A PROGRESS REPORT TOWARDS UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT, CARE AND SUPPORT IN THE CARIBBEAN

KEEPING SCORE II

A CONSOLIDATED REGIONAL ANALYSIS OF REPORTS SUBMITTED TO THE UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON HIV/AIDS - 2008

UNAIDS – CARIBBEAN REGIONAL SUPPORT TEAM (CAR-RST)
VOLUME 2 – 2008

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

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ACKNOWLEDGEMENTS

UNAIDS applauds Caribbean governments for their strong determination to honour the 2001 UN General Assembly Special Session on HIV/AIDS (UNGASS) Declaration of Commitment by submitting a record number of their 2008 Country and Territory Reports. It is also important to underscore the quality of the information provided and the initiatives undertaken to document best practices. Using UNGASS reporting standards, each of the 18 countries and territories under discussion has identified challenges affecting its national response to HIV and also developed a framework for the most effective approach to these challenges.

UNAIDS extends a very special acknowledgement to its 10 cosponsors, (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank), the Pan Caribbean Partnership against HIV/AIDS (PANCAP), the US Centers for Disease Control and Prevention (US-CDC) and the US Agency for International Development (USAID), the Caribbean Epidemiology Centre (CAREC/PAHO), the Caribbean Health Research Council (CHRC) and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). These partners have directly or indirectly contributed to the strengthening of data collection and monitoring and evaluation systems. In some instances they have also supported country-level activities to facilitate reporting on the 2008 UNGASS indicators.

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UNGASSindicators@unaids.org.

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARV/ART	Antiretroviral/Antiretroviral Treatment
BSS	Behavioural Surveillance Surveys
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CARIFORUM	Caribbean Forum
CCNAPC	Caribbean Coalition of National AIDS Programme Coordinators
CHRC	Caribbean Health Research Council
CDARI	Caribbean Drug Abuse Research Institute
CRIS	Country Response Information System
CRSF	Caribbean Regional Strategic Framework
CRN+	Caribbean Regional Network of People Living with HIV/AIDS
DHS	Demographic and Health Surveys
EU	European Union
FHI	Family Health International
FSW	Female Sex Workers
GAMET	Global AIDS Monitoring and Evaluation Team
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
DU	Drug User
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSM	Men who have Sex with Men
MSW	Male Sex Workers
OVC	Orphans and Vulnerable Children
OECS	Organisation of Eastern Caribbean States
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
US-CDC	United States-Centers for Disease Control and Prevention
USAID	United States Agency for International Development
UWI	University of the West Indies
WHO	World Health Organization

Country Abbreviations

ANT	Antigua & Barbuda
ARU	Aruba
BDO	Barbados
BEL	Belize
BHA	Bahamas
BVI	British Virgin Islands
CUB	Cuba
DOM	Dominica
DOR	Dominican Republic
GRE	Grenada
GUY	Guyana
HAI	Haiti
JAM	Jamaica
SKN	St Kitts & Nevis
SLC	St Lucia
SUR	Suriname
SVG	St Vincent & the Grenadines
TCI	Turks & Caicos Islands
TNT	Trinidad & Tobago

PREFACE

This consolidated regional analysis of 2008 UNGASS Reports, **Keeping Score II,** highlights progress made to date in the Caribbean response to the HIV epidemic. The review details successes and best practices but also focuses on the challenges still facing a region with a growing awareness of the multi-layered threat that AIDS represents. What has been done? What is working? What needs to be done? What can work better?

These are the questions posed and answered in **Keeping Score II** through the examination of the sustainability of political will and the use of knowledge and strategies to achieve impact and mitigate weaknesses. This document also provides a comparative analysis of developments since **Keeping Score I** was published in 2006.

World leaders have pledged their commitment to challenging HIV through signed global agreements such as the Political Declaration arising from a UN High-Level Meeting in June 2006. A follow-up meeting was held in June 2008 which re-affirmed the goal of universal access to HIV prevention, treatment, care and support services by 2010. Caribbean governments have joined this worldwide movement and, with assistance from their partners, have implemented strategies for a rapid scale-up towards the universal access goal, setting ambitious but realistic targets and devising strategies for greater effectiveness.

Keeping Score II, which has been able to draw on a marked increase in the number of UNGASS Reports submitted for this round, shows how the Caribbean is addressing these international commitments. Overall, it demonstrates that despite shortcomings, considerable progress in the response to HIV has been accomplished in the region. The will to strengthen the challenge to the epidemic has increased markedly, along with the availability of programmes and services. Through greater access to treatment, the quality of life for many people living with HIV has improved immeasurably and fewer of the region's children are dying from AIDS.

UNAIDS and CARICOM/Pan Caribbean Partnership on HIV/AIDS urge Caribbean governments to capitalise on these gains, while addressing the sometimes serious obstacles and challenges which remain. **Keeping Score II** offers a unique opportunity to review lessons learned in the past two years and to use those lessons to try to ensure that all of the region's children, women and men have access to the prevention, treatment, care and support that they need.

Edward Greene
Assistant Secretary-General
CARICOM Secretariat
Georgetown, Guyana

Michel Sidibe
United Nations Assistant Secretary-General
UNAIDS Deputy Executive Director, Programme
Geneva, Switzerland

Photo Credit: infomatique.org

FOREWORD

In June 2001, 189 United Nations Member States signed a Declaration of Commitment to respond to an HIV epidemic which has become a serious threat to human development and national and international security. The Member States used this Commitment, signed during the first United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, to pledge to combine efforts and share ideas about how to prevent the spread of the virus and mitigate its impact on individuals, families and communities.

The Caribbean was ready for the Declaration of Commitment. It had already established a regional partnership to challenge HIV in February 2001, the Pan Caribbean Partnership against HIV/AIDS (PANCAP) which embraced the 'One Caribbean' principle in its mandate. Operating under the leadership of the Caribbean Community (CARICOM), PANCAP is an outstanding partnership between regional institutions, international agencies and bilateral donors.

PANCAP has helped mobilise regional political leadership and the international community to support the Caribbean in responding to HIV. With the assistance of UNAIDS and its cosponsors, PANCAP and other regional institutions have developed Caribbean measurement tools to be used to monitor the epidemic and the response to it.

In June 2008 the world came together once again for a High-Level Meeting in New York to review progress towards international commitments such as universal access to prevention, treatment, care and support by 2010 and how these targets can be met. There was a consensus that in each region gains had been made and real results were visible: a certain optimism was warranted. However, it was clear that there was little room for complacency and that considerable work was still to be done in all aspects of the response.

At that High-Level Meeting the CARICOM/PANCAP delegation, led by Dr. the Hon. Denzil Douglas, Prime Minister of St Kitts & Nevis and Chair of PANCAP, was out in force. The Prime Minister and Ministers of Health, Family and Youth from the Caribbean demonstrated to the world that strengthening and deepening the challenge to AIDS in the region was an absolute priority.

Such a state of affairs is reflected in the fact that 2008 saw a total of 18 country and territory progress updates (known as UNGASS Reports) submitted to UNAIDS for review. In this publication, **Keeping Score II,** UNAIDS Caribbean Regional Support Team uses a consolidation of these reports to present decision makers and the regional and international community with a synthesis of achievements and challenges in the Caribbean response to HIV.

Best practices have been identified and included. Of importance is the progress accomplished in the area of political commitment, the broadening of the challenge to HIV by strengthening the involvement of civil society organisations in some countries (particularly the leadership role of people living with HIV), prevention of mother-to-child transmission and antiretroviral treatment.

Today, Caribbean countries are reviewing and improving their laws and their ethical standards, more resources are allocated to respond to the epidemic, more pregnant women are tested and fewer of their children are living with HIV. In addition, greater numbers of people with the virus have access to life-prolonging and life-enhancing treatment, more young people know HIV prevention measures and more vulnerable population groups are using condoms and testing and counseling services.

Gaps, however, remain in relation to prevention and social support for those affected. Strategies addressing the most vulnerable population groups, such as men who have sex with men, male and female sex workers, young women and prisoners should be at the very heart of the response. Yet they are not. This needs to change if we are to really make inroads against the epidemic.

It is imperative that key challenges are met and key successes are built upon if we are to fulfill our joint responsibility to make universal access by 2010 a reality.

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EXECUTIVE SUMMARY

Since the original UN General Assembly Special Session (UNGASS) on HIV/AIDS was held in June 2001, there have been a series of High-Level UNGASS meetings, in 2006 and 2008, to act as milestones to help shape and sharpen the challenge to the virus. **Keeping Score II** is a consolidated analysis of 18 UNGASS Country and Territory Reports which were submitted to the 2008 meeting. 21[1] reports were completed in total (the three which were narrative in nature have not been included here). This represents a significant increase from the 15 reports received in 2006.

The 2008 UNGASS round has shown some marked successes. As well as more countries and territories reporting, the great majority have submitted information on more than half of their indicators covering the period 2006 to 2007. Only five did not. **Keeping Score II** aims to help decision makers in the Caribbean to assess progress made in identifying gaps and challenges in the response to HIV. Steps forward in relation to UNGASS indicators are assessed in each *individual* country and there is also a *collective* review of these indicators to highlight regional accomplishments and shortcomings.

1. Leadership and Multisectoral Involvement

Political will and domestic and international support have generally increased in the region. In increasing instances the highest political offices, senior government officials and line ministries are responding to HIV. Several countries have National AIDS Commissions or Committees which continue to function under the central leadership of the Prime Minister's Office.

1 UN countries: Antigua & Barbuda, the Bahamas, Barbados, Belize, Cuba, Dominica, the Dominican Republic, Grenada, Guyana, Haiti, Jamaica, St Kitts & Nevis, St Lucia, St Vincent & the Grenadines, Suriname, Trinidad & Tobago.
Territories: Anguilla, British Virgin Islands, Netherlands Antilles, Aruba, Turks & Caicos

The region is committed to the attainment of universal access to prevention, treatment, care and support by 2010 and country targets have been set. The Pan Caribbean Partnership against HIV/AIDS and UNAIDS and its cosponsors have assisted in this process. Another significant development is that the project-orientated approach existing in many countries in 2004-2005 is being slowly replaced by joint planning and reporting through national programmes, including monitoring and evaluation structures.

Progressively, gains have been made in implementing the "**Three Ones**" which work towards greater harmonisation and coordination, **with one national action framework, one coordinating authority and one monitoring and evaluation system.** HIV is gradually being addressed across a variety of sectors, not just health ministries. This can change, however, and there is a threat among small island settings that HIV will be brought back under the sole remit of the health sector. This is due to limited human resource bases, low absorptive capacity and other challenges specific to such settings (*British Virgin Islands and Dominica, 2008 UNGASS Reports*).

Despite these potential drawbacks, small islands are encouraged to take into account the exceptionality of HIV and maintain the multisectoral aspect of their responses.

Other areas where leadership is key include: the recognition that more decentralised service delivery systems may be necessary (this has been highlighted by the Bahamas and Trinidad & Tobago), and the fact that long-term sustainability of scaled up services must be addressed.

2. Prevention

Prevention of mother-to-child transmission (PMTCT)

In terms of service delivery, gains have been made in the area of PMTCT. Several countries reported improvement in the quality of life of mothers living with HIV and fewer children are being infected or are dying from AIDS. PMTCT coverage is high in a number of countries. However, several larger islands such as the Dominican Republic and Haiti, with serious heterosexual epidemics, are lagging behind in the area of PMTCT and this could compromise success at a regional level.

Table 1: PMTCT coverage in the 10 larger Caribbean countries

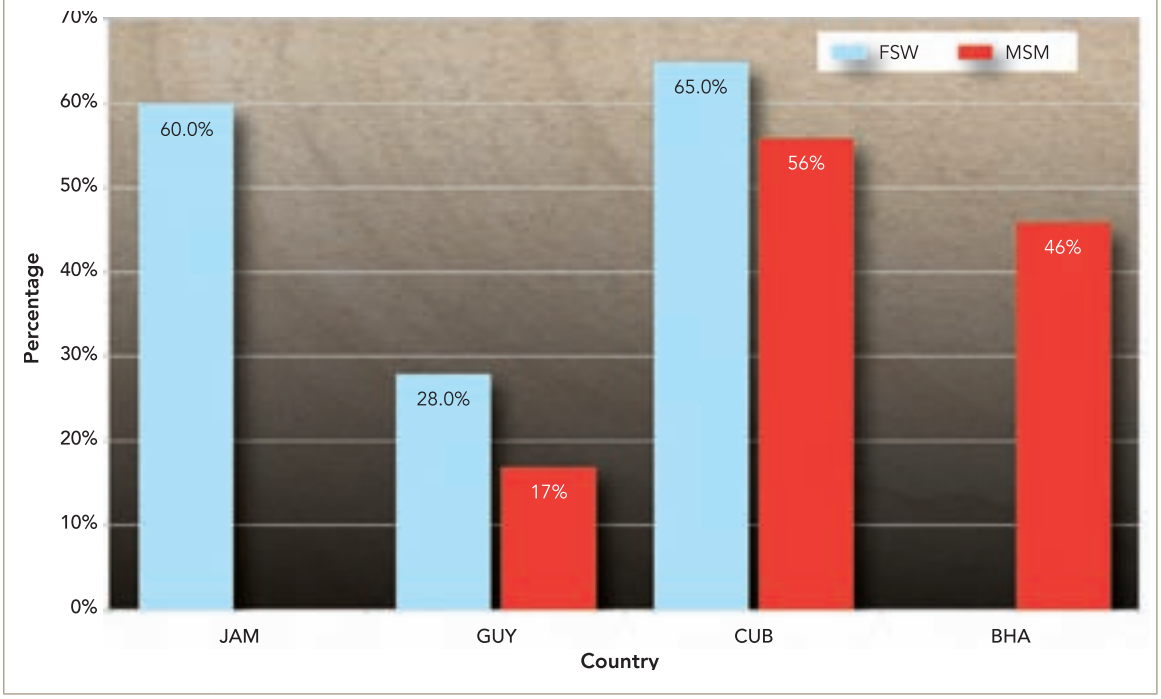
COUNTRY	PMTCT COVERAGE
Bahamas	95%
Barbados	95%
Belize	[24-64%]
Cuba	95%
Dominican Republic	41%
Guyana	[29%-95%]
Haiti	22%
Jamaica	[45%-95%]
Suriname	[18%-57%]
Trinidad & Tobago	[37%-78%]

Source: UNICEF/UNAIDS/WHO Second Stocktaking Report, 2008

Prevention among the general population and most vulnerable populations

Prevention programmes mainly target the general population but have achieved only limited impact. For example, data have shown that the percentage of adult women and men who use a condom during casual sex remains low. Voluntary counseling and testing campaigns implemented as a prevention measure have reached only 30% of the adult population in Cuba which provides the best case scenario. Also, the percentage of adults reporting multiple sex partners per year is high across the region. In Trinidad this figure is 85%. Regarding the most vulnerable populations, as demonstrated in the graph below, prevention programmes often reach a very low percentage of men who have sex with men, and male and female sex workers.

Graph 1: Percentage of female sex workers and men who have sex with men reached with HIV prevention programmes



Source: UNAIDS Report on the global AIDS epidemic, 2008

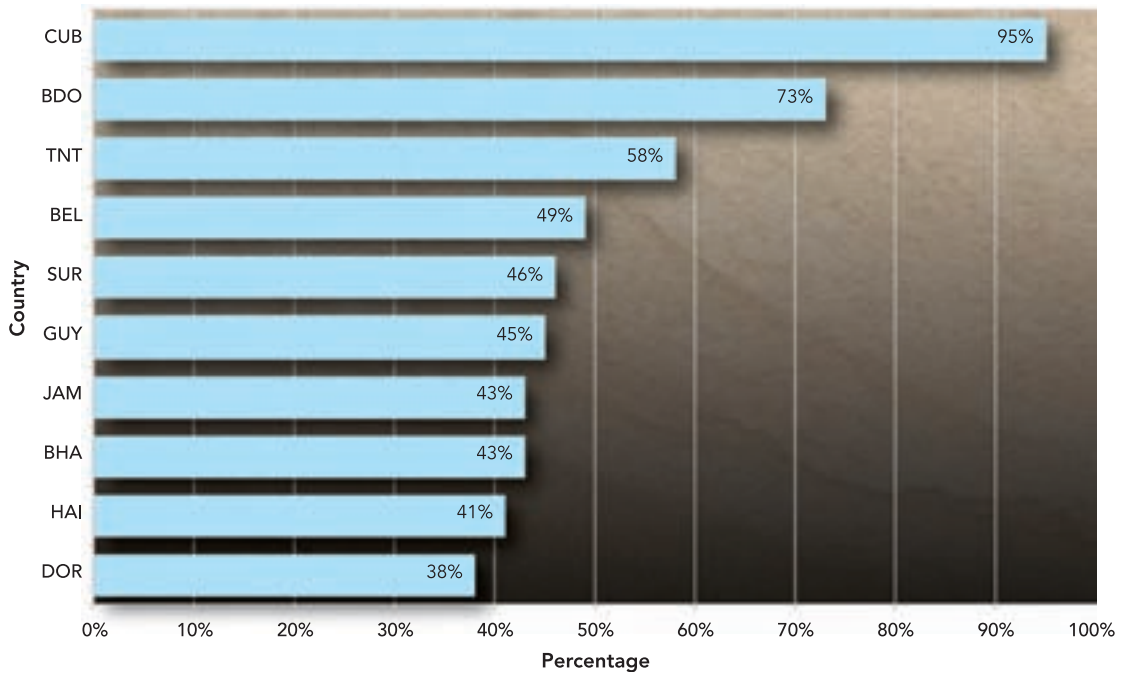
Prevention of HIV transmission through blood transfusion

Progress has been accomplished in this area; the majority of Caribbean countries reporting on this indicator have achieved a 100% HIV screening policy for donated blood units. Only two countries have not reached that target, but may be on track to do so in the near future.

3. Care and Treatment

In the area of care and treatment, many countries reported improvement in the quality of life of people living with HIV and fewer children are being infected or are dying from AIDS. There were 4,000 people under antiretroviral therapy in 2003: that figure had risen to 30,000 in 2007. However, larger countries such as the Dominican Republic and Haiti are lagging behind in this area *(UNAIDS Report on the global AIDS epidemic, 2008)* and this is having an impact on the success being accomplished regionally.

Graph 2: ART coverage rate in the 10 larger Caribbean countries, 2007



Source: UNAIDS Report on the global AIDS epidemic, 2008

Taking into account the estimated 14,000 deaths due to AIDS-related illness in 2007, there is a need for scaling up of interventions which are critical to access and quality of prevention, treatment, care and support services and programmes in the Caribbean.

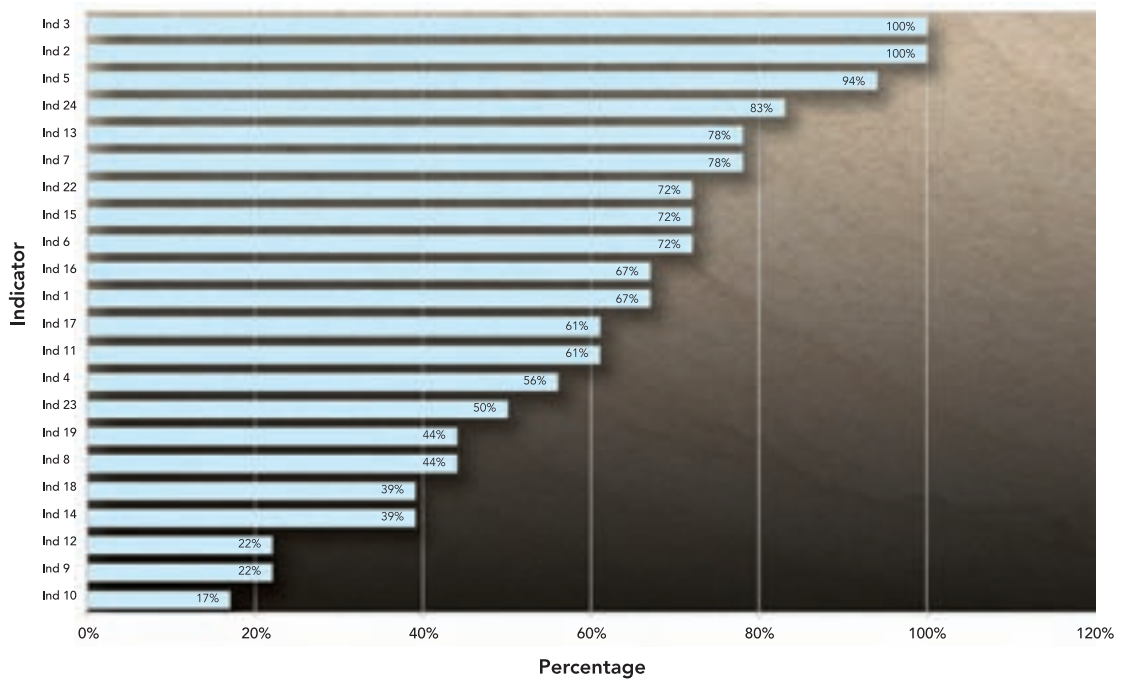
4. Civil Society Involvement

The role of civil society in the response cannot be overstated. A comprehensive strategic approach to engage these organisations so that they can play their central role in service provision, implementation and holding partners accountable is a prerequisite. In the Caribbean, civil society participation in the national response to HIV is growing and often includes representation from most vulnerable populations and people living with the virus. However, these organisations continue to need capacity building in several areas such as programme management, reporting, advocacy and communications.

5. Human Rights and Support

In the area of human rights and support for the most vulnerable populations including orphans and vulnerable children, there are reporting gaps as demonstrated in Graph 3[2]. In the majority of the countries, reporting on indicators related to those groups has been very low. Very few, for example, have submitted data on the situation for orphans and vulnerable children.

Graph 3: Percentage of Caribbean countries and territories reporting by indicator: UNGASS 2008



Source: UNAIDS Report on the global AIDS epidemic, 2008

The Caribbean has to move quickly to confront human rights issues facing most vulnerable populations (for example, the criminalisation of sodomy and sex work) and to engage in the meaningful involvement of these populations who do not receive the attention they need, given that they carry the greater burden of the virus.

Stigma and discrimination against those infected with and affected by HIV are widespread and are recognised as a major barrier to accessing prevention, testing and treatment. The five strategic areas highlighted in this chapter present the major strengths and challenges in the Caribbean response to HIV. In order to stimulate action in addressing identified gaps and expanding successes, key message and recommendation are highlighted on pages 12 and 13.

2 Indicator 10: Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child.
Indicator 9: Percentage of most-at-risk populations reached by prevention programmes
Indicator 12: Current school attendance among orphans and non-orphans aged 10-14
See Table 2 for full list of Indicators.

KEY MESSAGES AND RECOMMENDATIONS FOR CARIBBEAN DECISION MAKERS

1 Reporting on UNGASS indicators has improved in 2008 compared to 2006. But there are still information gaps. Most countries do not yet truly know their epidemic. Decision makers should step up their efforts to collect, analyse and use data for planning, policy formulation and assessing progress accomplished.

2 Domestic and international spending on AIDS has increased in the Caribbean. However, in many countries the level of spending still does not match the need. More resources should be mobilised and effectively invested where maximum impact can be achieved.

3 Political will and support have increased and a multisectoral approach has been adopted in many countries. This should be expanded and strengthened using the "**Three Ones**" approach.

4 Most Caribbean countries have achieved 100% coverage of screening donated blood units for HIV. In Antigua & Barbuda and Grenada, where full coverage has not been achieved, interventions to screen all donated blood should be implemented.

5 The number of people on antiretroviral therapy in the region increased from 4,000 in 2003 to 30,000 in 2007. But treatment coverage remains low in most countries: only Barbados, Cuba and Trinidad & Tobago achieved more than 50% coverage in 2007. National ART programmes should be scaled up.

6 The percentage of adults and children known to be on treatment 12 months after initiation of ART is below 80% in Antigua & Barbuda, the Bahamas, Guyana and St Vincent & the Grenadines, but above 80% in the majority of countries. Access to *early* diagnosis and treatment services, including ART, is a necessity.

7 Prevention of mother-to-child transmission coverage has increased in many countries. However, Haiti and the Dominican Republic have a low coverage rate, i.e. 22% and 41%, respectively. Caribbean decision makers should sustain or scale up PMTCT programmes.

8 During 2007, the coverage of treatment of HIV/TB co-infection was high in some countries but low or very low in others. Given that tuberculosis is one of the leading causes of AIDS-related death, decision makers should aim at 100% treatment coverage of HIV/TB co-infection.

9 Testing and counseling is an important strategy to reduce HIV transmission. In 2007, the percentage of women and men 15-49 tested for HIV was low in most countries. Decision makers should promote 'Know Your Status' campaigns to improve national coverage of testing and counseling.

10 Among most vulnerable population groups such as male and female sex workers and men who have sex with men, testing and counseling is higher than in the general population. This practice should be encouraged.

11 In the Caribbean, crack cocaine use has been and remains a driver which increases the risk of transmission of HIV and epidemiological data suggest that almost 18% of crack cocaine users are living with HIV – mainly in Jamaica, Trinidad & Tobago and St Lucia. Therefore UNAIDS encourages countries to collect information among crack cocaine users as part of most-at-risk populations.

12 Prevention programmes have generally not been very successful. In 2007, **10,000** people were put on ART while **20,000** new HIV infections occurred, i.e. for **every five people put on ART in the Caribbean 10 were newly infected.** Prevention programmes need a comprehensive and rapid scale-up to achieve an increase in knowledge about HIV, a reduction in sexual partners, condom use during casual sex and delayed initiation of sexual activity among young people.

13 Information relating to children affected by HIV was lacking in the UNGASS Reports. Caribbean decision makers should put systems in place to collect and analyse this data which is important from the perspective of child rights, human rights and social justice.

14 HIV is disproportionately affecting the most vulnerable population groups (MSM, FSW and MSW), young people and crack cocaine users *(see Indicator 23)*. Decision makers should scale up prevention, care, harm reduction, treatment and support interventions among all these groups.

15 Overall, significant progress has been made in the Caribbean: the epidemic appears to have stabilised in many countries, but it has done so at a high level. If this situation is to change, all interventions need to be scaled up, and beyond that, decision makers need to tackle stigma and discrimination effectively and implement legislative reform to ensure that the human rights of vulnerable populations and those infected with and affected by HIV are respected.

Lorna's Story

Lorna Henry was diagnosed with HIV in 2001. She is married with two children and is working hard to overcome stigma and discrimination

Lorna Henry takes to the podium at the launch of the 2008 UNAIDS Report on the global AIDS epidemic

Credit: UNAIDS

"By coming out openly at the beginning of 2008, I feel as if I have really empowered myself. It's been a weight off my shoulders and I have found a lot of support, sometimes in the most unlikely places. My mind is a little more at ease now and my health is better as I don't have the stress of hiding any more and hoping that no one will find out. Before when I was depressed I had to stay in depression alone, except for my husband. But now I have plenty of people who are there to hold my hand.

Going public with my status has not been the easiest thing, though. Discrimination is still very much out there. My husband, who's negative, used to be really sociable and have a lot of friends but not so many come around now. If someone is difficult with me he'll challenge them. He loves me and always puts me first.

My openness about my status has also affected our income as I lost my job in a supermarket and it's harder to make ends meet. My children have been barred from a particular nursery school even though they are not living with the virus. The teacher told me point blank that she didn't want my kids in her school. I am leaving her to God. It hurts me that my family has suffered like this.

But I know that people can change. My mother reacted badly when she first found out and told me to leave the house but she has a really different attitude now and she asked me to come back. She loves being with her grandchildren. Some of the people who I thought would run way from me have shown they are there for me. They tell me how brave I am. They're standing behind me.

I can see why people choose not to disclose their status. It's not an easy road to take. But I'm glad I did. I feel stronger and calmer. I'm happy, though I have down days where I just want to cry all the time. I'm teaching my kids to be stronger too in the midst of all of this. I am standing on my own two feet. I want to be treated like everyone else and have the same opportunities. I'm not a special case and I don't want anyone's pity or sorrow. Yes it's true I have HIV and too bad if that means you don't like me. I'm here to stay."

Photo credit: Steve Woods

I. INTRODUCTION AND BACKGROUND: UNGASS 2008

Goals and targets included in the 2001 UNGASS Declaration of Commitment relate to a core set of indicators designed and tailored to track progress in specific strategic areas. These indicators are all essential for the development of a comprehensive national response to HIV which is effective in its impact. These areas include:

- National commitment, policy, and organisational structure;
- Scaling up delivery of essential services in prevention, treatment, care and support;
- Change in knowledge and modification of behaviour;
- Measuring impact of the epidemic (levels of infection and survival rates);
- Global commitment and action.

To support the full implementation of the UNGASS 2001 Declaration at country level, a strategy with guidelines was made available to UN Country Teams and Regional Support Teams. That strategy has facilitated the target setting and the identification of milestones for 2003, 2005 and 2010. It is intended that 2010 should see the attainment of universal access to HIV prevention, treatment, care and support.

Countries have committed themselves to report on UNGASS targets on a biennial basis, covering data from 2001-2003, 2004-2005 and 2006-2007. In analysing reports from these different periods, **Keeping Score II** demonstrates both the level of completeness in reporting on these targets and progress achieved.

The regional process is fully endorsed by high-level leadership in the Caribbean, as well as the Pan Caribbean Partnership against HIV/AIDS and National AIDS Committees and Programmes at country level. Monitoring and evaluation has become a strategic area of importance in the management of the response and it has resulted in an increase in national data available for planning and decision making.

In the Caribbean, UNGASS reporting now involves greater numbers of civil society organisations and international and regional partners. The process is globally led by UNAIDS working closely with its cosponsors, (UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank). UNAIDS provides technical and financial support to sustain and strengthen the UNGASS process at national and regional levels.

Other bilateral and international funding agencies, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), World Bank-GAMET and the US President's Emergency Plan for AIDS Relief (PEPFAR), are contributing to the achievement of standardisation and harmonisation of indicators and the reporting process at all levels.

The strong commitment and sustained support provided by the various actors involved in the challenge to HIV have made a profound difference in the UNGASS reporting process. **From very few reports submitted in 2003, by early 2008 some 18 Caribbean governments had completed UNGASS Reports in time for submission for the 2008 Global Review. In addition, countries and territories have increased the number of indicators reported on and the quality of the data included.**

Table 2: UNGASS INDICATORS
National Commitment and Action

Indicator 1:	Domestic and international AIDS spending by categories and financing sources
Indicator 2:	National Composite Policy Index (NCPI)
NATIONAL PROGRAMMES	
Indicator 3:	Percentage of donated blood units screened for HIV in a quality assured manner
Indicator 4:	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy
Indicator 5:	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission
Indicator 6:	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV
Indicator 7:	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results
Indicator 8:	Percentage of men who have sex with men/female sex workers/male sex workers (MSM/FSW/MSW) who have received an HIV test in the last 12 months and who know their results
Indicator 9:	Percentage of most-at-risk populations (MSM/FSW/MSW) reached with HIV prevention programmes
Indicator 10:	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child
Indicator 11:	Percentage of schools that provided life skills-based HIV education in the last academic year
Indicator 12:	Current school attendance among orphans and non-orphans aged 10-14

KNOWLEDGE & BEHAVIOUR	
Indicator 13:	Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
Indicator 14:	Percentage of MSM/FSW/MSW who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
Indicator 15:	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15
Indicator 16:	Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months
Indicator 17:	Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse
Indicator 18:	Percentage of female and male sex workers reporting the use of a condom with their most recent client
Indicator 19:	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Indicators 20 and **21** related to injecting drug users are either irrelevant or no data are available for the Caribbean

IMPACT	
Indicator 22:	Percentage of young women and men aged 15-24 who are HIV-infected
Indicator 23:	Percentage of MSM/FSW/MSW and drug users (DU) who are HIV-infected
Indicator 24:	Percentage of adults and children with HIV infection known to be on treatment 12 months after initiation of antiretroviral therapy

Across the Caribbean an ever greater range of actors is becoming involved in the challenge to HIV. Grenada provides a case in point. The country's **'Put D Brakes on AIDS'** prevention campaign was launched in July 2008 with a motorcade that snaked its way across the country. Targeting youth aged 15-24 and timed to coincide with the carnival season, the campaign was spearheaded by the National AIDS Directorate in collaboration with two youth organisations; the Soubise Women's Group and the *Badd Cahh* Driving Club. Young people played a dynamic role in the planning and execution of the launch event, rendering it more likely that the messages involved (abstain, be faithful, use condoms) would resonate with the target audience. Soubise Women's Group and the *Badd Cahh* Driving Club also distributed condoms and pamphlets along the motorcade route and pledged their commitment to 'Put D Brakes on AIDS' by offering continued support to the July to December 2008 campaign.

Courtesy: Grenada National AIDS Directorate

Credit: Mark J. McArdle, Waterloo, Ontario, Canada

II. THE CARIBBEAN HIV EPIDEMIC

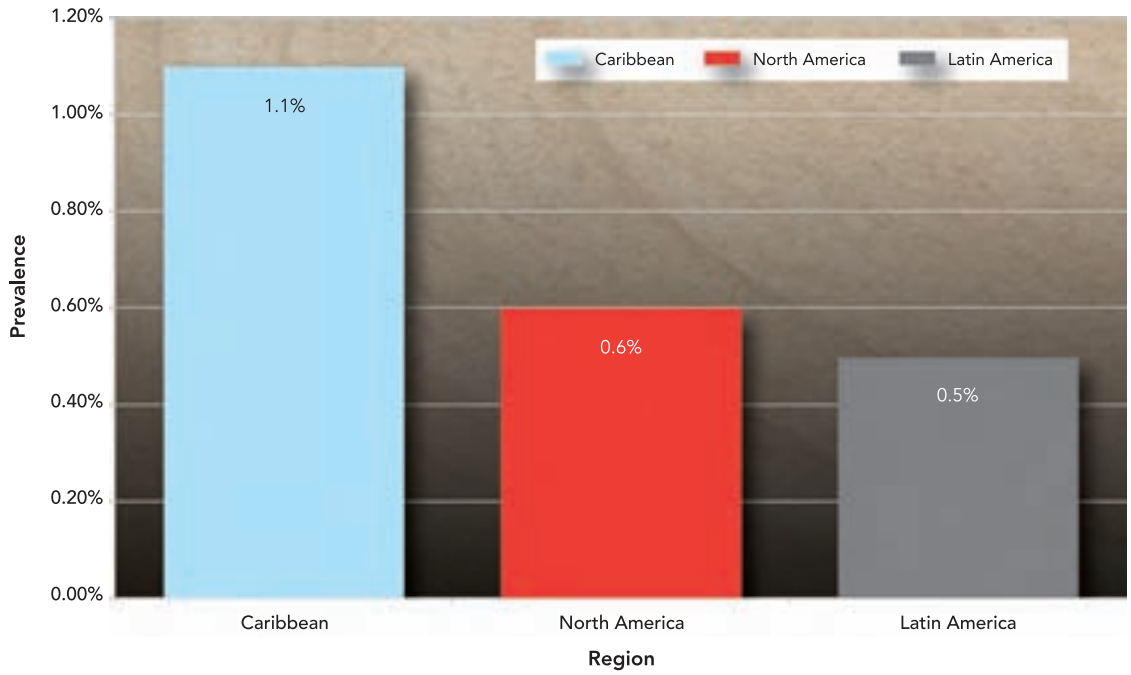
At the end of 2007 UNAIDS/WHO estimated that 230,000 people were living with HIV in the Caribbean, around 70% of them in Haiti and the Dominican Republic. Adult prevalence was estimated at 1.1% (1.0%-1.2%), making the Caribbean the second most affected region in the world. During 2007 alone, **the Caribbean lost 38 of its citizens to AIDS daily** (total deaths: 14,000 (11,000-16,000), most of them in the 25-44 age group.

Meanwhile, **every day 55 new HIV infections took place** (total new infections: 20,000 (16,000-25,000)). As Graph 4 shows, given an adult HIV prevalence double that in Latin America and almost double that in North America, the Caribbean bears the burden of the epidemic in the Americas.

It is important to mention that the number of people living with HIV in the region has grown from 210,000 (180,000-240,000) to 230,000 (210,000-270,000) between 2001 and 2007, close to a 10% increase (*UNAIDS Report on the global AIDS epidemic, 2008*). This calls for effective public health interventions leading to a reduction in new infections, decreasing the total numbers living with the virus, providing them with quality care and treatment and bringing the regional epidemic under control.

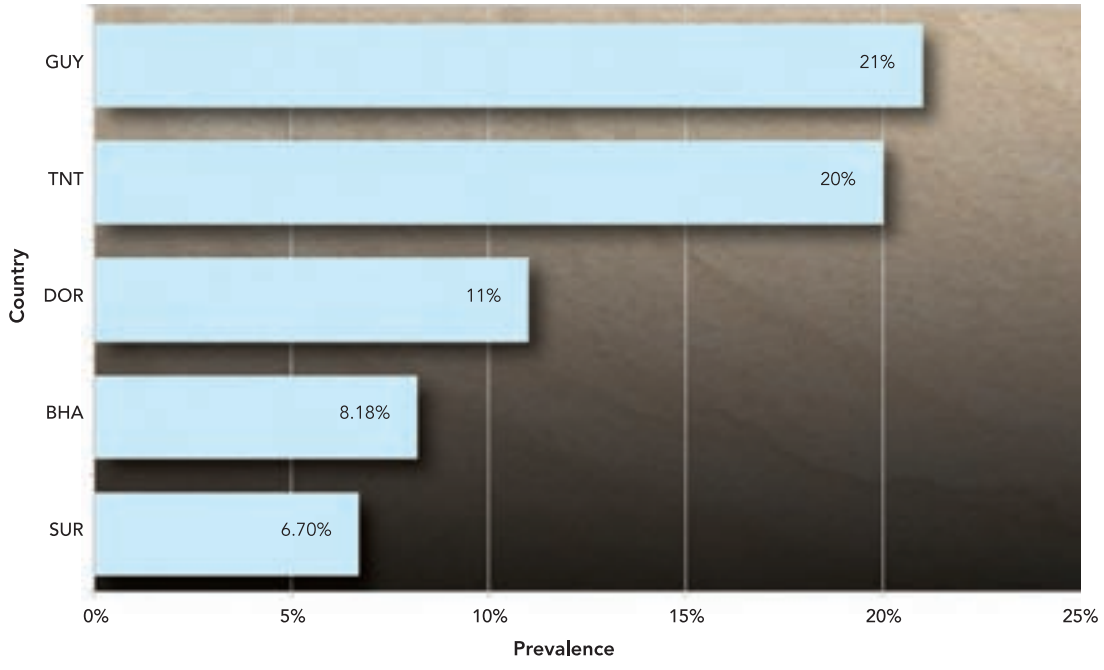
In the Caribbean, HIV is disproportionately affecting vulnerable groups: female and male sex workers, crack cocaine users, prisoners, young people and men who have sex with men.

Graph 4: Estimated adult HIV prevalence in the three regions of the Americas



Source: UNAIDS Report on the global AIDS epidemic, 2008

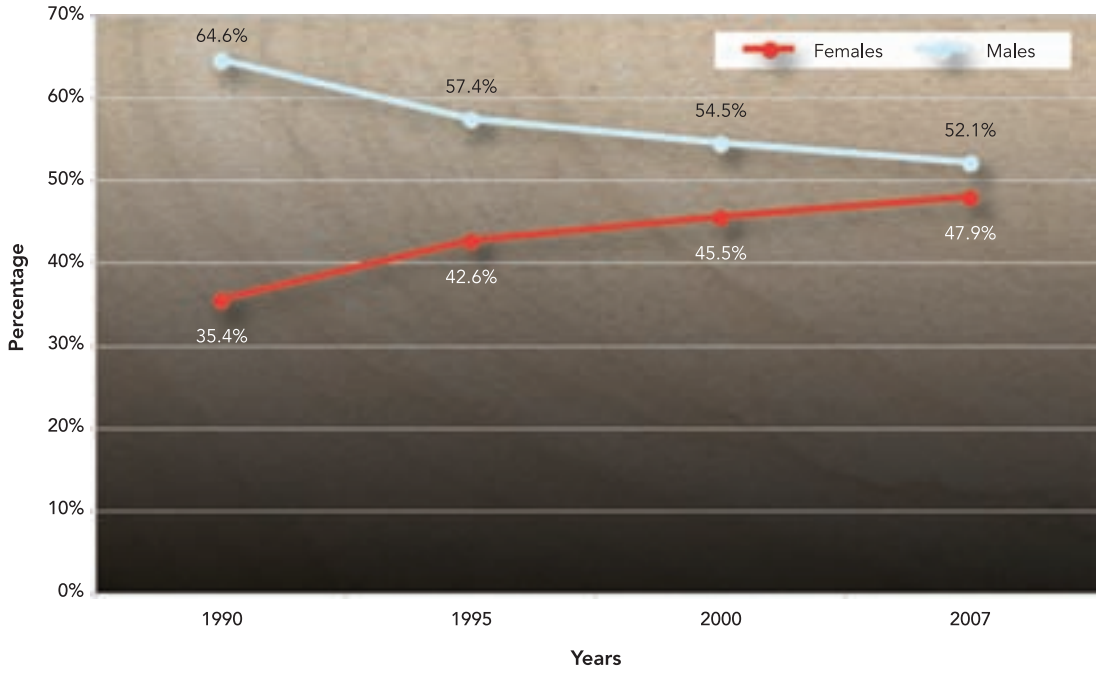
Graph 5: HIV prevalence among MSM in five Caribbean countries, 2005 – 2007



Source: UNAIDS Report on the global AIDS epidemic, 2008

The epidemic also has the specific characteristic of gradually affecting more and more women, especially the young. UNAIDS/WHO estimate that during the period 1990-2007, the male to female ratio in the population living with HIV has altered year on year from 65% male to 35% female in 1990 to 52% male to 48% female in 2007. Therefore, the percentage of women living with HIV in the Caribbean has increased by nearly 40% in the past 17 years.

Graph 6: Estimated percentage of adults living with HIV in the Caribbean – males & females, 1990 – 2007



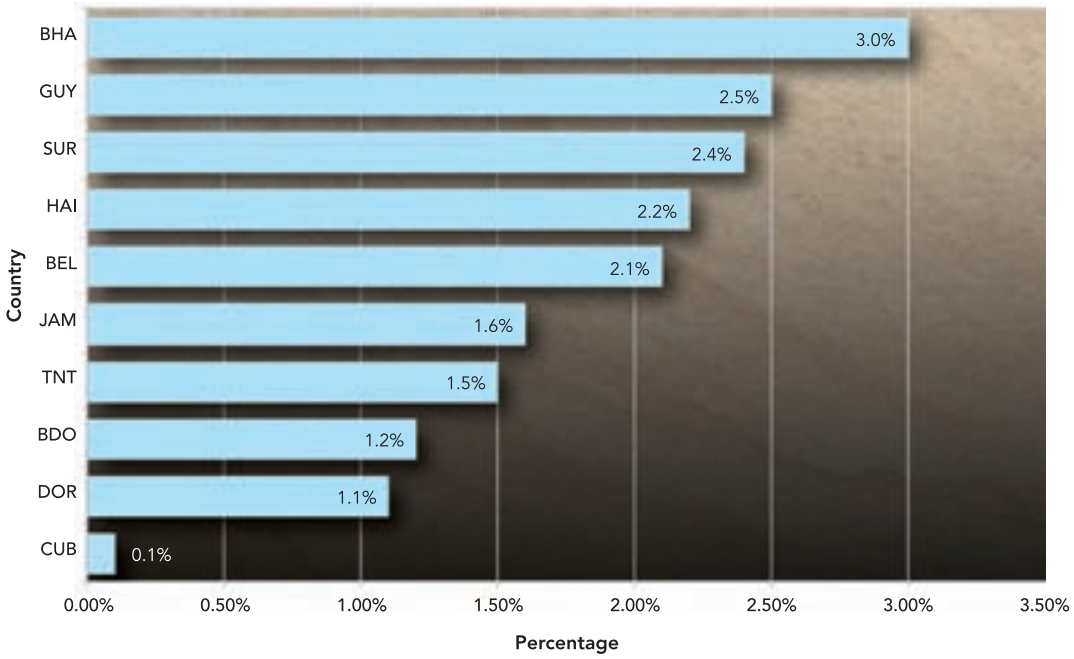
Source: UNAIDS Report on the global AIDS epidemic, 2008

The heterosexual aspect of the transmission of HIV has become increasingly evident and has serious consequences for the Caribbean family due to the unique role women play in its social and economic structures. 50% of heads of households in some Caribbean countries are female (*Report of the Caribbean Technical Expert Group Meeting on HIV Prevention and Gender, 2004*).

Data indicate that the region is confronting several HIV epidemics, with a nascent epidemic in Cuba and the oldest and most generalised in Haiti[3]. Also, the molecular distribution of HIV-1 subtypes indicates that there are several such subtypes circulating in the Caribbean *(Draft HIV Situational Analysis, UNAIDS-CAR, 2008).* As demonstrated in the graph below, variations in terms of HIV prevalence among adult populations exist between the 10 larger Caribbean countries. At 3%, the Bahamas has the highest adult prevalence; at 0.1 %, Cuba has the lowest.

3 **This consolidated summary of the HIV situation in the region is the result of an analysis of different types of data from national surveillance and case reporting systems, patients' cohort analysis, Behavioural Surveillance Surveys (BSS), Priorities for Local AIDS Control Efforts (PLACE), modeling and projections, scientific publications, and Demographic and Health Surveys (DHS).**

Graph 7: Adult HIV prevalence in the 10 larger Caribbean countries



Source: UNAIDS Report on the global AIDS epidemic, 2008

In conclusion, the epidemiological features of the HIV epidemic in the Caribbean are:

- The first AIDS cases were reported in Haiti in 1981. Since that time the Caribbean has been confronted with a growing HIV epidemic;
- The Caribbean is the most HIV-affected region of the Americas;
- The HIV epidemic is a mosaic, with a number of different epidemics within countries and across the region;
- AIDS is the leading cause of death among 25-44 year-olds with 38 deaths due to AIDS-related illness occurring every day;
- HIV is disproportionately affecting the most vulnerable population groups;
- HIV is gradually affecting men and women almost equally;
- 20,000 new HIV infections occurred in the Caribbean in 2007 representing close to 1% of the total new global HIV infections.

Credit: Jason Mical

III. THE CARIBBEAN RESPONSE

Map 1: The Caribbean Region

Courtesy of Dr. William A. Bowen, California Geographical Survey – http://geogdata.csun.edu

Several steps characterise the response to HIV in the region (*UNAIDS Best Practice Collection: PANCAP, 2004*). During the first phase (1981-1988), the World Health Organization established information centres around the world to share knowledge about the new epidemic. The Caribbean Epidemiology Centre (CAREC) was one of these, authorised by Ministers of Health to gather and publish information.

Initially, CAREC laboratory infrastructures assisted countries in collecting and shipping specimens for HIV diagnosis at CAREC/PAHO itself. This technology was quickly transferred to country level to ensure blood safety and support medical management of patients. For small island settings, CAREC/PAHO's laboratories are still providing the confirmatory HIV test results and providing direct support in case of natural disaster.

The second phase in the Caribbean response (1989-1994) was characterised by WHO/PAHO/CAREC supporting national AIDS programmes to develop and implement five year Medium Term Plans with focus on the health sector response to the epidemic.

There was also the tentative involvement of other sectors. During that phase, case definitions for HIV and AIDS were developed and a surveillance system established as well as a regional programme, the CAREC Special Programme on STI, which was staffed by public health specialists, epidemiologists, laboratory scientists and social communicators.

Phase three (1995-2000) was an attempt by the health sector to reach out to other sectors and establish a broad-based challenge to HIV. It became increasingly clear that the health sector could not carry the response to the epidemic alone. In 1996 UNAIDS was born and set about creating UN Theme Groups, which brought together different UN agencies at country level, to help strengthen the response.

New structures such as the Caribbean Regional Network of People Living with HIV/AIDS (CRN+) and the Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC) were established. Under the leadership of the CARICOM Health Desk, CAREC/PAHO and UNAIDS, a regional meeting was held in Kingston, Jamaica, to broaden regional action against the epidemic.

During that meeting the European Union pledged to support a multiagency plan of action. That plan was developed with the input and participation of CCNAPC, a range of institutions and UN agencies working in the region. In 1998, the Caribbean Task Force on AIDS was created and put under CARICOM's leadership. The Task Force developed a project proposal in 1998 for EU funding which became the EU-SIRHASC project (Strengthening the Institutional Response to HIV/AIDS/STI in the Caribbean). It included Haiti and the Dominican Republic as priority countries.

The current, fourth, phase started in 2001 and marks a turning point in the history of the Caribbean challenge to HIV. In Barbados during that year the Caribbean HIV/AIDS Task Force met to determine the future direction of the regional response. Its resolutions were submitted to the Heads of Government and the UNAIDS Executive Director for approval. These resolutions were based on CAREC/PAHO and SIRHASC experiences in managing 'multidonor' funded and 'multicountry' projects and partnerships and led to the establishment of the Pan Caribbean Partnership against HIV/AIDS. PANCAP embraces the 'One Caribbean' concept by involving all Caribbean countries and all major Caribbean donors. It mobilised new resources from the GFATM, the Clinton Foundation and the World Bank.

Guyana's Minister of Health, Dr Leslie Ramsammy, addressing an audience at the UNAIDS Guyana launch of the World AIDS Campaign, helps demonstrate that the Caribbean response to the epidemic is gearing up at all levels.

With the support of UNAIDS, PANCAP played a key role in the negotiation for price reduction of ARV drugs for the region. It has represented the Caribbean at international fora to highlight the seriousness of the epidemic and to share best practices with the rest of the world. In close collaboration with Member Countries, PANCAP/CARICOM, UNAIDS, Centers for Disease Control-Global AIDS Programme, the Clinton Foundation, the World Bank and CAREC/PAHO conceptualised and successfully implemented the "3 by 5" initiative in the Caribbean. (This global project aimed to get 3 million people in need on antiretrovirals by the end of 2005). As a result, a Regional Task Force on ART was formed and every Caribbean country developed and implemented an accelerated access to treatment plan. PANCAP has embraced the "**Three Ones**" principle in its entirety.

PANCAP enjoys strong support from UNAIDS and its 10 cosponsors, the University of the West Indies, the Caribbean Health Research Council, CRN+, Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC), the Caribbean Conference of Churches (CCC) and CARICOM. Each institution or agency participating in the PANCAP network plays a role based on its comparative advantage.

PANCAP functions under the chairmanship of the highest political offices in the Caribbean and the executive directorship of the CARICOM Assistant Secretary-General for Health and Social Development. It is a coordinating structure and relies on regional institutions, its own political and leadership network, UNAIDS and its 10 cosponsors for the implementation of projects, advice and technical support.

Financially assisted by donors and member countries, PANCAP also has donors, regional entities and UN agencies represented in its structure. It meets annually to assess progress and identify gaps to be address jointly in responding to HIV. Under the GFATM it oversees the Regional Coordinating Mechanism.

Efforts to respond to HIV in the Caribbean have resulted in many success stories in several countries. The most recent UNAIDS/WHO estimates published in 2008 show that the epidemic stabilised at around 1% adult prevalence between 2001 and 2007. The Bahamas, Barbados, Cuba and Jamaica have achieved more than 95% coverage of prevention of mother-to-child transmission, Barbados has reduced deaths due to AIDS by around 85% (2001-2006) and the Dominican Republic has lowered HIV prevalence among female sex workers. However, much remains to be done and specific attention should be paid to most vulnerable population groups and young women who are disproportionately affected by HIV.

There has been marked treatment success across the Caribbean with many countries able to provide ART free of charge to those in clinical need. In 2003 there were 4,000 people on treatment in the Caribbean. By 2007 that number had risen to 30,000. This has led to an often dramatic reduction of the number of AIDS-related deaths. For example, in Barbados between 2001 and 2006 such deaths dropped by more than 80%**

* WHO/UNAIDS/UNICEF: Towards Universal Access - Scaling-up Priority HIV/AIDS Interventions in the Health Sector. Progress Report 2008

** Government of Barbados. UNGASS Report 2008

Credit: UNAIDS/G. Pirozzi

IV. ENVIRONMENTAL AND SOCIAL INFLUENCES

The HIV epidemic started in population groups which were already stigmatised and ostracised by society at large and its religious tenets. HIV infection has been associated with commercial sex work and sex between men. This association between HIV infection and behaviours that have traditionally been stigmatised and taboo may lead to further stigma and discrimination and ostracism of key groups by religious communities. This in turn can affect the attitudes of society at large.

Such a religious and social interpretation of the virus has made it very difficult for decision makers, families, communities and leaders to openly engage in responding to the epidemic (**Keeping Score I**, *2006)*. Much remains to be done in the Caribbean to engage religious and cultural leaders in dialogue about the HIV response; in particular the need to include the most marginalised in society and those most vulnerable to infection in decision making processes.

It is generally admitted, then, that the first characterisations of groups at risk of HIV have not helped with the control of the virus. Casting the epidemic as an issue among men who have sex with men, injecting drug users, haemophiliacs and sex workers has allowed many in the remaining population to be lulled into a false sense of security and a belief that they are somehow immune to HIV. This false perception has resulted in many instances of transmission, especially among females in stable partnerships.

There is also widespread and well documented stigma and discrimination related to HIV in a variety of settings in the Caribbean, including communities, the workplace and the health care sector. Coupled with this is a serious lack of confidentiality and privacy in small island settings.

Because of such a situation, the response is hampered and take-up of strategic approaches such as expansion of testing and counseling, access to condoms and other prevention measures, as well as treatment services, has been somewhat limited.

When the HIV epidemic emerged in the early eighties, the response to the virus had to contend with what could be called an 'epidemic of health reform'. In some cases these often extensive reforms had a negative impact on issues disproportionately affecting the poor, such as HIV, as implementers were driven towards cutting costs by external forces. Charges were often attached to services. For example, fees were introduced for syphilis testing during pregnancy in all Eastern Caribbean States *(CAREC-SPSTI, Evaluation of STD/HIV/AIDS Surveillance Systems in the Eastern Caribbean States, 1997)* resulting in a decline in the coverage of such testing. In many instances there were no 'public goods' defined as a package of public health services, benefiting the nation's social and economic development which were to be safeguarded at all costs.

Breaking down a system to build a new one is a lengthy process and requires behavioural changes among all stakeholders including consumers *(PAHO, Analysis of Health Sector Reform in the English Speaking Caribbean Countries, 2002)*. The health system was, therefore, weakened when it most needed strength in the face of the new threat of HIV and increasing numbers of people living with the virus.

In addition, the massive investment in HIV may have also created disequilibrium in the internal management of the region's health systems. The **vertical approach** used to manage HIV projects has sometimes fragmented health systems' ability to effectively address the challenges posed by the epidemic, rather than helping to strengthen those systems as intended.

Despite these difficulties, it is generally accepted that the promotion of the effective monitoring and evaluation of HIV programmes by UNAIDS and its cosponsors, PEPFAR and the Global Fund has made a difference. It has helped countries to use essential tools to identify and address gaps. The 2008 UNGASS Reports have shown in many instances that it is possible to monitor and evaluate the impact being achieved in the HIV response.

V. DETAILS OF THE REPORTING PROCESS

Since 2001 and the signing of the UNGASS Declaration of Commitment which holds countries to biennial reporting on progress accomplished, UNAIDS has provided technical support in the area of monitoring and evaluation. Guidelines on construction of core indicators were published in July 2005 to support countries in the 'know how' of UNGASS reporting. They provide essential information on core indicators as well as copies of the methodology used for the National Composite Policy Index Survey which gives a snapshot of the country's HIV response. These guidelines were intended to achieve standardisation of the data collection and analysis process.

Countries were strongly encouraged to establish monitoring and evaluation units, develop plans of actions within the national response for M&E and to budget for related activities. In 2007, training was provided by UNAIDS and its cosponsors to strengthen skills among Caribbean nationals to understand the development of HIV estimates for their respective countries and to use the estimates to calculate UNGASS indicators in terms of coverage and impact.

These training sessions, using the *Workbook* and *Spectrum* computer projection programmes have equipped participants to develop estimates and the projected magnitude of the HIV epidemic in their respective countries, as well as the need for services and commodities, such as the projected number of pregnant women who will need PMTCT or adults and children needing ART in a given year.

In 2006, a Caribbean-wide regional workshop on the Country Response Information System (CRIS) was held in Port of Spain and facilitated by informatics experts from UNAIDS-Geneva. CRIS is software developed by UNAIDS to enable countries to enter programmatic data and produce their indicators.

During the workshop, participants were trained to enter data and extract these indicators. UNAIDS Caribbean Regional Support Team also provided financial support to help countries secure consultants and technical assistance to carry out the UNGASS reporting process. This enabled many Caribbean countries and territories to 'stand up and be counted' in this UNGASS round.

The region is fortunate to have a strong working relationship between key actors in the field of HIV such as UNAIDS, the World Bank, USAID/Measure Evaluation, the Global Fund and regional institutions and partnerships such as CAREC, CHRC and PANCAP. These relationships have facilitated the collection of data at country level to construct UNGASS indicators and report on progress attained during 2006-2007.

VI. COMPLETENESS OF REPORTING ON INDICATORS

There are 25 UNGASS indicators to be reported on. Because of the specificity of the Caribbean HIV epidemic, and despite acknowledging the relevance of these indicators, no country has provided information on indicators 20 and 21 concerning injecting drug use as this is not a significant problem in the region. However, it will be useful for countries to monitor indicators regarding *crack cocaine users* given their vulnerability in the acquisition and spread of HIV. (Exchanging sex for drugs is a well known phenomenon among those on crack cocaine). Some information concerning the activity has been added to this consolidated analysis.

For indicator 25, countries rely on UNAIDS/UNICEF/WHO estimates on prevention of mother-to-child transmission coverage and of the number of children born to HIV-positive mothers who are infected.

As stated, 18 Caribbean countries and territories have submitted full 2008 UNGASS progress reports to UNAIDS. That of the Netherlands Antilles (Bonaire, Curacao, Saba, St Eustatius, and St Maarten) was included in the overall report submitted by the Kingdom of the Netherlands. It should be noted that reports from Anguilla, the British Virgin Islands and the Netherlands Antilles were narratives and no measurement of indicators was included. Territories such as Bermuda, Cayman Islands, Montserrat and the French Departments of French Guiana, Guadeloupe and Martinique have not submitted a 2008 UNGASS Report.

In all of these small island settings issues of confidentiality and stigma and discrimination were identified as major challenges to be addressed. Discussed, too, were obstacles to accessibility of services and the lack of human resources and technical expertise in certain settings. The analysis of the 22 specific indicators which were relevant and reported on is summarised in the next chapter.

Keith's Story

Courtesy: Keith Deyalsingh

Keith Deyalsingh is a recovering crack cocaine user who is living with HIV

"I've always had an addictive personality. I consider addiction to be a disease. From a very young age I drank and smoked. I had my first cigarette at eight years old. It wasn't long before I graduated to marijuana and then crack cocaine in my twenties. I tried anything and everything. It was a reaction to fear and insecurity, I think.

Drugs gave me the courage that I didn't have when I was sober. I also know that when it came to sex they really clouded my judgement. I had to have drugs at all cost, and did what I had to do to get them… When I was high, condoms, safe sex, protecting myself – they were the furthest thing from my mind and I see that in a lot of young people today who take drugs too.

In June 1996 I was diagnosed with HIV. I was taken into hospital literally at death's door and was given 24 hours to live. My CD4 count was 85. With the love and support of my family and medical care I got better but that still didn't stop me taking crack.

By September of that same year I was back on drugs. I lost everything and ended up homeless. But I've managed to kick the habit and have been clean for nearly eight years now. I'm on treatment and I'm feeling well. I now do outreach with people already on drugs and those living on the streets.

I also use my experience to tell young people about the dangers of drugs and a culture that seems to celebrate getting high. I let them know that if you get addicted you don't see things clearly and can easily get caught up in unsafe behaviour. I really wish I had had someone to talk to me like that when I was young and perhaps my life would have turned out differently. I'm determined to stay off crack, although I'm taking each day as it comes.

For me there's definitely a link between drugs and HIV and I don't want young people to find that out the hard way, like I did."

VII. SCOPE OF REPORTING

The scope of reporting for UNGASS 2008 is illustrated in Table 3 below with the horizontal reading summarising the number of countries reporting on each indicator and the vertical reading summarising the number of indicators reported on by each of the 18 countries and territories.

The extent of reporting on the 22 UNGASS indicators varied from country to country, as Graph 8 shows. In the eight small island settings in the Caribbean[4] the level of reporting on indicators ranged from 27% in Aruba, Turks & Caicos Islands and Dominica (the lowest) to 77% in St Lucia (the highest). Half of the countries and territories have reported on 50% or more of the indicators.

In the 10 larger Caribbean countries[5] the level of reporting on the 22 indicators varied from 45% in Belize which had the lowest percentage to 95% in Cuba which had the highest. All of these countries except Belize have reported on 50% or more of the 22 indicators.

There are also variations in the percentage of indicators reported by countries and territories *(see Graph 10).* Of great concern is the observation that less than 50% of the countries and territories have reported on indicators 8, 9, 12, 14, 18, and 19, relating to most vulnerable populations, i.e. orphans and vulnerable children, men who have sex with men and male and female sex workers. It is a clear indication that in many instances national decision makers and implementers of country responses to HIV have not achieved a clear understanding of the role played by these most-at-risk populations in their epidemic. Such challenges exist across the Caribbean.

4 Antigua & Barbuda, Aruba, Dominica, Grenada, St Kitts & Nevis, St Lucia, St Vincent & the Grenadines and Turks & Caicos.

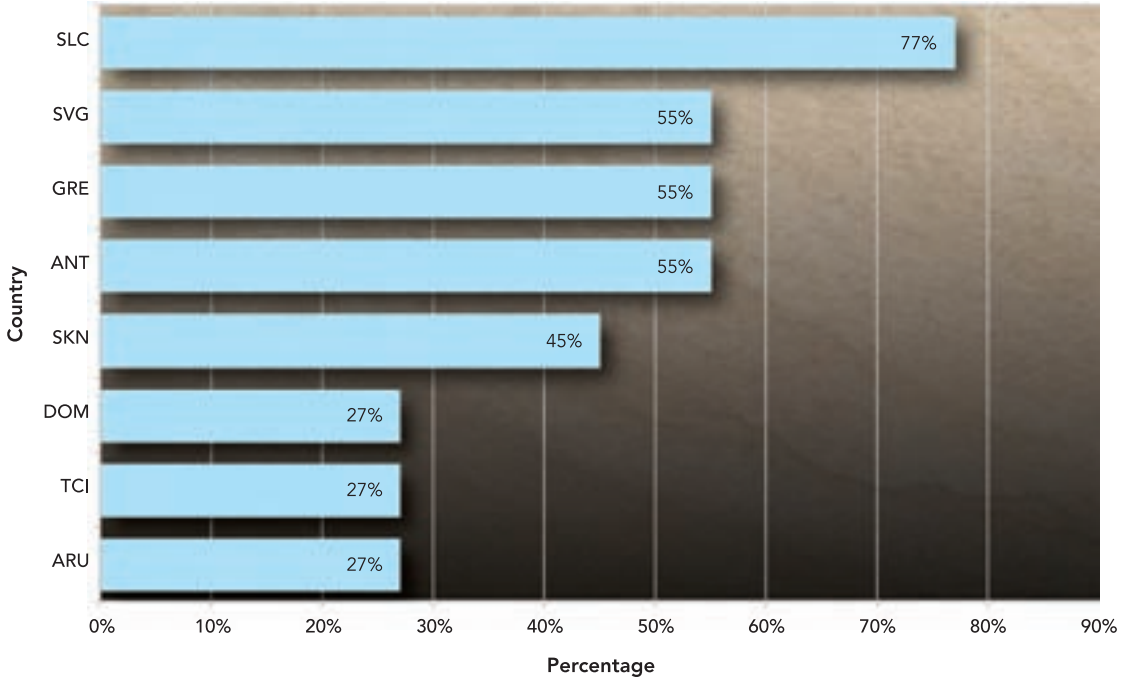
5 The Bahamas, Barbados, Belize, Cuba, the Dominican Republic, Guyana, Haiti, Jamaica, Suriname and Trinidad & Tobago

Table 3: Scope of reporting on UNGASS indicators

	ANT	ARU	BHA	BDO	BEL	CUB	DOM	DOR	GRE	GUY	HAI	JAM	SKN	SLC	SVG	SUR	TNT	TCI	TOTAL
IND1	X	X	X	X	NA	X	NA	X	X	NA	X	X	NA	X	NA	NA	X	X	12
IND2	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	18
IND3	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	18
IND4	NA	NA	X	X	X	X	NA	X	NA	X	X	X	NA	NA	NA	X	X	NA	10
IND5	X	NA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	17
IND6	NA	X	X	X	X	X	X	X	X	NA	X	X	X	X	X	NA	NA	NA	13
IND7	X	NA	NA	X	X	X	NA	X	X	X	X	X	X	X	X	X	X	NA	14
IND8	NA	NA	X	X	NA	X	NA	X	NA	X	X	X	NA	NA	NA	X	NA	NA	8
IND9	NA	NA	X	NA	NA	X	NA	NA	NA	X	NA	X	NA	NA	NA	NA	NA	NA	4
IND10	NA	NA	NA	NA	NA	NR	NA	X	NA	NA	X	NA	NA	X	NA	NA	NA	NA	3
IND11	X	NA	X	X	NA	X	X	X	X	NA	NA	X	NA	X	X	NA	NA	X	11
IND12	NA	NA	NA	NA	NA	X	NA	NA	NA	X	X	NA	NA	X	NA	NA	NA	NA	4
IND13	X	X	NA	NA	X	X	NA	X	X	X	X	X	X	X	X	X	X	NA	14
IND14	NA	NA	X	X	NA	X	NA	NA	NA	X	X	X	NA	NA	NA	X	NA	NA	7
IND15	X	X	NA	NA	X	X	NA	X	X	X	X	NA	X	X	X	X	X	NA	13
IND16	X	NA	NA	NA	X	X	NA	X	X	X	X	X	X	X	X	X	NA	NA	12
IND17	X	NA	NA	NA	NA	X	NA	X	X	X	X	X	X	X	X	X	NA	NA	11
IND18	NA	NA	NA	X	NA	X	NA	X	NA	X	X	X	NA	NA	NA	X	NA	NA	7
IND19	NA	NA	X	NA	NA	X	NA	X	NA	X	X	NA	NA	X	NA	X	X	NA	8
IND 20*																			
IND21*																			
IND22	X	NA	X	X	X	X	NA	X	NA	X	X	X	NA	X	X	X	X	NA	13
IND23	NA	NA	X	NA	NA	X	NA	X	NA	X	X	X	NA	X	NA	X	X	NA	9
IND24	X	NA	X	X	NA	X	X	X	X	X	X	X	X	X	X	X	NA	X	15
IND25*																			
TOTAL	12	6	14	13	10	21	6	19	12	18	20	18	10	17	12	16	11	6	

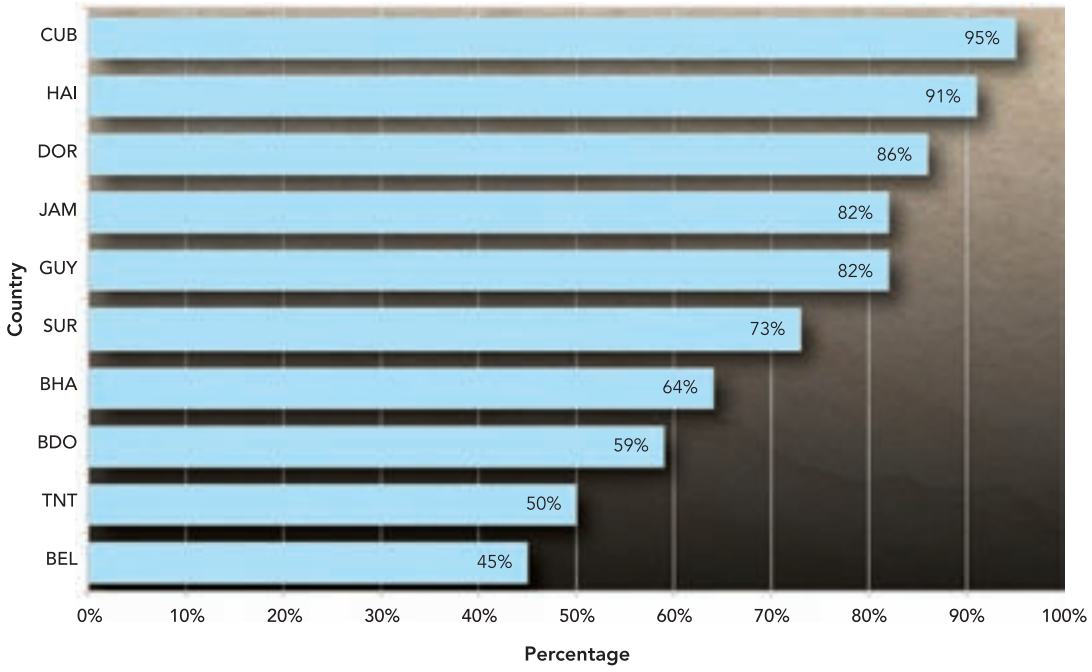
NA: Not Available *X: Reported* *NR: Not Relevant* ** Indicators 20 and 21 are not relevant * Indicator 25 will be estimated by UNAIDS*

Graph 8: Percentage of indicators reported by country or territory: small Caribbean island settings, 2007



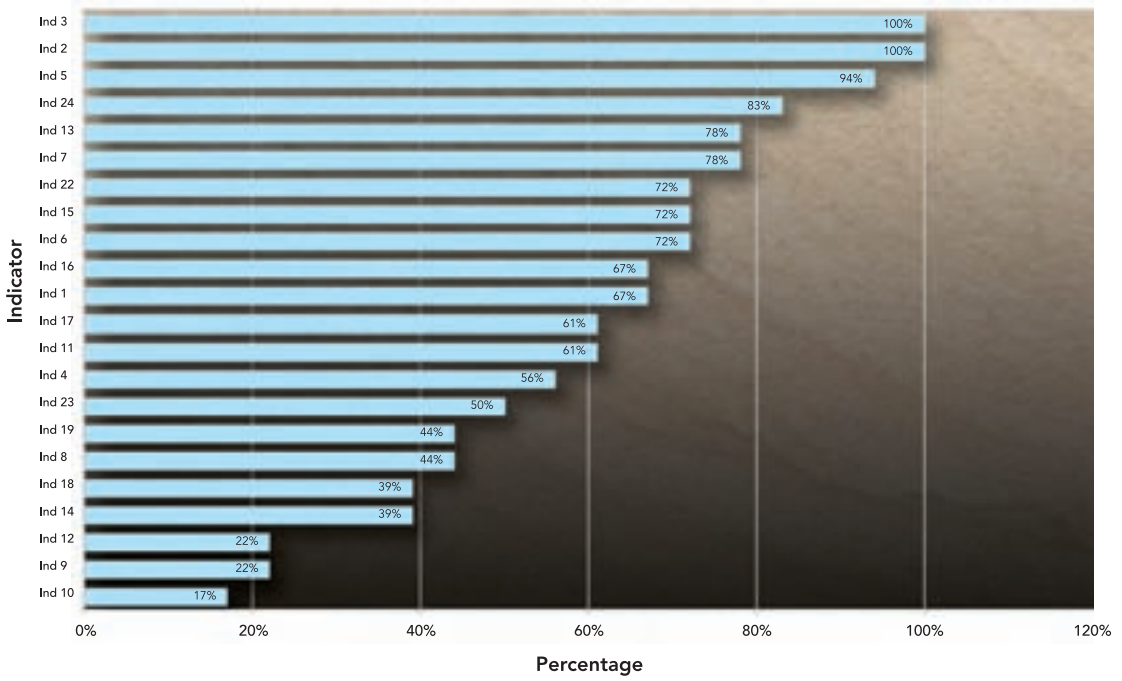
Source: 2008 UNGASS Reports. UNAIDS Report on the global AIDS epidemic, 2008

Graph 9: Percentage of indicators reported by country: larger Caribbean island settings, 2007



Source: 2008 UNGASS Reports. UNAIDS Report on the global AIDS epidemic, 2008

Graph 10: Percentage of Caribbean countries and territories reporting by indicator: UNGASS 2008



Source: 2008 UNGASS Reports. Reference: Table 2 with detail on indicators
UNAIDS Report on the global AIDS epidemic, 2008

Monitoring and evaluation to generate strategic information is a key focus. The 2008 UNGASS Reports have shown gaps in this area and it is critical that action is undertaken at international, regional and country levels to ensure it is strengthened and that M&E systems are integrated into the management of the national response. A comprehensive data set which supports decision making, planning and monitoring and evaluation is necessary.

Creative approaches should be found to support small island settings in their challenges to improve their data gathering systems and strategic information structures. UNAIDS has initiated an innovative project to establish Technical Support Facilities (TSF) in the region *(UNAIDS TSF for the Caribbean, 2008)* which will assist in the location and use of technical expertise. National M&E systems should be strengthened and integrated into the management of the national response to HIV.

Series of Behavioural Surveillance Surveys, Demographic and Health Surveys and surveys on prevalence should be conducted at the earliest possible opportunity. Accurate and comprehensive HIV and AIDS case reporting, research into molecular epidemiology and HIV drug resistance surveillance are necessary to update existing information and support strategic planning. This will accelerate the implementation of universal access to HIV prevention, treatment, care and support.

There is clearly a lack of information regarding key population groups which should be a priority in responding to HIV. This situation needs to be improved urgently if Caribbean countries are to avoid planning without evidence, achieve universal access and make their challenge to HIV more effective.


Photo: Stefan Szczelkun

VIII. FINDINGS FOR EACH INDICATOR

INDICATOR 1:

Domestic and international AIDS spending by categories and financing sources

According to the World Bank classification, the 18 countries and territories reporting on UNGASS indicators are low, lower-middle, upper-middle or high income: a clear demonstration of the diversity of Caribbean economic development. For instance, Antigua & Barbuda, Aruba, the Bahamas, Barbados and Trinidad & Tobago are defined as high income. Belize, Dominica, Grenada, St Kitts & Nevis, St Lucia and St Vincent & the Grenadines are classified as upper-middle income. The remaining countries are ranked as lower-middle (e.g. Guyana) or low income (e.g. Haiti).

This classification opens or closes the door for countries to access international funding and grants. Diversity in investing national resources in public health is also a reality in the Caribbean with some countries focusing their efforts on prevention and primary health care and others on tertiary health care and disease management.

It should also be noted that the Caribbean is in epidemiological transition and has competing priorities. In conjunction with the threat of HIV, there has been an increase in chronic non-communicable diseases which are becoming more and more of a threat to public health in the region *(Caribbean Cooperation on Health and Development Report, 2005).*

During the past few years, a considerable number of Caribbean countries and regional institutions and partnerships have benefited directly or indirectly from the financial support of the World Bank mainly in the form of a mix of loans and grants. However, for a number this resource is drawing to a close.

Another major resource is the Global Fund which has provided grants to PANCAP and regional structures such as the Organisation of Eastern Caribbean States (OECS), CRN+ and to a number of Caribbean countries with the exception of the Bahamas, Barbados, Trinidad & Tobago, the Netherlands Antilles and the UK Overseas Territories.

In early 2008, a regional workshop was held in the Dominican Republic in which UNAIDS and PAHO/WHO supported Global Fund efforts to train Caribbean nationals on the development of proposals to be submitted. This is an important step regarding the readiness of the GFATM to continue to fund proposals from the Caribbean in the area of AIDS, tuberculosis and malaria. All 18 UNGASS Reports underlined the very important technical and financial contribution UNAIDS and its 10 cosponsors have made to their national HIV responses.

Other multilateral and bilateral donors are also providing grants or funds to assist Caribbean action on HIV via direct support to individual countries or indirectly through regional institutions such as PAHO/WHO, PANCAP, CHRC, the University of West Indies, etc. Among these are: US-PEPFAR (focusing on Haiti and Guyana but also moving towards support for other islands), USAID, the Canadian International Development Agency, the European Union, Germany's KfW-GTZ, French Technical Cooperation, GVC Italia, HIVOS Holanda, Junta de Andalucía y Medicos del Mundo España, Corporación de Desarrollo Solidaridad Socialista de Bélgica and the United Kingdom Department for International Development (DfID).

Of the 18 countries and territories reporting, 12 have submitted comprehensive or partial information on indicator 1. Attempts were made to report on all categories of expenditure from all sources, ranging from various ministries to civil society organisations. However, in a few instances it was not clear if reported figures were *budgets* or *real* expenditures. On occasion, expenditures in terms of use of the funds were also presented, as was the source of these expenditures, whether domestic (governmental and private) or international.

There is no doubt that domestic spending on AIDS and international support is increasing, as demonstrated in the case of Jamaica over the past three years where spending has risen from US$11 m in 2005 to almost US$15 m in 2007 *(see Graph 11)*.

This same trend of increasing financial support to the national HIV response has also been observed in Trinidad & Tobago. A total of US$ 42 m was spent during the period 2002 – 2006 (starting from US$ 4.18 m in 2002 to US$14.37 m in 2006) *(see Graph 12)*.

Graph 11: National AIDS spending in millions of USD – Jamaica, 2005 – 2007

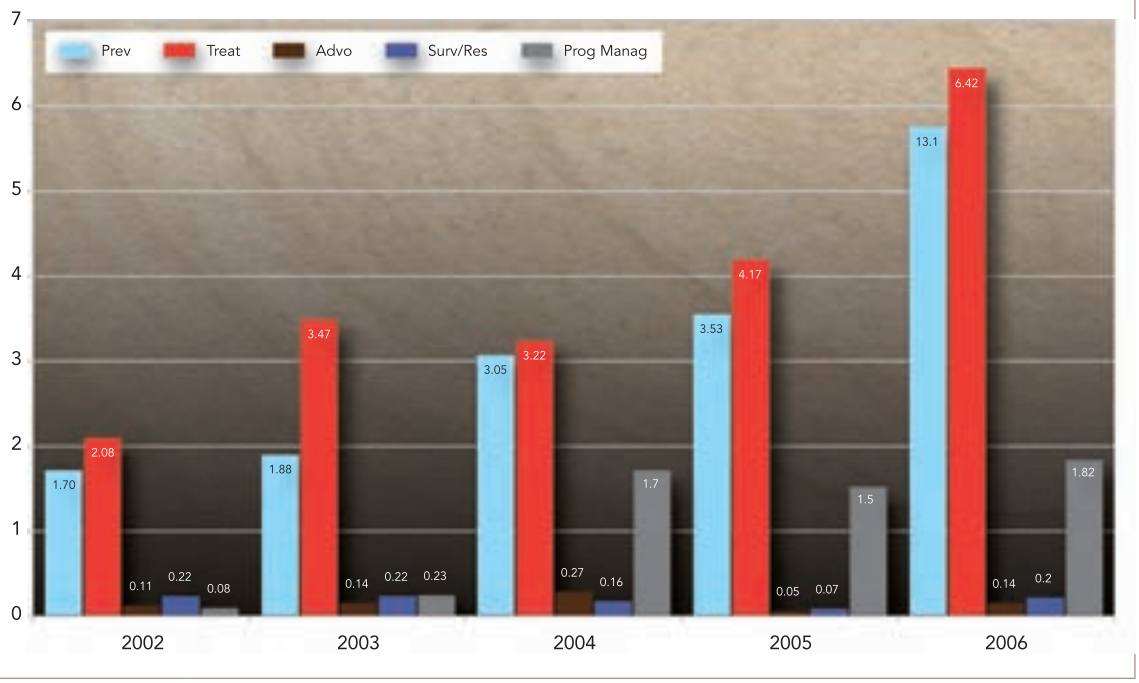
Source: UNAIDS Report on the global AIDS epidemic, 2008
UNGASS Country Report, Jamaica, 2008

Graph 12: National AIDS spending by financing sources in millions of USD – Trinidad & Tobago, 2002 – 2006

Source: UNAIDS Report on the global AIDS epidemic, 2008
UNGASS Country Report, Trinidad & Tobago, 2008

It is important for each country to put systems in place which will facilitate the capture of information regarding different expenditures on AIDS (as has been the case in Trinidad & Tobago) and to critically analyse that information in the context of the epidemiological situation. This is the only way to 'make the money work' by demonstrating that resources are effectively allocated to address issues contributing to the spread of HIV and are relevant to its prevention and control.

Graph 13: National AIDS spending by strategy in millions of USD – Trinidad & Tobago, 2002 – 2006



Source: UNAIDS Report on the global AIDS epidemic, 2008
UNGASS Country Report, Trinidad & Tobago, 2008

Efforts undertaken by UNAIDS to train nationals in conducting NASA (National AIDS Spending Assessments) during 2006 were fruitful. Compared to 2006 reporting, when only four countries and territories provided limited data on AIDS spending, 12 out of 18 countries and territories reported different levels of detail in 2008. It is necessary to continue promoting the NASA exercise at country level as part of the national monitoring and evaluation mechanism. A simple way to achieve this financial tracking process is to develop and cost a countrywide annual work plan which will include all activities to be implemented by each sector involved.

Table 4: Countries reporting on domestic and international AIDS spending by categories and financing sources

Antigua & Barbuda	Yes
Aruba	Yes
Bahamas	Yes
Barbados	Yes
Belize	NA
Cuba	Yes
Dominica	NA
Dominican Republic	Yes
Grenada	Yes
Guyana	NA
Haiti	Yes
Jamaica	Yes
St Kitts & Nevis	NA
St Lucia	Yes
St Vincent & the Grenadines	NA
Suriname	NA
Trinidad & Tobago	Yes
Turks & Caicos	Yes

Source: UNAIDS Report on the global AIDS epidemic, 2008
NA: Not Available

INDICATOR 2:

National Composite Policy Index (NCPI)

This is a very important indicator which measures the degree of development and implementation of different strategies and polices to respond to the epidemic. It combines both quantitative and qualitative information which helps national authorities understand the impact of their HIV response. Data used for this purpose are collected through a questionnaire which is divided into two essential components.

Component A: This questionnaire is administered to government officials within National AIDS Coordination Committees/Councils or the equivalent and covers five important areas:

1. Strategic plan;
2. Political support;
3. Prevention;
4. Treatment, care and support and;
5. Monitoring and evaluation.

The objective is to assess opinions about the overall development and implementation process of strategies in each of the five areas in 2006 and 2007 and measure changes over time.

Component B: This questionnaire is administered to stakeholders such as representatives from primary partners of national programmes, including UN agencies, civil society organisations, NGOs and bilateral agencies. It is a qualitative information-gathering process which focuses on policy implementation and covers four major areas:

1. Human rights;
2. Civil society involvement;
3. Prevention;
4. Care and support.

Being qualitative in nature, the answers to the questions asked here are subjective and differences are not uncommon. However, having all national stakeholders sitting at the same table for the consolidation of the UNGASS Report helps to build consensus and facilitate mutual understanding among partners. It is an important collaboration which can, in many instances, identify gaps and policy issues and resolve them accordingly.

All of the 18 reports submitted contain at least partial data for this indicator. To aid interpretation of the information submitted, similar topics in Components A and B will be treated at the same time.

National Strategic Plans

HIV presents governments and decision makers with a challenge. It requires, for example, a change in the way allocations of budgets are done and how responsibilities are divided among line ministries. There is a need for a multisectoral strategic plan involving all national sectors. In reporting for UNGASS, several Caribbean countries mentioned the multisectoral nature of their response to HIV, with the slow but steady inclusion of civil society.

Table 5 demonstrates that a number of Caribbean countries and territories have a National HIV/AIDS Strategic Plan which is being implemented while the others have expired plans and are developing new ones. (Because of the importance of National Strategic Plans, Anguilla and BVI were added to this table).

Table 5: Status of National Strategic Plans during 2006 – 2007

Anguilla	**Expired: new plan under consideration**
Aruba	**2003-2007 recently expired: new plan under consideration**
Antigua & Barbuda	**Recently expired: new plan under development: 2008-2012**
Bahamas	The Bahamas Roadmap to Scaling Up Towards Universal Access to HIV/AIDS Prevention, Treatment, Care and Support Services, 2006-2010
Barbados	National Strategic Plan: 2008-2013 with a National Monitoring and Evaluation Framework and Operational Plan for HIV Prevention and Control
Belize	National Strategic Plan: 2006-2011
BVI	**Expired: new plan under consideration**
Cuba	National Strategic Plan: 2001-2011
Curacao	National Strategic Plan: 2003-2008
Dominica	**Expired: new plan under development: 2008-2012**
Dominican Republic	National Strategic Plan: 2007-2015
Grenada	**Expired: new plan under development: 2008-2012**
Guyana	National Strategic Plan: 2007-2011
Haiti	National Strategic Plan: 2008-2012
Jamaica	National Strategic Plan: 2008-2012
St Kitts & Nevis	**Expired: new plan being developed for 2008-2012**
St Lucia	National Strategic Plan: 2005-2009
St Maarten	Strategic Plan: 2007-2011
St Vincent & the Grenadines	National Strategic Plan: 2005-2009
Suriname	National Strategic Plan: 2004-2008
Trinidad & Tobago	National Strategic Plan: 2004-2008
Turks & Caicos	**Expired: new plan under consideration**

Source: UNGASS Reports, 2008

The 2008 UNGASS Reports have shown a level of achievement in other areas not limited to the traditional health sector (e.g. the HIV and the workplace programmes in Barbados and Jamaica). However, there is a need for more information from newly involved sectors to reflect the truly broad-based multisectoral nature of the response to the HIV epidemic.

Dr Carol Jacobs, Chairman of the Barbados National HIV/AIDS Commission and Sir Roy Trotman, General Secretary of the Barbados Workers Union at the major BWU annual May Day Rally.

Credit: Barbados National AIDS Commission

For the past three years the Barbadian trade union movement has made HIV a central theme of the May Day Rally, liaising with other key organisations and branches of government to promote prevention messages and offer practical interventions such as onsite voluntary counseling and testing (VCT).

There has also been a concerted effort to ensure that workplace policies dealing with both awareness-raising and safeguarding the rights of those infected and affected by HIV have been developed. A number of companies are implementing extensive programmes, often centred on behaviour change communication and ensuring that employees have access to prevention products such as condoms.

Scotiabank, for example, in conjunction with the Caribbean Broadcast Media Partnership and the Ministries of Health, offered voluntary counseling and testing at a number of branches across the region during a designated testing day on June 27, 2008.

Businesses and trades unions have also worked with the International Labour Organisation/United States Department of Labour project to develop workplace education and prevention programmes. The AIDS Foundation, an amalgamation of businesses and their partners, who recognise the potential damage the epidemic can cause to the economy of Barbados and are determined to do something about it, are also very active in terms of education.

Moves have also been made by the Ministry of Labour to introduce an HIV/AIDS and non-communicable diseases policy and code of practice for the public sector.

According to Orlando Scott of the Barbados Workers Union, “We have really stepped up a gear in tackling HIV in the workplace. Now employers are really starting to take HIV seriously and developing their own programmes. And some have been doing exceptionally well.”

Understanding the link between poverty and HIV and vice versa is crucial and no country has mentioned the existence of that link in their UNGASS reporting. Therefore, it is recommended that Caribbean countries connect their poverty alleviation or eradication programmes to the national response. There should be strategies which address the economic implications of the epidemic in any given country.

To sum up; new National Strategic Plans should aim at broadening the involvement of different national sectors and civil society in the planning process, especially people living with HIV, and include strategies which address poverty and it implications for the epidemic.

Political support

There is no doubt that the Caribbean has been able to involve its political leadership either individually or collectively in action against the epidemic. The establishment of the Pan Caribbean Partnership against HIV/AIDS is a clear indication of the regional will to unite countries to work towards a common goal.

The Hon. Bruce Golding, Prime Minister of Jamaica takes an HIV test. There has been a broadening and deepening of political commitment to the Caribbean HIV response at the highest political levels, nationally, regionally and internationally. Leaders recognise that HIV has the potential to devastate their countries and their region and are voicing that message at home and abroad.

In many instances, line ministries are budgeting and planning to respond to HIV as a serious threat to *development* rather than purely as a health issue. For several countries National HIV Committees or equivalents come under the jurisdiction of the Prime Minister's Office.

However, there is a need for some caution regarding the reported multisectoral approach. This is especially true in small island settings where the human resources base is limited. There is some evidence of a growing trend to bring HIV back under the sole purview of national health sectors.

Prevention

This has been recognised as a fundamental focus in the challenge to HIV since the epidemic emerged in the early 1980s, but it has not generally received the strong attention it requires. The fact that HIV often occurs among the most vulnerable and marginalised groups has certainly not aided the development and implementation of effective prevention initiatives at country level.

As suggested above, in the 2008 UNGASS Reports, indicators related to vulnerable groups, especially in terms of their access to prevention programmes, were very often lacking. Several countries reported the gaps in their prevention efforts as a challenge to be addressed. Beyond the lack of human resources with appropriate skills to lead such programmes, the widespread stigma and discrimination against vulnerable groups is not helping to create the supportive environment conducive to effective prevention programmes among young people and most-at-risk populations.

Through the increasing trend towards the greater involvement of civil society organisations, there is an opportunity to reach out to vulnerable populations and get them involved in the planning and implementation of effective prevention programmes. Each country can embrace this strategic approach. However, it must be acknowledged that the capacity of CSOs needs to be built, especially in the area of monitoring and evaluation.

Credit: REd Initiatives

Civil society involvement has been growing across the region and one key rallying point is the annual AIDS Candlelight Memorial which takes place on the third Sunday in May across 121 countries. In Trinidad & Tobago REd Initiatives has hosted the Memorial for the past four years. The event takes the form of a commemorative concert, health fair with HIV testing, condom demonstration and distribution and other health services.

However, the memorial is not only an opportunity to promote awareness and prevention of HIV but is now being used to launch a platform of advocacy in a range of areas including:

- *A rights-based approach to reducing stigma and discrimination;*
- *Ensuring equal access to HIV/AIDS services for marginalised communities;*
- *Increasing resources for HIV/AIDS and other related issues;*
- *Promoting greater involvement of affected communities (who are often sidelined in the decision making processes which aim to assist them).*

Regarding primary prevention, condom use promotion among female sex workers in the Dominican Republic was fruitful with HIV prevalence remaining low (2.7%) and stable for the past 5 years (*Johns Hopkins University-Horizons, Combining Community Approaches and Government Policy to Prevent HIV Infection in the Dominican Republic*). Such a '100% condom use' project among sex workers can be replicated across the Caribbean.

In the area of secondary prevention, a number of countries have reported success stories in terms of mother-to-child transmission, including testing and counseling and coverage of antiretroviral treatment. For Barbados and the Bahamas, for instance, the impact of PMTCT programmes has been demonstrated in the steady reduction of AIDS mortality among children.

Human rights

There are two aspects to be considered in this area: the rights of individuals belonging to vulnerable population groups and those of HIV-infected and HIV-affected individuals. In terms of the latter, many countries (the Bahamas, the Dominican Republic, Barbados, St Lucia etc.) reported the establishment of national programmes which can support PLHIV and affected individuals when needed.

People living with HIV in Guyana describe the range of rights they should enjoy

For vulnerable population groups such as men who have sex with men, only the UK Overseas Territories have introduced laws to effectively decriminalise homosexuality and Dutch laws (relevant to Aruba and the Netherlands Antilles) prohibit discrimination against individuals on the basis of their sexual orientation.

The sex trade is illegal in the English speaking Caribbean and Haiti. However, countries have recently demonstrated an increasing willingness to consider changes which can be beneficial to the most vulnerable population groups and enhance the rights of people living with HIV. But there is still a long way to go. There is a need for greater advocacy, which could be undertaken with the support of, for example, UNAIDS and its cosponsors, as well as UNIFEM and PANCAP, to help countries review their legislation in the fundamental yet sensitive areas of rights, ethics, HIV, vulnerable groups and gender.

Civil society participation

The capacity of civil society organisations in the Caribbean is growing.

In some instances CSOs took part in the 2008 UNGASS reporting and in others they are taking their place in the development and implementation of national responses to HIV. For example, the networks supporting those infected and affected with HIV in Grenada and Barbados, Hopepals and CARE, played an integral role in the development of their country's National Strategic Plan.

CSOs are becoming more involved in more meaningful ways. Despite the challenges they face, especially in smaller island settings, PLHIV have been leading that process but other groups, such as men who have sex with men and male and female sex workers, are getting increasingly involved in the national and regional response.

Comedians on stage in Haiti lend their voices to the HIV response as part of civil society; entertainers in general are playing an increasing role in the challenge to HIV across the region.

There is still a need to proactively encourage National HIV/AIDS Committees and Commissions to create a supportive environment for CSOs and involve all vulnerable population groups in every step of the national challenge to HIV and to build the capacity of both national bodies and CSOs to work together. This should be a measurable indicator for each country's HIV response given the myriad benefits such CSO involvement can bring.

Young people are playing their part more and more often in national responses to HIV and Boy Scouts in Barbados, who receive HIV badges, are learning and sharing their knowledge with others on prevention measures and the fight against stigma and discrimination.

Treatment, care and support

Under the leadership of PANCAP, PAHO/WHO, UNAIDS, USAID/CDC and the CAREC-SPSTI, the "3 by 5" project to bring ART to three million people by the end of 2005 was a successful initiative in the Caribbean and the momentum it has created continued during 2006-2007. The majority of countries have reported that ART coverage is increasing and more and more people who need such treatment are accessing it. This was possible because of the introduction and promotion of new standards, policies and norms in the provision of care and treatment in the health sector and at community level *(see Indicator 4)*.

Of note is the quality and standard of ART in the Caribbean. Fortunately, as reported by many countries, the majority of people on ART are still receiving it after 12 months of beginning treatment. This is an important marker in terms of patient follow-up and quality of care.

There have been significant developments and initiatives in the area of care and support in a number of countries. For example, several such as Guyana and Barbados have established food banks for people living with the virus. In the Bahamas, church organisations have established day care facilities for PLHIV and their families.

However, one area in which care and support should be increased is in regard to orphans and vulnerable children. In this reporting cycle, a large number of countries have submitted limited information about this group. More action is required to address the needs of such children who may be especially vulnerable to HIV.

Monitoring and evaluation

During this 2006-2007 reporting period, UNAIDS, its cosponsors and the Global Fund continued the promotion of monitoring and evaluation as a key strategy in national responses. At international level several mechanisms were established to harmonise indicators and data being submitted through UNGASS reporting. These include the *UNICEF/UNAIDS/WHO Stocktaking Report on HIV and Children* (which covered PMTCT, paediatric AIDS, prevention among young people and protection of orphans and vulnerable children), GAMET (World Bank) and WHO reporting on universal access indicators from the health sector.

The regional monitoring and evaluation working group which was established in September 2003 and included CHRC, CAREC, CDC/USAID/Measure Evaluation and UNAIDS continued its work in harmonisation and standardisation of indicators and training tools and programmes.

A number of Caribbean countries implemented their monitoring and evaluation frameworks in 2005-2006. National M&E structures were established in several of them. These structures helped to gather information for the reporting for UNGASS 2008. There were variations in the overall ratings in this area, but it is certain that progress has been made in a region where M&E has not been part of public health culture and traditions. There is, however, still considerable progress to be made in terms of collecting and using strategic information for planning and programming.

Several countries have reported the following constraints or challenges:

1. Lack of comprehensive monitoring and evaluation frameworks;
2. Lack of standardised tools and software for monitoring and evaluation and universal use of the Country Response Information System;
3. Vertical approach to M&E needs to be horizontal and integrated;
4. Lack of budgetary support to the monitoring and evaluation component of the national response to HIV;
5. Weak M&E infrastructure with limited human resources;
6. Lack of advocacy for culture change in favour of monitoring and evaluation;
7. Too heavy a dependence on epidemiological information, rather than using information gleaned from comprehensive monitoring and evaluation.

These issues were raised by countries in the *Challenges* chapter of individual UNGASS Reports. It is essential that information gathered through this reporting process should be used by national authorities to improve the implementation of their HIV programmes and shape the country response, especially in the spheres of target setting, budget estimation and resource allocation.

INDICATOR 3:

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

All 18 countries reported on this indicator. However, in Antigua & Barbuda and Grenada only 33% and 91% respectively of the total donated blood units were screened for HIV antibodies. In the remaining 16 countries, 100% of donated blood units were screened for HIV.

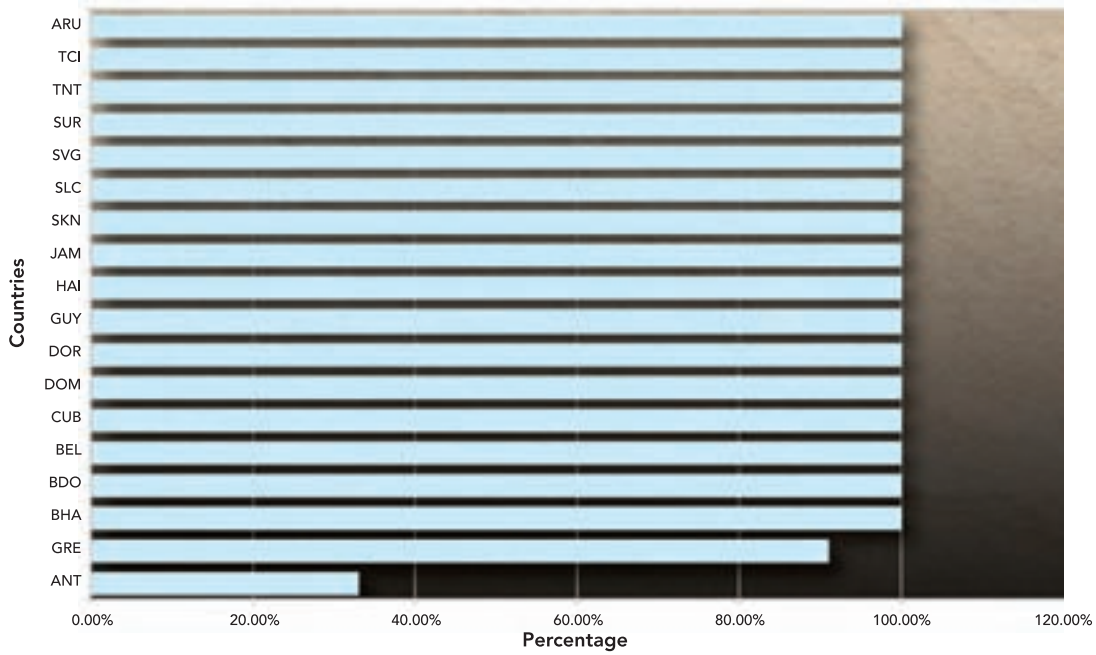
Aruba, Barbados, Belize, Cuba, Dominica, Guyana, St Vincent & the Grenadines and Turks & Caicos reported on this indicator for the last two years and show that they have kept the screening of HIV from donated blood units at the highest level. For 2007, 10 countries reported on this indicator and in 90% of these countries, every single donated blood unit was screened for HIV in a quality assured manner.

Table 6: Percentage of donated blood units screened for HIV in a quality assured manner

COUNTRY	2006	2007
Antigua & Barbuda	33%	
Aruba	100%*	100%*
Bahamas	100%	
Barbados	100%	100%
Belize	100%	100%
Cuba	100%	100%
Dominica	100%	100%
Dominican Republic		100%
Grenada	91%	
Guyana	100%	100%
Haiti	100%	
Jamaica		100%
St Kitts & Nevis	100%	
St Lucia		100%
St Vincent & the Grenadines	100%	100%
Suriname	100%	
Trinidad & Tobago	100%	
Turks & Caicos	100%*	100%*

Source: UNAIDS Report on the global AIDS epidemic. 2008
** 2008 UNGASS Report*

Graph 14: Percentage of donated blood units screened for HIV in a quality assured manner, 2006 or 2007



Sources: UNAIDS Report on the global AIDS epidemic, 2008
2008 UNGASS Reports

INDICATOR 4:

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

IMPORTANT NOTE

Official WHO/UNAIDS/UNICEF data regarding coverage of ART in middle and low income countries is published in ***Towards Universal Access – Scaling Up Priority HIV/AIDS Interventions in the Health Sector. Progress Report, 2008***

Reporting on this indicator in small island settings is often problematic because the best calculations emanate from the output of the *Workbook* and *Spectrum* programmes which are difficult to use with small populations. Therefore, the data reported from small island Caribbean settings such as Antigua & Barbuda, Aruba, Grenada, Dominica, St Kitts & Nevis, St Lucia, St Vincent & the Grenadines and Turks & Caicos have to be expressed in the number of people on ART rather than the coverage rate.

All 10 larger Caribbean countries reported on indicator 4 and variations are observed in terms of ART coverage *(see Table 7)*. In 2007 the lowest ART coverage rate was seen in the Dominican Republic (38%) and the highest in Cuba (more than 95%).

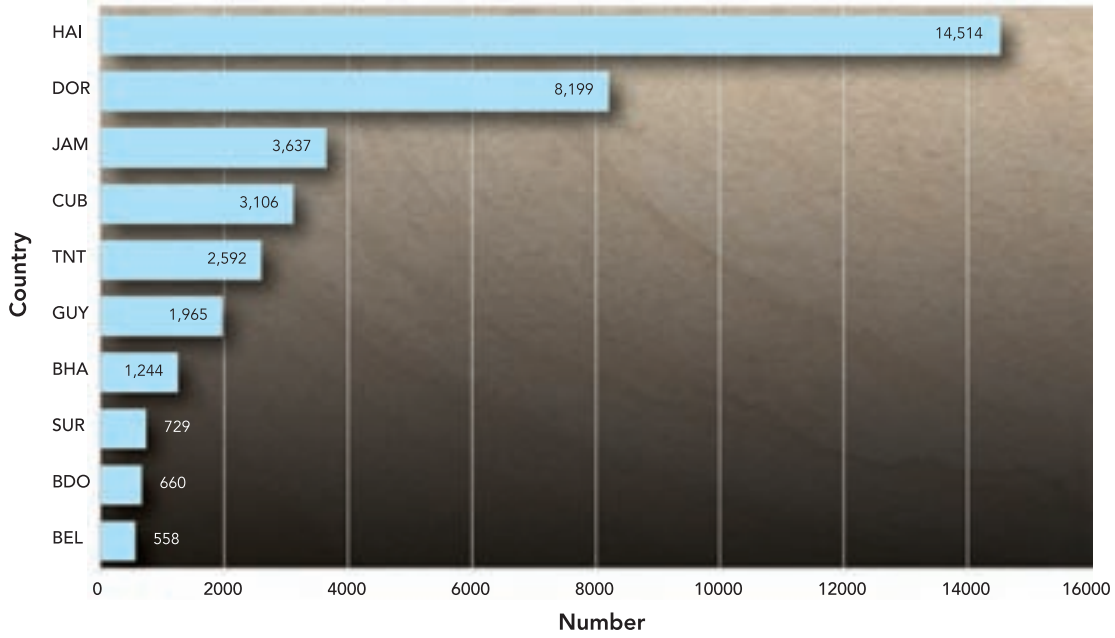
It is important to underline that seven larger countries, the Bahamas, Belize, Haiti, the Dominican Republic, Guyana, Jamaica and Suriname, reported a relatively low ART coverage rate in 2007 (below 50%). These include the three countries which are among the most affected by HIV in the Caribbean and their low ART coverage rate will impact negatively on the region as a whole in terms of achieving goals set for universal access to treatment.

Table 7: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

COUNTRY	2005	2006	2007
Antigua & Barbuda		NA	148 PLHIV*
Aruba		NA	90 PLHIV*
Bahamas			43%
Barbados			73%
Belize			49%
Cuba			> 95%
Dominica		NA	39 PLHIV*
Dominican Republic		24%	38%
Grenada		NA	47 PLHIV*
Guyana		37%	45%
Haiti		26%	41%
Jamaica	20%	33%	43%
St Kitts & Nevis		NA	53 PLHIV*
St Lucia		NA	78 PLHIV*
St Vincent & the Grenadines		NA	104 PLHIV*
Suriname		35%	46%
Trinidad & Tobago		53%	58%
Turks & Caicos		NA	70 PLHIV*

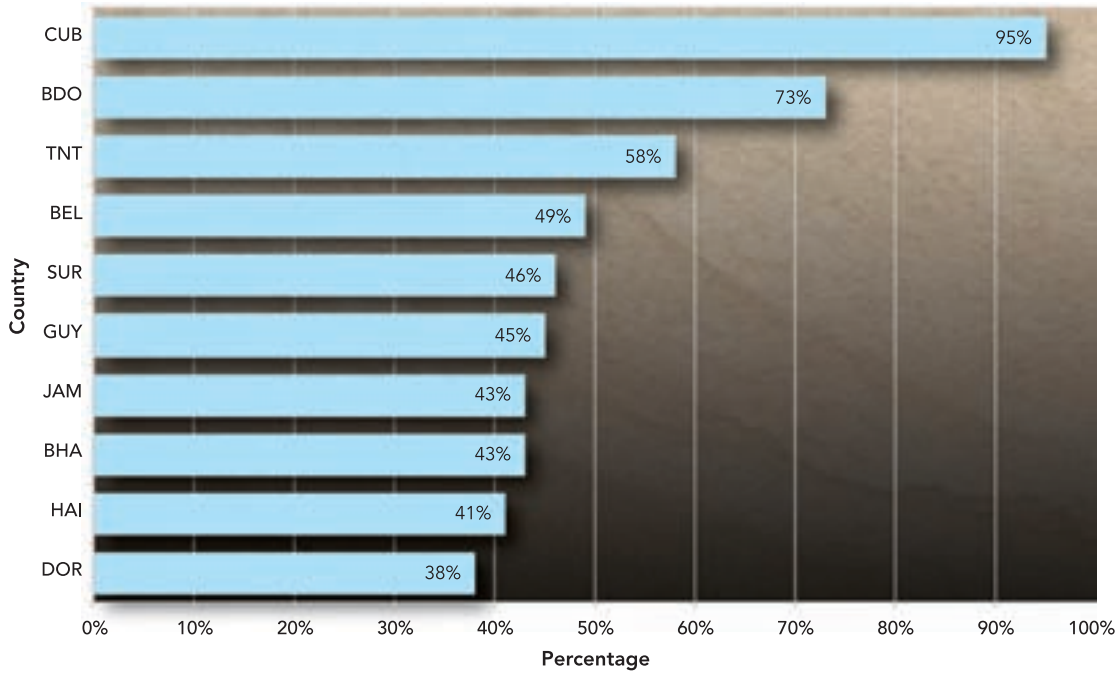
NA: Not Available
Source: UNAIDS Report on the global AIDS epidemic, 2008
** Not harmonised with the UNGASS Guidelines*

Graph 15: Number of PLHIV on ART in the 10 larger Caribbean countries: UNAIDS 2008



Source: UNAIDS Report on the global AIDS epidemic, 2008

Graph 16: ART coverage rate in the 10 larger Caribbean countries in 2007



Source: UNAIDS Report on the global AIDS epidemic, 2008

There was no uniformity regarding the disaggregation of the information submitted. Some countries reported data disaggregated by age and others by sex. Therefore, it is difficult to arrive at a full interpretation of the regional picture. It is necessary for more countries to monitor this indicator, given its importance for child health programmes and the human rights-based approach which places emphasis on the right of children to benefit from ART programmes.

However, using the UNAIDS methodology for development of estimates for larger countries, It can be seen that overall there was a degree of progress accomplished between 2006 and 2007. Although it remains the case that only three Caribbean countries, i.e. Barbados, Cuba and Trinidad & Tobago had an ART coverage rate above 50% in 2007.

UNAIDS/WHO estimated that ART coverage in the Caribbean was 31% in 2006 and increased to 43% in 2007, this is a 39% increase. In absolute numbers, there were only 4,000 PLHIV on ART in 2003 but in 2007 that number increased to 30,000. However, given that an estimated number of 14,000 people died of AIDS in 2007, there is a need for more scaling up of the antiretroviral treatment programmes in the Caribbean.

INDICATOR 5:

Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission of HIV

IMPORTANT NOTE

Official UNICEF/UNAIDS/WHO data regarding coverage of PMTCT in middle and low income countries is published in ***Children and AIDS, Second Stocktaking Report, Unite for Children, Unite Against AIDS, 2008***

With the exception of Aruba, 17 countries and territories have reported on this indicator. The interpretation of data submitted by small islands based on local calculations calls for caution because of the previously discussed problems inherent in using the *Workbook* and *Spectrum* programme for small populations. The reported PMTCT coverage in small island settings is therefore not harmonised with UNGASS Guidelines.

Table 8 shows that for larger countries, the Bahamas, Barbados, Cuba and Jamaica are on track to achieve the universal access goal for prevention of mother-to-child transmission. Cuba reported having virtually eliminated HIV among children. However, countries such as Belize, Guyana, Haiti, Suriname, Trinidad & Tobago and the Dominican Republic need to rapidly scale up their PMTCT programmes if they are to achieve their universal access goals in this area. (It is important to stipulate that PMTCT coverage data reported from small island settings is not the product of the UNICEF/UNAIDS/WHO estimation method).

Table 8: Percentage of HIV-positive pregnant women who have received ART to reduce mother-to-child transmission of HIV

COUNTRY	2006	2007
Antigua & Barbuda	83%*	
Aruba		NA
Bahamas		>95%
Barbados		[73 – >95%]
Belize		[24 – 64%]
Cuba		[>95%]
Dominica	>95%*	
Dominican Republic		[36 – 65%]
Grenada	50%*	
Guyana	[29 – >95%]	NA
Haiti	20%	22%
Jamaica		[45 – >95%]
St Kitts & Nevis	>95%*	
St Lucia	64%*	
St Vincent & the Grenadines	85%*	
Suriname		[18 – 57%]
Trinidad & Tobago		[37 – 78%]
Turks & Caicos	78%*	83%*

NA: Not Available
**Data reported by small countries and not calculated using UNICEF/UNAIDS/WHO methodology*
Source: UNAIDS Report on the global AIDS epidemic, 2008

Moving towards HIV-free generations in the Caribbean

The 'Abuja Call to Action' commitment was developed and approved during the 2005 Prevention of Mother-to-Child Transmission High-Level Global Partners Forum in Abuja, Nigeria. Its aim is to scale up national PMTCT programmes and move towards achieving HIV-free and AIDS-free generations by the end of 2010. That goal is realistically achievable in the Caribbean when the following five important strategic approaches are simultaneously implemented at country level:

- For small island settings where antenatal care and services coverage is very high and where almost all annual pregnancy cohorts are tested for HIV, national PMTCT programmes should aim at 100% PMTCT coverage. Every single pregnant woman should be tested for HIV antibodies and the few found HIV- positive should be provided with the full ART regimen.
- For larger countries, especially Haiti and the Dominican Republic, which are a priority given the heterosexual nature of their epidemic and its magnitude, there is a need to scale up PMTCT services using the existing high antenatal care and services coverage. Specific studies (social epidemiology, ethnographic, etc.) should be undertaken in these countries to map out epidemiological, geographic, economic or social markers which may predict the status of a pregnant woman more likely to be HIV-positive and guide immediate public health actions to prevent mother-to-child transmission.

This could include prompt administering of ART to pregnant women in this category who do not know their serostatus and consult at a late stage in their pregnancy or do so solely to give birth.

- Countries should avoid single dose antiretroviral therapy for PMTCT by moving towards more potent ART regimens which carry fewer consequences for the future treatment of the mother or the baby. Therefore, single dose regimens which induce rapid drug resistance should not be used for PMTCT.
- As a region, the Caribbean can achieve its goal of HIV-free and AIDS-free generations by reducing prevalence among women, especially young females and girls. This critical strategy will not only impact positively on prevention of mother-to-child transmission but will result in an overall reduction of new HIV infections.
- Taking into consideration epidemiological patterns, HIV prevalence among women and young females and the low coverage of PMTCT in certain settings, priority countries for scaling up and/or sustaining PMTCT programmes are included in the map below. Success in these countries will determine if the Caribbean as a region achieves the goals set in the 'Abuja Call to Action' by the end of 2010.

Map 2: Priority countries for PMTCT of HIV in the Caribbean: moving towards HIV-free generations

Priority countries for PMTCT of HIV:

Bahamas, Barbados, Belize, Dominican Republic, Guyana, Haiti, Jamaica, Suriname and Trinidad and Tobago

Credit: Dave Hiebert

In Jamaica there has been a marked reduction in mother-to-child transmission after a collaborative approach to address the issue was used which brought together academics and government healthcare professionals. The project was first implemented as a pilot in Greater Kingston with the intention that it would be rolled out across the country. Results were dramatic. By the end of the five year period under scrutiny, from 2002-2007, mother-to-child transmission was reduced from 29% to 1.6% in Kingston, St Andrew and St Catherine and 4.75% across the island.

Source: Effectiveness of Highly Active Antiretroviral Drugs in Preventing Mother-To-Child HIV Transmission and Reducing HIV-attributable Mortality in Jamaican Children. C.D.C. Christie et al, UWI-Mona, Jamaica

INDICATOR 6:

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

Five out of 18 countries and territories reporting on this indicator have no data available for 2006 and 2007. In the remaining 13, two have no cases of TB/HIV co-infection reported during that period. In the 11 reporting (with the exception of Haiti at 5%), the percentage of estimated HIV-positive incident TB cases that received treatment for HIV was equal to, or above, 50% *(see Table 9).*

Taking into account the fact that international literature pinpoints tuberculosis as one of the commonest causes of illness and death among people living with HIV in developing countries, it will be important for Caribbean islands such as Guyana, Suriname and Trinidad & Tobago to monitor the impact of TB on this population. The measurement of TB deaths among PLHIV will also help gauge whether people are presenting early or late with their symptoms and help assess the quality of care and treatment provided.

Table 9: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

COUNTRY	2006	2007
Antigua & Barbuda		NA
Aruba		0 cases
Bahamas	81%	
Barbados	100%	100%
Belize		69%
Cuba		90%
Dominica		100%
Dominican Republic		115%*
Grenada		0 cases
Guyana		NA
Haiti		5%
Jamaica		72%
St Kitts & Nevis		100%
St Lucia		50%
St Vincent & the Grenadines		100%
Suriname		NA
Trinidad & Tobago		NA
Turks & Caicos		NA

NA: Not Available
**** Data have been overestimated***
Source: UNAIDS Report on the global AIDS epidemic, 2008

INDICATOR 7:

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

Overall, there is a low percentage of HIV testing in the general population. The highest level is observed in Cuba where 30% were tested for HIV antibodies and knew their result. Testing and counseling in the general population is a powerful tool not only for behavioural modification but also for early detection, care and treatment. The strategy should be promoted in all countries to increase the coverage rate for this indicator.

Table 10: Percentage of women and men aged 15 – 49 who received an HIV test in the last 12 months and who know their results

COUNTRY	2004	2005	2006	2007
Antigua & Barbuda			Total: 25%	
Aruba				NA
Bahamas				NA
Barbados			Total: 99%*	
Belize			15% in 15-24 years old M: 10.% F: 20%	
Cuba			Total: 30 M: 28% F: 32%	
Dominica				NA
Dominican Republic				M: 19% F: 21%
Grenada			Total: 10% M: 6% F: 13%	
Guyana		Total: 11%		
Haiti			Total: 7% M: 5% F: 8%	
Jamaica	Total: 16% M: 12% F:19%			
St Kitts & Nevis			Total: 10%*	
St Lucia			Total: 36%*	
St Vincent & the Grenadines			Total: 10% 15-24: 9% 25-49: 11%	
Suriname			F: 30%	
Trinidad & Tobago			Total: 8%*	
Turks & Caicos				NA

M: Males F: Females
** Methodology not harmonised with UNGASS guidelines*
Source: UNAIDS Report on the global AIDS epidemic, 2008

INDICATOR 8:

Percentage of men who have sex with men/female sex workers/male sex workers who received an HIV test in the last 12 months and who know their results

In small island settings it is always challenging to collect this type of information because of issues related to confidentiality. This should not be the case for larger countries which can use such information for planning and programming purposes. However, only five larger Caribbean countries reported on this indicator among the population of men who have sex with men (the Bahamas, Barbados, Cuba, Guyana and Haiti). Among female sex workers there were seven reports from larger countries (Barbados, Cuba, the Dominican Republic, Guyana, Haiti, Jamaica and Suriname). Only Suriname submitted information on male sex workers.

Table 11: Percentage of men who have sex with men/female sex workers/male sex workers who received an HIV test in the last 12 months and who know their results

COUNTRY	2004	2005	2006	2007
Antigua & Barbuda				NA
Aruba				NA
Bahamas				MSM: 61%
Barbados				MSM: 85% FSW: 73%
Belize				NA
Cuba				MSM: 33%, MSW: 38% FSW: 32%
Dominica				NA
Dominican Republic	FSW: 64%			
Grenada				NA
Guyana		FSW: 64% MSM: 44%		
Haiti			FSW: 71% MSM: 48%	
Jamaica				FSW: 43%
St Kitts & Nevis				NA
St Lucia				NA
St Vincent & the Grenadines				NA
Suriname		FSW: 59% MSW: 75%		
Trinidad & Tobago				
Turks & Caicos				

NA: Not Available.
Source: UNAIDS Report on the global AIDS epidemic, 2008

It should be underscored that information submitted by some countries is outdated and does not correspond to the reporting period of 2006-2007. This needs to be addressed through conducting new Behavioural Surveillance Surveys in the Dominican Republic, Guyana and Suriname. With the exception of MSM groups in Barbados, testing coverage overall is below 80% in each of the three most vulnerable populations. Caribbean countries should aim at scaling up testing and counseling services for such groups.

There is a high burden of HIV among these populations and testing and counseling for most vulnerable groups has proven to be an effective strategy for responding to the epidemic. It is, therefore, strongly recommended that all Caribbean countries make the necessary effort to collect, analyse and use this information to achieve solid knowledge of their epidemic and to plan and implement programmes effectively.

INDICATOR 9:

Percentage of men who have sex with men/female sex workers/male sex workers reached with HIV prevention programmes

Table 12: Percentage of most-at-risk populations reached with HIV prevention programmes: men who have sex with men/female sex workers/male sex workers

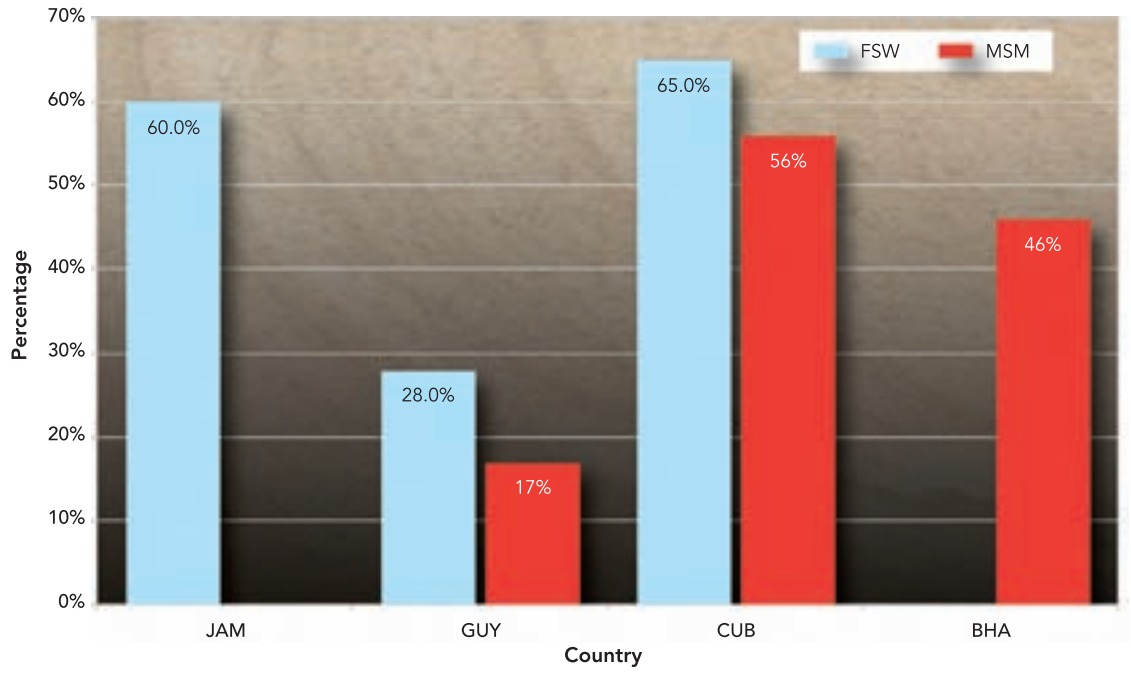
COUNTRY	2005	2006	2007
Antigua & Barbuda			NA
Aruba			NA
Bahamas			MSM: 48%
Barbados			NA
Belize			NA
Cuba		SW: 60% MSW: 59% FSW: 65% MSM: 56%	
Dominica			NA
Dominican Republic			NA
Grenada			NA
Guyana	FSW: 28% MSM: 17%		
Haiti			NA
Jamaica	FSW: 60 %		
St Kitts & Nevis			NA
St Lucia			NA
St Vincent & the Grenadines			NA
Suriname			NA
Trinidad & Tobago			NA
Turks & Caicos			NA

NA: Not Available.
Source: UNAIDS Report on the global AIDS epidemic, 2008

It is imperative that the most vulnerable population groups have access to prevention programmes and services to minimise the spread of HIV in their communities and beyond. Only four countries of the 18 reporting have submitted information on this indicator. This is not a good marker of the effectiveness of a national or regional response to HIV.

The percentage of most-at-risk populations reached with HIV prevention programmes was below 70% in all instances and as low as 17% among men who have sex with men in Guyana. The situation needs immediate improvement if the Caribbean is to achieve universal access to prevention.

Graph 17: Percentage of FSW and MSM reached with prevention programmes



Source: UNAIDS Report on the global AIDS epidemic, 2008

The Caribbean has to move quickly towards the meaningful involvement of its most vulnerable populations who do not receive the attention they need, given that they carry the greater burden of the virus. **Prevention programmes** mainly target the general population and reach a very low percentage of men who have sex with men, male and female sex workers and crack cocaine users.

Credit: Paige Foster

INDICATOR 10:

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

It is expected that issues related to orphans and vulnerable children would be a higher burden in larger countries confronting a heterosexual HIV epidemic. The Bahamas, Belize, the Dominican Republic, Guyana, Haiti, Jamaica, Suriname and Trinidad & Tobago fall into this category. Unfortunately, for the 2008 UNGASS Reports only three of 18 countries and territories have submitted information on this indicator.

One country has high percentages of OVC households receiving external support (St Lucia) and two report very low percentages, i.e. the Dominican Republic and Haiti. To achieve universal access to care for orphans and vulnerable children, data on this indicator should be collected and analysed by all countries to fulfill one key component of the UNGASS Declaration of Commitment.

Table 13: Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child

Antigua & Barbuda	NA
Aruba	NA
Bahamas	NA
Barbados	NA
Belize	NA
Cuba	NR
Dominica	NA
Dominican Republic	4%*
Grenada	NA
Guyana	NA
Haiti	5%
Jamaica	NA
St Kitts & Nevis	NA
St Lucia	69%*
St Vincent & the Grenadines	NA
Suriname	NA
Trinidad & Tobago	NA
Turks & Caicos	NA

NA: Not Available. NR: Not Relevant
Source: UNAIDS Report on the global AIDS epidemic, 2008
** Not harmonised with UNGASS Guidelines*

INDICATOR 11:

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

Seven out of 18 countries reporting on this indicator have not submitted information. Among the remaining countries, small island settings like Dominica, Turks & Caicos, St Lucia and St Vincent & the Grenadines have shown high percentages of schools providing life skills-based HIV education in the last academic year. Understanding that such education is essential for the protection of young people against HIV, it is strongly recommended that these programmes should be scaled up. Given epidemiological patterns in the region, this will markedly contribute to improving the effectiveness of national responses to HIV.

Table 14: Percentage of schools that provided life skills-based HIV education in the last academic year, 2007

Antigua & Barbuda	Total: 13%
Aruba	NA
Bahamas	72% Primary and Secondary
Barbados	Total: 41 %
Belize	NA
Cuba	Total: 71%
Dominica	Total: 100%
Dominican Republic	Total: 1%
Grenada	0
Guyana	NA
Haiti	NA
Jamaica	Total: 24%
St Kitts & Nevis	NA
St Lucia	Total: 91% Primary: 96% – Secondary: 69%
St Vincent & the Grenadines	Total: 87% Primary: 91% – Secondary: 77%
Suriname	NA
Trinidad & Tobago	NA
Turks & Caicos	Total: 100%*

NA: Not Available
Source: UNAIDS Report on the global AIDS epidemic, 2008
** Not harmonised with UNGASS Guidelines*

INDICATOR 12:

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

Only four of 18 countries and territories have reported on this indicator. Of those reporting, data show that a higher ratio of non-orphans than orphans currently attends school in Guyana and Haiti. This indicator is a strong marker for social support to be extended to children affected by HIV and should be utilised for programming purposes.

Table 15: Current school attendance among orphans and non-orphans aged 10-14

Antigua & Barbuda	NA
Aruba	NA
Bahamas	NA
Barbados	NA
Belize	NA
Cuba	2006: orphans: 1.00
Dominica	NA
Dominican Republic	NA
Grenada	NA
Guyana	2005: 0.95%
Haiti	2000: 0.87%*
Jamaica	NA
St Kitts & Nevis	NA
St Lucia	2006: orphans: 1.7
St Vincent & the Grenadines	NA
Suriname	NA
Trinidad & Tobago	NA
Turks & Caicos	NA

NA: Not Available
** Data differs from UNICEF reporting*
Source: UNAIDS Report on the global AIDS epidemic, 2008

INDICATOR 13:

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

All 18 countries and territories reporting on this UNGASS indicator stated that it was relevant, but in 22% of these countries no data was available about this very important population group, one of the most affected by HIV. In several instances, information is outdated. With this in mind, another round of Behavioural Surveillance Surveys should take place as soon as possible.

In the majority of countries the percentage of young females and males aged 15-24 years who both correctly know HIV prevention measures and reject myths surrounding its transmission is below 60%. Special efforts should be put in place to accelerate access to knowledge about prevention by this population group in every country.

Table 16: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

COUNTRY	2004	2005	2006	2007
Antigua & Barbuda		Total: 48%		
Aruba				5.2% males and females in school settings*
Bahamas				NA
Barbados				NA
Belize			Total: 26% M: 26% F: 26%	
Cuba			Total: 58% M: 55% F: 61%	
Dominica				NA
Dominican Republic				Total: 37% M: 34% F: 41%
Grenada			Total: 41% M: 43% F: 40%	
Guyana		Total: 39% M: 34% F: 44%		
Haiti			Total: 35% M: 40% F: 32%	
Jamaica	Total: 35% M: 23% F: 47%			
St Kitts & Nevis			Total: 52%	
St Lucia			Total: 59% M: 61% F: 57%	
St Vincent & the Grenadines			Total: 49% M: 59% F: 40%	
Suriname			Total: 41% females only	
Trinidad & Tobago				Total: 56%
Turks & Caicos				NA

NA: Not Available M: males F: female
Source: UNAIDS Report on the global AIDS epidemic, 2008
** Methodology not harmonised with UNGASS Guidelines*

INDICATOR 14:

Percentage of men who have sex with men/female sex workers/male sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

More than 60% of countries have not reported on this important indicator. The reality is that almost three decades after the emergence of the virus many in key population groups, such as men who have sex with men and male and female sex workers, believe in myths surrounding HIV transmission.

For some countries well under 40% of these populations have comprehensive understanding of HIV prevention measures and also reject myths. In Haiti, only 6% of female sex workers have this knowledge. For FSW in Barbados that figure is 37%. In order to achieve universal access to HIV prevention, countries should collect and analyse information on this indicator and aim to quickly increase the percentage of MSM, FSW and MSW who have an understanding of how to protect themselves against HIV.

Table 17: Percentage of men who have sex with men/female sex workers/males sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

COUNTRY	2005	2006	2007
Antigua & Barbuda			NA
Aruba			NA
Bahamas			MSM: 45%
Barbados			FSW: 37%
Belize			NA
Cuba		MSM: 54% MSW: 49% FSW: 61%	
Dominica			NA
Dominican Republic			NA
Grenada			NA
Guyana	MSM: 67% FSW: 63%		
Haiti		MSM: 36% FSW: 6%	
Jamaica	FSW: 26%		
St Kitts & Nevis			NA
St Lucia			NA
St Vincent & the Grenadines			NA
Suriname		Total: 78% MSW: 75% FSW: 79%	
Trinidad & Tobago			NA
Turks & Caicos			NA

NA: Not Available
Source: UNAIDS Report on the global AIDS epidemic, 2008

INDICATOR 15:

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

As Table 18 shows, with the exception of the Bahamas, Barbados, Dominica, Jamaica and Turks & Caicos, the remaining 13 countries and territories reported on this indicator. Data suggest intercountry variations in terms of the percentage of young females and males having had sex before the age 15. However, from the information gathered it is clear that there needs to be a strengthening of sex education among young people to increase the age of their sexual debut.

Table 18: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

COUNTRY	2005	2006	2007
Antigua & Barbuda		F&M: 25%	
Aruba	F&M*: 25%		
Bahamas			NA
Barbados			NA
Belize		Total: 9% M: 11% F: 6%	
Cuba			Total: 24% M: 33% F: 15%
Dominica			NA
Dominican Republic			M: 24% F: 15%
Grenada		Total: 25% M: 32% F: 20%	
Guyana	M: 13% F: 9%		
Haiti		M: 43% F: 15%	
Jamaica			NA
St Kitts & Nevis		F&M: 22%	
St Lucia		F&M: 26%	
St Vincent & the Grenadines		F&M: 22%	
Suriname		F&M: 8%	
Trinidad & Tobago			F&M: 12%
Turks & Caicos			NA

NA: Not Available F&M: females and males F: females M: males
Source: UNAIDS Report on the global AIDS epidemic, 2008
** Method not harmonised with UNGASS guidelines*

INDICATOR 16:

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

12 countries have reported on this indicator and the level of multiple partnerships in the general population varied between countries, with females reporting lower numbers of casual sexual partners. In the case of Trinidad & Tobago and Antigua & Barbuda the reported number seems very high and should be a call to action. Prevention programmes in the general population should aim at the strengthening of partner reduction messages.

Table 19: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months

COUNTRY	2004	2005	2006	2007
Antigua & Barbuda				Total: 55%
Aruba				NA
Bahamas				NA
Barbados				NA
Belize				Total: 8% M: 13% F: 4% (15-24 years old)
Cuba				Total: 23% M: 35% F: 10%
Dominica				NA
Dominican Republic				Total: 17% M: 30% F: 4%
Grenada			Total: 21% M: 30% F: 13%	
Guyana		Total: 5% M: 9% F: 1%		
Haiti			Total: 12% M: 23% F: 1%	
Jamaica	Total: 29% M: 48% F: 11%			
St Kitts & Nevis			Total: 36% M: 53% F: 19%	
St Lucia				Total: 35% M: 42% F: 25%
St Vincent & the Grenadines			Total: 17% M: 25% F: 10%	
Suriname				NA
Trinidad & Tobago				Total: 85% M: 94% F: 79%
Turks & Caicos				NA

NA: Not Available F: females M: males
Source: UNAIDS Report on the global AIDS epidemic, 2008

INDICATOR 17:

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

Seven out of the 18 countries and territories reporting on this indicator have no data. In the remaining 11, the percentage of condom use among the general population during sexual encounters varied from country to country but has remained below 70% among males as well as females. That percentage was as low as 33% in Haiti and 37% in the Dominican Republic *(see Table 20).* Larger countries such the Bahamas, Barbados, Belize and Trinidad & Tobago are encouraged to collect this information so that a regional picture of the percentage of those in the general population using condoms during sexual encounters emerges.

Table 20: Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

COUNTRY	2004	2005	2006	2007
Antigua & Barbuda			Total: 87%	
Aruba				NA
Bahamas				NA
Barbados				NA
Belize				NA
Cuba				Total: 39% M: 41% F: 33%
Dominica				NA
Dominican Republic				Total: 37% M: 42% F: 33%
Grenada			M: 68% F: 52%	
Guyana		Total: 53% M: 53% F: 56%		
Haiti			Total: 33% M: 34% F: 21%	
Jamaica	Total: 64% M: 67% F: 54%			
St Kitts & Nevis			Total: 67%	
St Lucia				2007: 45% M: 48% F: 39%
St Vincent & the Grenadines			Total: 59% M: 62% F: 52%	
Suriname			Total: 49%	
Trinidad & Tobago				NA
Turks & Caicos				NA

NA: Not Available F: females M: males
Source: UNAIDS Report on the global AIDS epidemic, 2008

INDICATOR 18:

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

Condom use during last sexual intercourse with clients among FSW and/or MSW was reported from seven larger Caribbean countries only. More than 50% of female and male sex workers stated that they used a condom under these circumstances in all instances. However, with the exception of the Dominican Republic and Haiti, it remained below 90% *(see Table 21)*.

The ultimate goal for Caribbean countries should be 100% condom use among FSW and MSW as priority groups, given their high HIV prevalence and their increased vulnerability to infection. The 100% condom use among FSW in the Dominican Republic should be sustained and replicated in other countries and among other vulnerable population groups.

Table 21: Percentage of female and male sex workers reporting the use of a condom with their most recent client

COUNTRY	2005	2007
Antigua & Barbuda		NA
Aruba		NA
Bahamas		NA
Barbados		FSW: 80%
Belize		NA
Cuba		Total: 61% MSW: 63% FSW: 56%
Dominica		NA
Dominican Republic	FSW: 96% (data collected before 2005)	
Grenada		NA
Guyana	FSW: 89%	
Haiti		FSW: 90%
Jamaica		FSW: 84%
St Kitts & Nevis		NA
St Lucia		NA
St Vincent & the Grenadines		NA
Suriname	Total: 70% MSW: 79% FSW: 68%	
Trinidad & Tobago		NA
Turks & Caicos		NA

NA: Not Available
Source: UNAIDS Report on the global AIDS epidemic, 2008

INDICATOR 19:

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

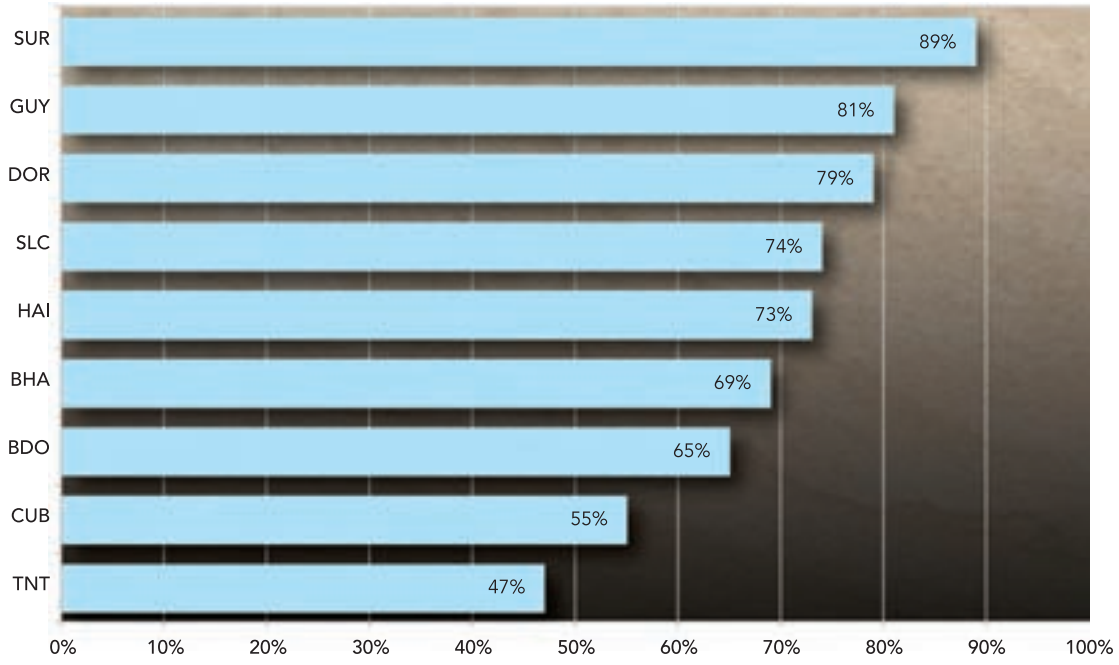
Eight countries have submitted information on this indicator using international standard methodologies; among them seven larger ones where the percentage of MSM reporting the use of a condom at last anal sex varied between 47% in Trinidad & Tobago and 89% in Suriname *(see Table 22 and Graph 18).* Again, because of the very high HIV prevalence observed among MSM and their vulnerability to HIV infection, Caribbean countries should aim at achieving 100% condom use among this group. There is also a need for more up to date information on MSM in settings such as Trinidad & Tobago, Guyana and the Dominican Republic.

Table 22: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

COUNTRY	2004	2005	2006	2007
Antigua & Barbuda				NA
Aruba				NA
Bahamas				69%
Barbados				NA
Belize				NA
Cuba				55%
Dominica				NA
Dominican Republic			79% (data collected before 2005)	
Grenada				NA
Guyana		81%		
Haiti				73%
Jamaica				NA
St Kitts & Nevis				NA
St Lucia				74%
St Vincent & the Grenadines				NA
Suriname		89%		
Trinidad & Tobago	47% (data collected before 2005)			
Turks & Caicos				NA

NA: Not Available
Source: UNAIDS Report on the global AIDS epidemic, 2008

Graph 18: Percentage of MSM reporting condom use at last anal sex, 2004 – 2007



Source: UNAIDS Report on the global AIDS epidemic, 2008

It is extremely important for young people to get the message about HIV. Peer educators lead a session on communication skills for secondary school students.

WOMEN IN THE REGION, ESPECIALLY THE YOUNG, ARE OFTEN DISPROPORTIONATELY AFFECTED BY THE EPIDEMIC.

Courtesy: Stock Xchng www.sxc.hu

The study **Lives lived at risk** highlights the dangerous relationship between a history of violence and HIV risk behaviours for women in the Dominican Republic. It was prepared as the result of a wide-ranging collaboration between the PLHIV networks ASOLIDA and REDOVIH, as well as UNAIDS, UNFPA, UNICEF and an International NGO, the Margaret Sanger Centre.

For many women, according to the study, the origins of their vulnerability lie in childhood abuse and the inability of their parents to provide for their basic physical, psychological and emotional needs. It also highlights the manner in which different forms of childhood abuse, particularly psychological and physical violence, inhibit women's capacities to negotiate effective prevention measures such as condom use.

Violence - and the fear of violence – from current partners also led some of the women featured to engage in behaviours that increased the risk of HIV transmission and thus endangered their lives. Women living with the virus were also often afraid to disclose their HIV status to their partners.

The results obtained in **Lives lived at risk** have facilitated the development of a national multisectoral strategy for a comprehensive approach to reduce HIV prevalence among the female population in the Dominican Republic.

The situation is serious. According to one participant in the study, disclosing their status has had deeply damaging consequences for several of her friends. **"Some of my friends have been diagnosed with HIV and haven't known what to do. I have one friend that went to talk with her husband and he killed her with a pistol in a motel. With another friend, when she told her boyfriend she was positive, he beat her."**

INDICATOR 22:

Percentage of young women and men aged 15-24 who are HIV-infected

Two approaches are used to report on this indicator: HIV prevalence among pregnant women 15-24 years old and the Demographic and Health Survey measuring HIV prevalence among males and females aged 15-24. The latter is much more solid and reflects the real status of the epidemic among young people. Among the 18 countries reporting on this indicator, five small island settings have not submitted information and in the remaining 13 only three have reported data from the DHS (Cuba, the Dominican Republic and Haiti) with the last two reporting disaggregated data by sex. In Cuba and the Dominican Republic HIV prevalence among young females was at least twice that of their male counterparts *(see Table 23 and Graph 19).*

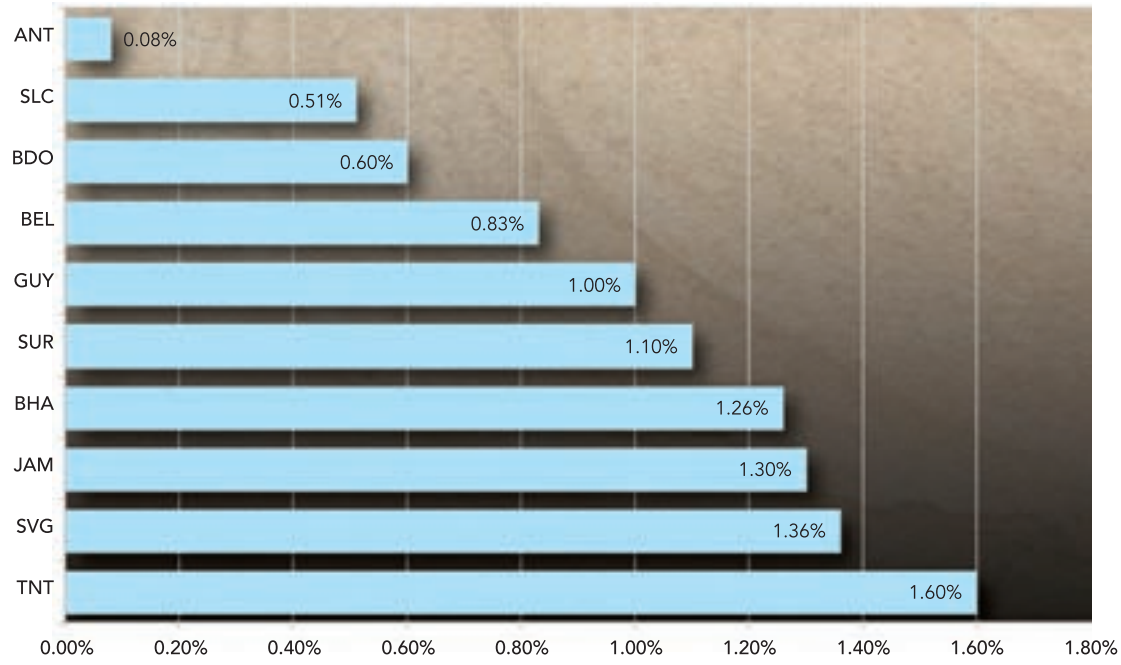
Table 23: Percentage of young women and men aged 15-24 who are HIV-infected

COUNTRY	2005	2006	2007
Antigua & Barbuda		F: 0.08%	
Aruba			NA
Bahamas		F: 1.26%	
Barbados		F: 0.60%	
Belize			F: 0.83%
Cuba			DHS: M&F: 0.05%
Dominica			NA
Dominican Republic			DHS Total: 0.30% M: 0.2% F: 0.4%
Grenada			NA
Guyana		F: 1%	
Haiti		DHS Total: 1.0% M: 0.5% F: 1.5%	
Jamaica			F: 1.3%
St Kitts & Nevis			NA
St Lucia			F: 0.51%
St Vincent & the Grenadines			F: 1.36%
Suriname	F: 1.10%		
Trinidad & Tobago		F: 1.64%	
Turks & Caicos			NA

NA: Not Available M&F: males and females F: females M: males
Source: 2008 UNGASS Reports. HIV prevalence surveys among pregnant women

Among the 10 countries reporting on this indicator using results of HIV prevalence surveys among pregnant women 15-24 years old, intercountry variations were observed. Trinidad & Tobago had the highest prevalence rate and Antigua & Barbuda the lowest. Caribbean countries should aim at decreasing HIV prevalence among young people as agreed upon in the UNGASS Declaration of Commitment.

Graph 19: HIV prevalence among young females 15-24 years old: annual pregnancy cohort, 2006 – 2007



Source: 2008 UNGASS Reports

INDICATOR 23:

Percentage of men who have sex with men/sex workers/drug users who are HIV-infected

Because of the specific epidemiological pattern in the Caribbean, four most vulnerable population groups were included in this reporting: men who have sex with men, female sex workers, male sex workers and crack cocaine users. Half of the 18 countries reporting on this indicator have not submitted information. Data come from seroprevalence surveys conducted among each individual group using the BSS methodology.

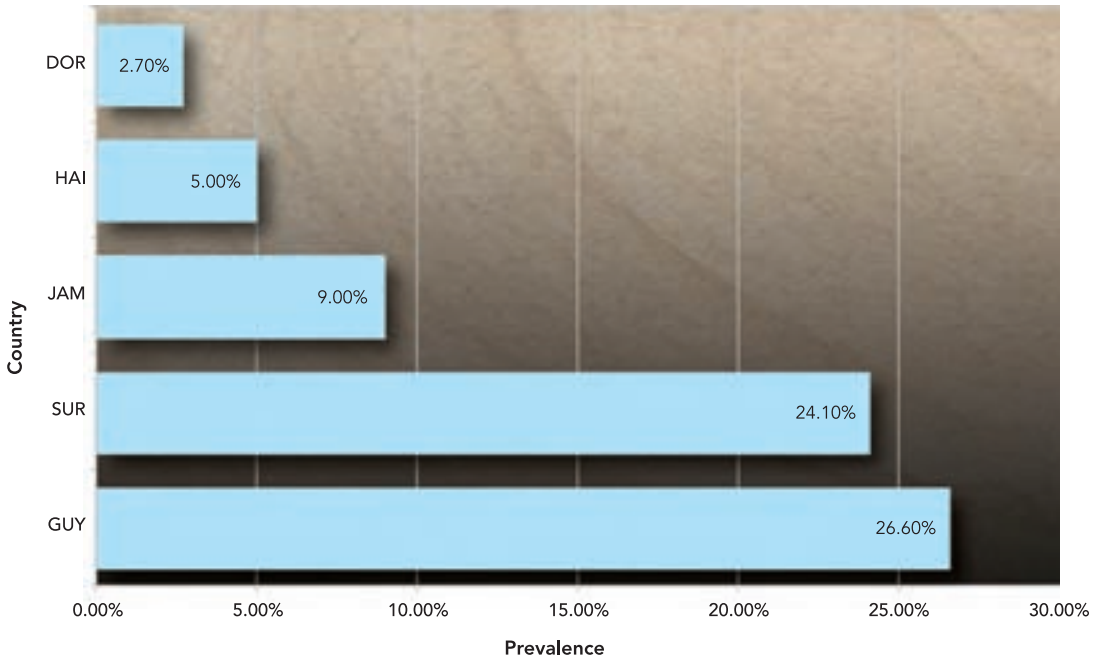
In the remaining nine countries, with the exception of Cuba, HIV prevalence among all these vulnerable groups is very high, with intercountry variations being observed. There is need to scale up prevention, care, treatment and support programmes among these vulnerable groups and to provide comprehensive services which are accessible and acceptable.

Table 24: Percentage of MSM, SW and DU who are HIV-infected

COUNTRY	2004	2005	2006	2007
Antigua & Barbuda				NA
Aruba				NA
Bahamas				MSM: 8.18%
Barbados				NA
Belize				NA
Cuba				MSM: 0.86% SW: 0.12% MSW: 0.13% FSW: 0.12%
Dominica				NA
Dominican Republic			MSM: 11%	
Grenada				NA
Guyana		FSW: 26.6% MSM: 21.25%		
Haiti			FSW: 5.23%	
Jamaica				MSM: 25% to 30% estimated crack cocaine users: 5%
St Kitts & Nevis				NA
St Lucia				crack cocaine users: Total: 7.5% M: 6.8% F: 11.1%
St Vincent & the Grenadines				NA
Suriname		MSW: 36.2% FSW: 21.1% MSM: 6.7%		
Trinidad & Tobago	20%			
Turks & Caicos				NA

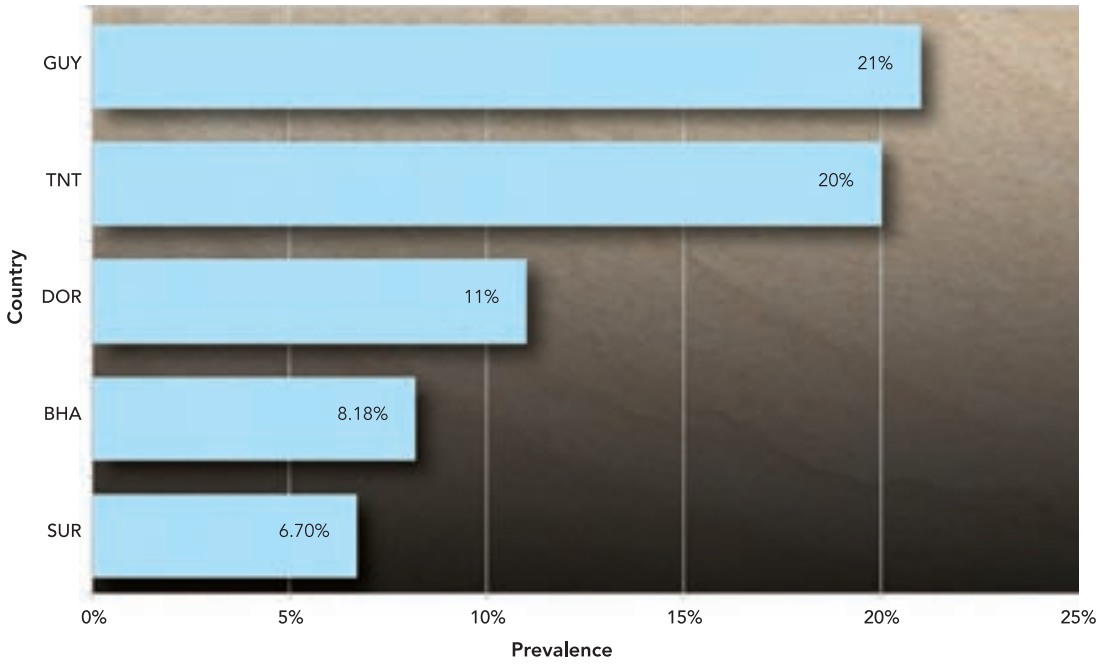
NA: Not Available
Source: 2008 UNGASS Reports
BSS among MSM, SW and DU (CAREC-FHI-USAID and CDARI) 2005-2007.

Graph 20: HIV prevalence among female sex workers in five Caribbean countries



Source: 2008 UNGASS Report

Graph 21: HIV prevalence among MSM in five Caribbean countries, 2005 – 2007



Source: 2008 UNGASS Reports

INDICATOR 24:

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

Among the 18 countries reporting on this indicator only three, Aruba, Belize and Trinidad & Tobago, had not submitted the necessary information. Overall, the percentage of adults and children with HIV infection known to be on treatment 12 months after initiation of antiretroviral therapy was above 50% in all 15 countries and territories reporting. In countries where data was disaggregated by sex, the percentage among females was higher than among men.

That could mean that there is no discrimination against women in ART programmes and it could also reflect the greater adherence to ART by women than men. Cuba is the only country reporting coverage for children, which was high for those both above and below the age of 15. This indicator measures the accessibility and quality of care and treatment provided to PLHIV as well as their early treatment-seeking behaviour. Caribbean countries should aim at increasing the percentage of adults and children with HIV infection known to be on treatment 12 months after initiation of antiretroviral therapy to at least 80% to 90%.

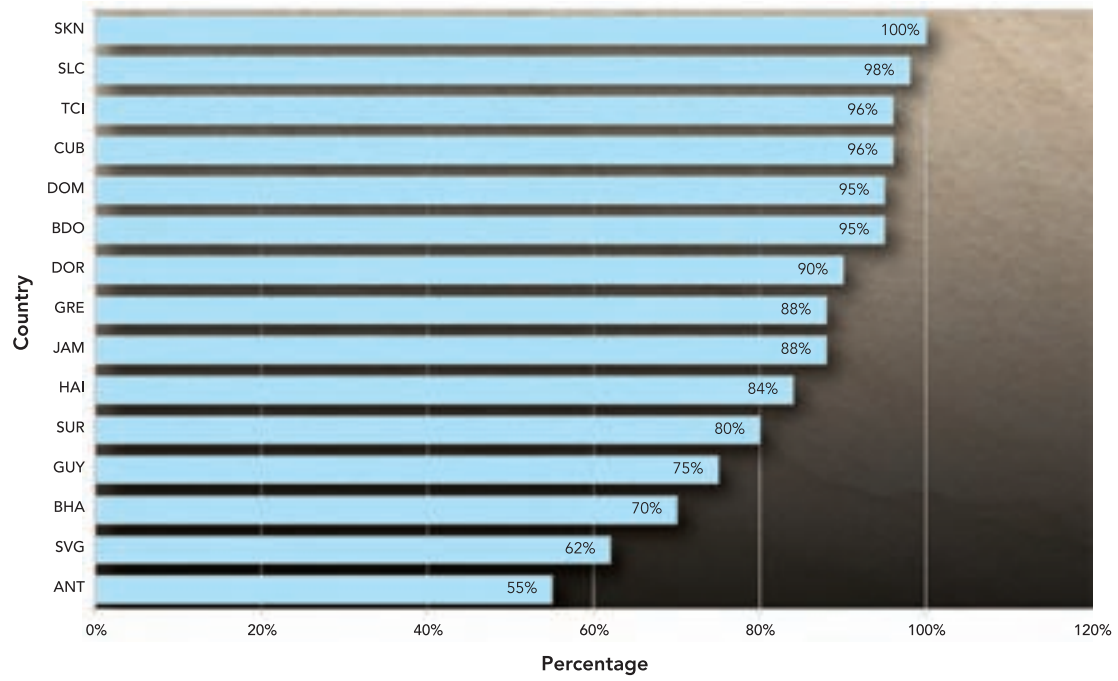
Table 25: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

COUNTRY	2006	2007
Antigua & Barbuda		55%**
Aruba		NA
Bahamas	70%	
Barbados		95%
Belize		NA
Cuba		Total: 96% – M:96% F:96% with 100% in <15 years-old and 96% in >15 years-old
Dominica		95%*
Dominican Republic		90%
Grenada	Total: 88% – M: 83% F: 100%	
Guyana	75%	
Haiti	84%	
Jamaica		88%
St Kitts & Nevis	100%	
St Lucia		98%
St Vincent & the Grenadines	Total: 62% – M: 43% F: 80%	
Suriname		80%
Trinidad & Tobago		NA
Turks & Caicos		96%*

NA: Not Available F: females M: males
**Country Report - not reported in the UNAIDS Report on the global AIDS epidemic, 2008*
*** Cumulative survival. UNAIDS Report on the global AIDS epidemic, 2008*

As Graph 22 demonstrates, the momentum created by efforts to reduce antiretroviral drug prices and the "3 by 5" treatment initiative continued during the reporting period 2006-2007. Increasing numbers of people are getting access to ART (4,000 in 2003 and 30,000 in 2007) and the positive impact on the quality of life of PLHIV is being felt profoundly.

Graph 22: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART



Sources: UNAIDS Report on the global AIDS epidemic, 2008
2008 UNGASS Reports

However, a fundamental concern is that the majority of domestic and international resources are spent on ART programmes at the expense of other key components of the response. This is a serious challenge because in the long term if new HIV infections are not prevented ART programmes will be unable to cope with the demand of a growing population living with HIV. They will collapse. Such a situation can be avoided through the conducting of National AIDS Spending Assessments (NASA) to identify and address funding gaps, as well as through a simultaneous scaling-up of HIV prevention and treatment. That is the winning option for the Caribbean.

IX. CHALLENGES, DEVELOPMENT PARTNERS AND BEST PRACTICES

During this reporting period, there was an opportunity for countries to collect, analyse and report on their challenges in every single strategic area. This information is available in each UNGASS Report and should be used immediately to update National Strategic Plans. Numerous challenges were reported by each of the 18 countries reporting. These included the following:

- Lack of youth friendly services and a gender-based approach to policy formulation;
- Lack of a comprehensive HIV/AIDS surveillance system which covers the public and private sectors;
- Widespread stigma and discrimination which keep individuals away from testing and counseling services and treatment programmes;
- Lack of innovative and specific interventions for vulnerable population groups;
- Centralised antiretroviral treatment delivery systems and a vertical approach to ART;
- A limited human resources base and the need for stronger CSO involvement;
- Lack of financial support for small countries classified as upper-middle or high income;
- Limited coordination among multiple donors, agencies and different actors at country level;
- The need for expanded prevention programmes to reach out to the most-at-risk populations;
- Lack of strategies for long term sustainability of the national responses to the epidemic.

Development partners involved in the challenge to HIV include all the major multilateral and bilateral donors and UNAIDS and its cosponsors UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. Input from UNIFEM, which promotes gender equality and the rights of women and girls, has also been critical.

Many best practices and innovative HIV projects have been highlighted by countries in their 2008 UNGASS Reports, such as creative prevention programmes (e.g. the Youth on the Block programme in St Vincent & the Grenadines). In addition, blood safety standards are generally high and coverage of PMTCT is increasing in a number of countries, such as the Bahamas, Barbados, Cuba and Jamaica.

Other areas in which great strides have been made include:

- AIDS and the work place initiatives (e.g. the Barbershop programme in St Lucia);
- Improvement of care and treatment services (such as the development of a patient tracking system in Dominica);
- Reduction in the number of deaths due to AIDS in the Bahamas, Barbados, Guyana, Jamaica, and Trinidad & Tobago;
- Strengthened political leadership (e.g. inclusion of senior government officials in the national response to HIV in the Bahamas);
- Greater focus on human rights (for instance, the assessment of national laws in relation to human rights and ethics in Dominica and the establishment of a Unit to investigate discrimination against PLHIV and a discrimination register in Barbados);
- Multisectoral coordination (e.g. the National HIV/AIDS Commission in Barbados);
- Greater involvement of civil society (such as the joint review of the national response to HIV and specific men who have sex with men and sex worker outreach programmes in Suriname).

In the near future, it is recommended that these best practices are scientifically and carefully documented for a regional publication, because, when adapted and replicated at country level, they will contribute to accelerating the implementation of universal access goals by 2010.

Credit: Rayudu NVS

X. LESSONS LEARNED FROM THE UNGASS REPORTING PROCESS

The Caribbean has made considerable progress in building national leadership and ownership in the response to HIV. Increasing numbers of national, political and community leaders are voicing their support for efforts to tackle the virus. Notwithstanding these efforts, considerable challenges remain.

It is evident from the 2008 reports that governments have striven to provide leadership in four areas: 1) national-level strategic planning and visioning; 2) technical and logistical support to an array of stakeholders; 3) monitoring the course of the epidemic and implementation programmes and 4) resource mobilisation.

As has been shown, in 2008 21 Caribbean countries submitted UNGASS Reports. This was a great improvement from the 15 countries that reported in 2006. Three reports (Anguilla, British Virgin Islands and the Netherlands Antilles) were narratives and, therefore, 18 submissions were analysed. The quality of these submissions has improved, as evidenced by the number of indicators reported on and analyses undertaken.

The reports additionally provided details on programmatic lessons learned that would benefit the region as a whole. Those interested are encouraged to consult the reports for a fuller and richer account of country experiences, such as the scaling up of prevention of mother-to-child transmission programmes in the Bahamas, Barbados, Belize, Jamaica, Trinidad & Tobago and Guyana.

Table 2 provides a summary of the levels of reporting. One of the difficulties faced was the fact that some of the indicators were not comparable across the countries in the region because of different methodologies used, different reporting periods and the underlying variations in the quality of reporting.

This section provides lessons learned in four general areas:

1. Challenges countries face in reporting on UNGASS;
2. Capacity of countries to report on indicators;
3. Regional support to countries for reporting;
4. Way forward: future support and feedback to countries on the UNGASS process.

1. Challenges Countries Face in UNGASS Reporting

- **Dedicated resources**: As in the past, dedicated resources allocated for a full report were often insufficient or arrived late in the day. With competing demands from multiple sectors and partners, National AIDS Commissions/Committees are stretched thin. This is especially the case with events such as UNGASS reporting which fall at the end of the year along with other donor reports and the need to carry out concurrent national exercises with important financial stakeholders for review of planning exercises. National AIDS Programme staff members, who are required to do the UNGASS reporting, are facing challenges. Resources needed for UNGASS should be integrated into the government budget.
- **Integration and normalising of ad hoc resources:** It has been useful to have some external technical support to maintain the momentum for reporting and extra budgetary support has often been required from partners such as UNAIDS. The mechanisms for government to integrate such post budget support for management of these resources are often laborious, further slowing down the absorptive capacity and timely use of mobilised support. Fast track procedures for national obligations such as UNGASS reporting should be defined.
- **Large data needs for small territories:** For countries with low or concentrated epidemics, as is the case in most of the Caribbean, some of the indicators are complex and require an inordinate amount of effort to obtain the necessary data. It is impossible to present disaggregated data if these were never systematically collected in the first place. As proposed in the last regional report, **Keeping Score I,** the Caribbean needs to focus on a few key indicators for which data collection must be complete and accurate.
- **Data quality**: This has been a challenge for the response in Haiti, for example, as different partners report data differently. Anguilla also highlights the lack of data analysed in such a way as to assist decision makers to assess the exact need for, and coverage of, existing HIV prevention programmes.
- **M&E system structures:** While cognisance should be given to the high cost and complexities of a fully automated data management system, it becomes extremely difficult to provide detailed and comprehensive analyses for different population groups using the paper-based system. The region would benefit from more frequent exchanges of experiences to establish functional systems.
- **Data use for policy and response:** Disaggregation of epidemiological data in Cuba allowed the identification of most affected regions that led to targeted, expanded service delivery at the sub-national level. Antigua & Barbuda, however, found that though critical strategic data existed, they were not used for orientating a more targeted response, e.g. for establishing programmes for orphans and vulnerable children and populations such as female sex workers.

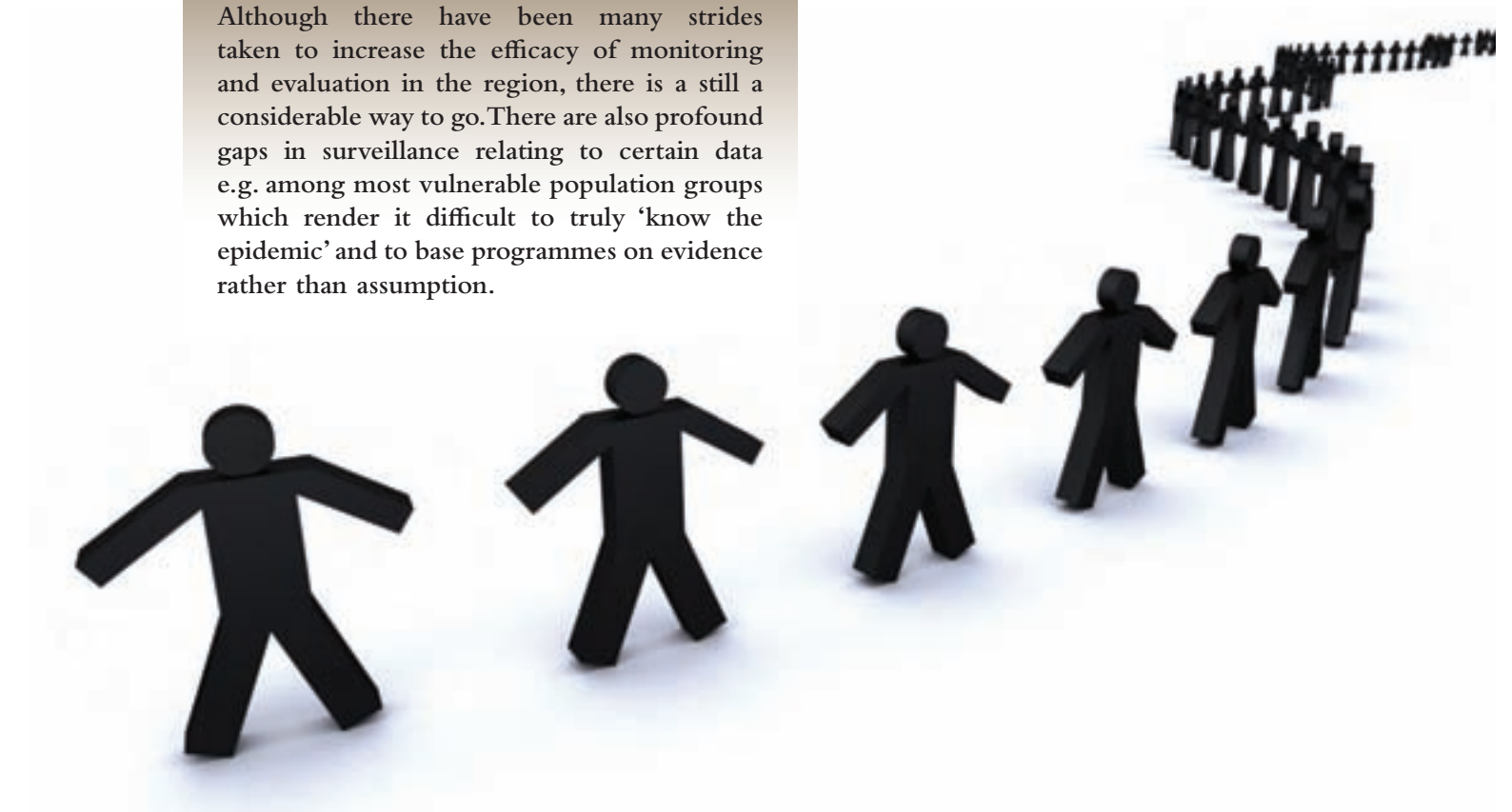
2. Capacity of Countries to Report on Indicators

- **Harmonised reporting at micro-level**: The UNGASS report requires nationally harmonised reporting procedures. The difficulty of attaining this is evident when countries provide different reports on the same indicator that are not consistent. Barbados is a good example of the Caribbean experience of having to harmonise multiple micro-level operations for a diversity of programmes being implemented by civil society agencies which have limited capacity and insufficient funds to implement some of the programmes.
- **Unreached populations in concentrated epidemic zones:** Key most-at-risk populations that need to be fully engaged in the national response to ensure that monitoring and evaluation efforts are accurate are not yet part of nationally systematised reporting frameworks. Neither have the venues for socialising, clubs, bars, sex work sites and communities where active HIV transmission occurs been sufficiently mapped. Although it was recommended in the 2006 **Keeping Score I** report that countries should consider devising and monitoring targeted prevention programmes related to crack cocaine use this has not generally taken place. Sometimes the link between use of this drug and the spread of HIV is denied but evidence suggests that this link may exist.
- **Indicator data needs:** Although many countries have started to observe the impact of AIDS, such as increasing numbers of children who are orphaned or made vulnerable, either no programmes have been instituted yet or their scope has not been fully assessed, despite mounting evidence. Monitoring will not take place if the interventions have not been nationally adopted or included in the national plan.
- **National M&E conceptual frameworks:** Experience from some countries showed that it is critical to identify gaps in the conceptual framework so that these can be addressed in a scale-up strategy. The conceptual methodology and framework were developed to identify, plan and implement strategies based on specific capacity and resources available within a given country. However, these need to be supported by effective tools for evaluation and measurement of existing resource capacity across all the involved sectors.

3. Regional Support to Countries for the Reporting Process

- **Financial support:** The UNAIDS Caribbean Regional Support Team rapidly mobilised critical financial resources for countries requesting additional technical support to get UNGASS reporting underway. Without this support, the UNGASS process might have been more of a challenge.
- **Technical support:** In an innovative strategy, the Caribbean RST mobilised existing monitoring and evaluation resources to cover all the countries in the region which were divided between three dedicated M&E officers. The regional office dealt with the lion's share and outsourced some countries to nationally-based M&E officers.
- **Reporting tools**: Technical support was provided by the UNAIDS regional office in the form of the use of an electronic database to harmonise reporting.
- **Regional support for future UNGASS Reports**: The strategy of parsing out mobilised resources in the region has proven effective and could be improved with a strategy of earlier intervention.

Although there have been many strides taken to increase the efficacy of monitoring and evaluation in the region, there is a still a considerable way to go. There are also profound gaps in surveillance relating to certain data e.g. among most vulnerable population groups which render it difficult to truly 'know the epidemic' and to base programmes on evidence rather than assumption.



4. The Way Forward: Future Support and Feedback to Countries on UNGASS Reporting

- **Effective leadership:** If the Caribbean is to achieve harmonisation and a well-coordinated approach in responding to HIV, it is imperative that countries have outstanding, effective leadership that promotes a culture of excellence in the multisectoral challenge to the epidemic.
- **Involvement of civil society:** CSOs, and most importantly people living with HIV, are central stakeholders in effective responses to the HIV epidemic in the region. They have greater access to key populations and greater expertise in understanding and responding to their needs. At risk populations have higher rates of HIV and other sexually transmitted infections, thus it is crucial that they are involved in the design and implementation of activities to increase access to HIV treatment and care services. For the most-at-risk to benefit from HIV prevention interventions they need to be fully engaged in the development of HIV prevention services. CSOs also play an integral role in supporting programmes for PLHIV and their families through a continuum of care, treatment and mitigation efforts related to home-based care, psychosocial support to address emotional needs, food aid to improve nutrition and incomes and vouchers for legal services to protect assets. They often have a wealth of information and human resources that remain untapped if their efforts are under-resourced and they are not fully included in the "**Three Ones**" national process.
- **Making the money work:** A few major lessons stand out here. Significant financial resources, both domestic and external, have been put towards the implementation of National AIDS Strategic Plans with some progress being made, as outlined in the UNGASS 2008 Reports. However, a lot more needs to be done to ensure the national targets on universal access to HIV prevention, treatment, care and support are achieved by 2010.

- Short and long term technical support has been provided to governments by various partners within an environment of a human resource crisis. However, this support has been largely fragmented, haphazard and mainly donor-driven with little commitment from national partners in terms of continuity.
- It is therefore imperative for all stakeholders to scale up the response to addressing implementation bottlenecks, solving problems of process and increasing the commitment to 'make the money work' immediately.
- **Building strong M&E environments:** One of the keys for effective action against the epidemic is the establishment of an efficient and sustainable monitoring and evaluation system that can be used to report on results and impact. While the Caribbean is becoming richer in data on HIV, the failure to share information between partners about planned activities, missions and reports produced leads to duplication and lessens the ability to build synergies between implementing and financing efforts.

In order to achieve this, National AIDS Programmes must provide leadership with other national entities to proliferate solid M&E practice throughout national and sub-national systems at the country level. At present, a Caribbean Regional M&E Framework has been drafted and the operational phase is beginning. This phase must be carried forward in step with an ambitious human and structural capacity development plan and activities. The plan must satisfy short term critical human capacity and information needs while maintaining a vision for longer-term system implementation and maintenance.

Photo: Farhan Amoor, Toronto, Canada

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