RAPE	PARTNER & VOLUNTEER	725-9390	cnjnisbett@yahoo
8	Patricia Galloway	ANTIGUA/BARBUDA HIV/AIDS	PEER COUNSELLOR	770-3508	Heartthylove96@hotmail.
9	Wonetta Corbin	Health Hope & HIV Network	Partner & Volunteer	7850557	Wonetta-4@hotmail.
10	Rev Karen Brathwaite	Health Hope & HIV Network		764-8249	Honeycity@hotmail
11	Jacqueline Wise	MSJMC	Infection Control Nurse	484-2766	infectioncontrol@msjmc.o
12	Abel Barrios Blanco	AIDS Secretariat	Epidemiologist	7288676	barriosblanco@yahoo.u
13	Everton Pigott	AIDS Secretariat	Counsellor/Educator	764-8254	evertonpigott@Gmail.com
14	Condon Jarvis	MSJMC	Chief Medical Technologist	7645618	cajarvis@hotmail.co
15	WESLEY SIMON	IMMIGRATION DEPT.	SNR SUPERVISOR	725 2530	wsimon1@hotmail.com
16	Paulette Ambrose	Labour DEPT	SNR LABOUR OFFICER	764 0453	RJbambro@hotmail.co
17	Dr Maria Pereira	Min of Health	CCC	725-6000	mfpereira@gmail
18	Keithly Thomas	Immigration Dept.	Grade V Officer	779-4310	timbeeland_kbt@hotmail.
19	SHERILYN FREDERICK	ABHAN		771-2005	
20	Elisha Walker	ABHAN	Peer Counsellor	774 1888	EGwalker57@gmail.c
21	Eleanor Frederick	ABHAN	Executive Director		helenfred@hotmail.
22	ALEXANDRINA WONG	WHR	PRESIDENT	721-5553.	Womenagainstrapeab

1. Documents reviewed.

2. Human Rights Report

3. List of Participants interviewed

Annex Two

A number of policies and guidelines reflect programmatic guidance and addresses issues of HIV integration.

1 . Poverty Alleviation Strategy

2. Food and Nutrition Guidelines

4. Antigua and Barbuda HIV Care and Treatment guidelines
5. Antigua and Barbuda HIV Testing Policy

6. United Nations Development Assistance Framework (UNDAF) for Barbados and the Organisation of Eastern Caribbean States (OECS) 2012 to 2016

7. HIV in the Workplace Policy (Not ratified but assisting in guidance of the Labour department in addressing HIV related Labour matters)

8. Antigua and Barbuda HIV Care and Treatment Guidelines.

a. While HIV testing is provided by eight VCT sites and four private facilities in Antigua and Barbuda, only government run VCT sites and the Antigua Planned Parenthood Association provides counseling. Additionally, data on HIV testing uptake are only accessed from government run facilities. HIV testing disaggregated by gender is outlined below.