

**UNGASS 2008**

**COUNTRY PROGRESS REPORT**

**ANTIGUA and BARBUDA**

**Reporting period: January 2006-December 2007**

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## **Acknowledgements**

The AIDS Secretariat of the Ministry of Health acknowledges the contributions of government ministries, civil society organisations, including PLHIV networks, NGOs and faith-based organisations in the preparation of this report.

Information for the report was obtained from reviewing relevant documents, interviewing stakeholders and convening a three-day workshop, which brought together partners and stakeholders to develop targets towards achieving Universal Access to HIV prevention, treatment, care and support services by 2010. The process was funded by UNAIDS.

## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CDC	Centers for Disease Control & Prevention
CHAI	Clinton Foundation HIV/AIDS Initiative
CHART	Caribbean HIV/AIDS Regional Training
CHRC	Caribbean Health Research Council
CIDA	Canadian International Development Agency
CMO	Chief Medical Officer
CRIS	Country Response Information System
DFID	Department for International Development of the United Kingdom
DOTS	Direct Observed Treatment Short-course
FBO	Faith-based Organisation
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HSPA	HIV and AIDS Service Provision Assessment
ILO	International Labour Organisation
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
NAC	National AIDS Committee
NAP	National AIDS Programme
NGO	Non-Governmental Organisation
OECS	Organisation of Eastern Caribbean States
OVC	Orphans and Vulnerable Children
PAHO	Pan-American Health Organisation
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
SFH	Society for Family Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
UCC	UNAIDS Country Coordinator
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS

UNICEF	United Nation Children's Fund
USAID	United States Agency for International Development
UWI	University of the West Indies
VCT	Voluntary Counselling and Testing

## **I. Status at a glance**

### ***Inclusiveness of stakeholders in the report writing process***

The 2001 Declaration of Commitment (DoC) of the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) calls for national periodic reports on the progress of the national response to the HIV/AIDS epidemic. The Government of Antigua and Barbuda has signed up to this commitment and requested technical support from UNAIDS to prepare this UNGASS 2008 report. The preparation involved discussions with stakeholders and partners involved in the national response to AIDS as well as a review of relevant documents. The list of those who participated in the discussions is attached in Annex 3 and the documents reviewed are in Annex 4.

### ***Status of the epidemic***

The first case of HIV was diagnosed in 1985 and since then and up to the end of September 2007, the total number of persons infected with HIV was 663, with a male to female ratio of 1:1. The major mode of HIV transmission is through heterosexual contact. The data indicate that the economically active population is being hardest hit by the HIV epidemic and at the end of September 2007, of the 663 persons testing positive for HIV, the majority are in the age group 15-49 years. Women out-number men among HIV-positive persons in the age group 25-29 years. As of the end of September 2007 there were 161 persons (men, women and children) diagnosed with AIDS/advanced HIV infection and of these 60% (88 persons) are alive and are receiving ART.

Deaths from HIV-related causes are among the ten leading causes of all deaths in all age groups, and in the age group 20-59 years, AIDS is the leading cause of death (30 deaths which represented 9.8% of all deaths in this age group).<sup>1</sup>

Determinants of the epidemic include multiple sexual partners, sex workers, sex tourism, inconsistent condom use and underlying psycho-social and economic factors, which include an increasing migrant labour population; mobility among native Antiguan; interest in high-end commodities which stretch earning power; an economy rooted in tourism; and gender inequalities.

### ***Policy and programme response***

A National AIDS Committee (NAC) under the direction of the Chief Medical Officer (CMO) and comprising persons from the Ministries of Health, Education and Home Affairs, civil society

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<sup>1</sup> Health in the Americas, 2007, Volume II - Countries

and faith-based organisations was appointed in 1985 after the first case of AIDS was diagnosed. The NAC has a functioning Secretariat headed by an AIDS Programme Manager and operates as a unit within the Ministry of Health. The AIDS Secretariat is the coordinating body for all HIV and AIDS efforts and works closely with other government ministries, PLHIV and civil society to implement HIV/AIDS strategies and programmes. It also serves as the focal point for the collection and dissemination of information about HIV and AIDS, other STI and related issues.

In keeping with the Strategic Plan for the National Response to HIV/AIDS 2002-2005, which was developed in 2001, the NAP has been incorporated into the existing public health infrastructure. Several policies and procedural manuals have been developed to guide the operations of the NAP and provision has been made for the establishment of the Office of an Ombudsman to deal with issues pertaining to workers rights including those associated with HIV and AIDS.

### ***Prevention***

The PMTCT programme continues in which 99% of pregnant women are tested for HIV and those testing positive receive antiretroviral drugs free of cost. In addition, HIV-positive mothers are given infant formula and discouraged from breast-feeding. VCT services are available at all community health centres, private medical offices and laboratories of the hospitals in Antigua and Barbuda. Free HIV testing is provided at the public laboratory and is available for all pregnant women and their partners. Standard drug kits for managing STI are provided by the Ministry of Health. Condoms are available free of cost at government health centres, and the AIDS Secretariat. They are sold at pharmacies, supermarkets, places of entertainment, the Antigua Planned Parenthood Association and through PSI/SFH.

### ***Treatment, care and support***

A Clinical Care Coordinator who heads the Clinical Care Team was appointed in 2005. This appointment serves to standardise and improve the quality of care and treatment for PLHIV as well as strengthen surveillance and monitoring and evaluation of the NAP. ARV drugs are dispensed at no cost to PLHIV from the hospital pharmacy at the public hospital.

The Health, Hope and HIV Network, a support group for PLHIV, is active and continues to work with the NAP in HIV/AIDS educational activities, especially the aspect of putting a face to HIV and AIDS. Tri-Star Alliance, a group of MSM, who target at-risk men and educate them on HIV/AIDS and other STI, continues to work with the AIDS Secretariat and other partners involved in the response to the AIDS epidemic.

Activities continued in the following areas: social marketing of condoms; school-based AIDS education for youth; Voluntary Counselling and Testing; programmes for sex workers, MSM and

other most-at-risk populations; blood safety; PMTCT; and programmes to ensure safe injections in health care settings; and programmes for men who have sex with men. A mechanism to ensure that PLHIV receive appropriate medical care, home care and supportive palliative care has been developed.

International, non-governmental and national agencies continue to provide support for the NAP through grants, loans and technical cooperation.

### Overview of UNGASS indicator data

Indicators	Achievements (2007)
<b>A. National Commitment and Action</b>	
1. Domestic and international AIDS spending by categories and financing sources.	<ul style="list-style-type: none"> <li>Govt. Expenditure - EC \$279,765.07</li> <li>DFID – EC \$108,000.00 (US \$40,000.00)</li> <li>Global Fund Project – EC \$37,009 (expenditure during the fiscal year March 1, 2006 – February 28, 2007).</li> </ul> <p style="text-align: right;"><b>Exchange rate: EC \$2.7 = US \$1</b></p>
2. National Composite Policy Index	See Annex 2
<b>B. Prevention</b>	
3. Percentage of donated blood units screened for HIV in a quality assured manner	<ul style="list-style-type: none"> <li>2006 – 32.8%</li> <li>2007 – 31.9%</li> </ul>
5. Percentage of HIV-positive pregnant women who received antiretroviral therapy to reduce the risk of mother-to-child transmission	<ul style="list-style-type: none"> <li>2006 – 83%</li> <li>2007 – 60%</li> </ul>
9. Percentage of most-at-risk (female sex workers) populations reached with HIV prevention programmes	<ul style="list-style-type: none"> <li>Data not available</li> </ul>
<b>C. Care, Treatment and Support</b>	
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	<ul style="list-style-type: none"> <li>60% - (88 out of 148 adults and children)</li> </ul>
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	<ul style="list-style-type: none"> <li>Data not available</li> </ul>
10. Percentage of orphaned and vulnerable children aged 0–17 years whose households received free basic external support in caring for the child.	<ul style="list-style-type: none"> <li>Data not available</li> </ul>
11. Percentage of schools that provided life skills-based HIV education in the last academic year	<ul style="list-style-type: none"> <li>13% - UNICEF-funded pilot project in 13 public schools.</li> </ul>
12. Current school attendance among orphans and among non-orphans aged 10–14 years	<ul style="list-style-type: none"> <li>Not relevant for the country as education is free and compulsory for all children between the ages of 5 and 16 years</li> </ul>
<b>D. Knowledge and Behaviour Change</b>	
7. Percentage of women and men aged 15-49 years who received an HIV test in the last 12 months and who know their results	<ul style="list-style-type: none"> <li>15-24 yrs – 8%</li> <li>25-49 yrs – 17%</li> </ul>
8. Percentage of most-at-risk populations (female sex workers) that have received an HIV test in the last 12 months and who know their results	<ul style="list-style-type: none"> <li>Data not available</li> </ul>

<b>Indicators</b>	<b>Achievements (2007)</b>
13. Percentage of young women and men aged 15–24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	<ul style="list-style-type: none"> <li>• 15-24 yrs – 48%</li> </ul>
14. Percentage of most-at-risk populations (sex workers) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	<ul style="list-style-type: none"> <li>• Data not available because of an insufficient number of participants for a pilot BSS survey among MSM and FSW, 2006-2007.</li> </ul>
15. Percentage of young women and men aged 15–24 years who have had sexual intercourse before the age of 15 years	<ul style="list-style-type: none"> <li>• 15-24 yrs – 25%</li> </ul>
16. Percentage of women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months	<ul style="list-style-type: none"> <li>• 15-24 yrs – 41%</li> <li>• 25-49 yrs – 14%</li> </ul>
17. Percentage of women and men aged 15–49 years who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	<ul style="list-style-type: none"> <li>• 15-24 yrs – 60%</li> <li>• 25-49 yrs – 53%</li> </ul>
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	<ul style="list-style-type: none"> <li>• Data not available because of an insufficient number of participants for a pilot BSS survey among MSM and FSW, 2006-2007.</li> </ul>
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	<ul style="list-style-type: none"> <li>• Data not available because of an insufficient number of participants for a pilot BSS survey among MSM and FSW, 2006-2007.</li> </ul>
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	<ul style="list-style-type: none"> <li>• Although relevant for the country, information on injecting drug users is not available.</li> </ul>
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	<ul style="list-style-type: none"> <li>• Although relevant for the country, information on injecting drug users is not available.</li> </ul>
<b>E. Impact</b>	
22. Percentage of young women and men aged 15–24 years who are HIV infected	<ul style="list-style-type: none"> <li>• 2006 – 0.07% (9 out of 13,586 pop. 15-24 yrs)</li> <li>• 2007 – 0.08% (11 out of 13,841 pop. 15-24 yrs)</li> </ul>
23. Percentage of most-at-risk populations who are HIV infected	<ul style="list-style-type: none"> <li>• Data not available</li> </ul>
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	<ul style="list-style-type: none"> <li>• 60% (88 out of 148 persons with advanced HIV infection are on ARV drugs)</li> </ul>
25. Percentage of infants born to HIV-infected mothers who are infected	<ul style="list-style-type: none"> <li>• Data not available</li> </ul>

## II. Overview of the AIDS epidemic

Antigua and Barbuda, a three-island chain comprises the inhabited islands of Antigua (108 square miles), Barbuda (68 square miles) and the uninhabited island of Redonda (½ square mile) which is a nature reserve. Known as the ‘gateway to the Caribbean’ since the end of the 18<sup>th</sup> century because of its advantageous location, Antigua and Barbuda is considered a minor trans-shipment port for the illegal passage of narcotics bound for the US and Europe. It appears that the existence of this gateway has had an impact on drug use and other social behaviours, especially among the country’s youth<sup>2</sup>.

The 2001 Census of Population and Housing projected a resident population for the years 2006 and 2007 of 84,330 persons and 85,903 persons respectively, with a male to female ratio of 1:1. The estimated resident population for 2010 is projected to be 90,801 persons (approximately 42,642 males and 48,159 females). In 2006, life expectancy was estimated at 69.5 years for males and 74.4 years for females. There is a steady inflow of immigrants and, in 2001, this inflow represented 21.3% of the population.

In 2006, the crude birth rate was 14.7 per 1,000 population, the crude death rate was 5.9 per 1,000 population and the infant mortality rate was 16 per thousand live births. There were no reported maternal deaths in 2006 and the Total Fertility Rate was 2 children per woman. Approximately 30% of the population lives in poverty.<sup>3</sup> Deaths from HIV-related causes were among the ten leading causes of death and in the age group 20-59 years, AIDS was the leading cause of death (30 deaths which represented 9.8% of all deaths) in this age group.

The economy depends heavily on tourism for foreign exchange, employment and government revenue. This dependence, coupled with the introduction of casinos and gambling spots, has resulted in the growth of sex work.

The health system is financed through public taxation, levies, private insurance and the Social Security Fund. User fees, the main source of revenue in the private sector, have a negligible role in public sector financing.<sup>4</sup> During the period 2001-2005, government expenditure on health averaged 12.6% of the national budget, the recurrent expenditure in health in 2004 was US \$27.9 million and the estimated recurrent expenditure in health was US \$24.5 million.<sup>5</sup> International, non-governmental and national agencies continue to provide technical and financial support for the NAP.

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<sup>2</sup> The Link between Drug Use and HIV/AIDS among Young People in Antigua and Barbuda: A Semi-Qualitative Research Study, 2003

<sup>3</sup> Caribbean Region HIV and AIDS Service Provision Assessment Survey 2005

<sup>4</sup> Caribbean Regional HIV and AIDS Service Provision Assessment Survey, 2005

<sup>5</sup> Health in the Americas, 2007

***“HIV is no longer just a health issue; it is also a social issue, a human rights issue and an economic issue. This disease affects young adults just as they are in the most reproductive years of their lives, when they should be contributing to the economic development of the country and raising their children. It also affects our young women and leaves many children as orphans.”<sup>6</sup>***

The first case of AIDS was reported in December 1985 in a homosexual male and since then and up to the end of September 2007, a cumulative total of 663 persons have tested positive for HIV and a cumulative total of approximately 250 AIDS cases were reported to the AIDS Secretariat. A total of 163 persons have died from AIDS-related causes, giving a 65% case fatality rate. Since the advent of free ART in September 2004, the death rate among HIV-positive persons has remained below 10 persons per year. Heterosexual transmission is the leading mode of acquiring HIV.

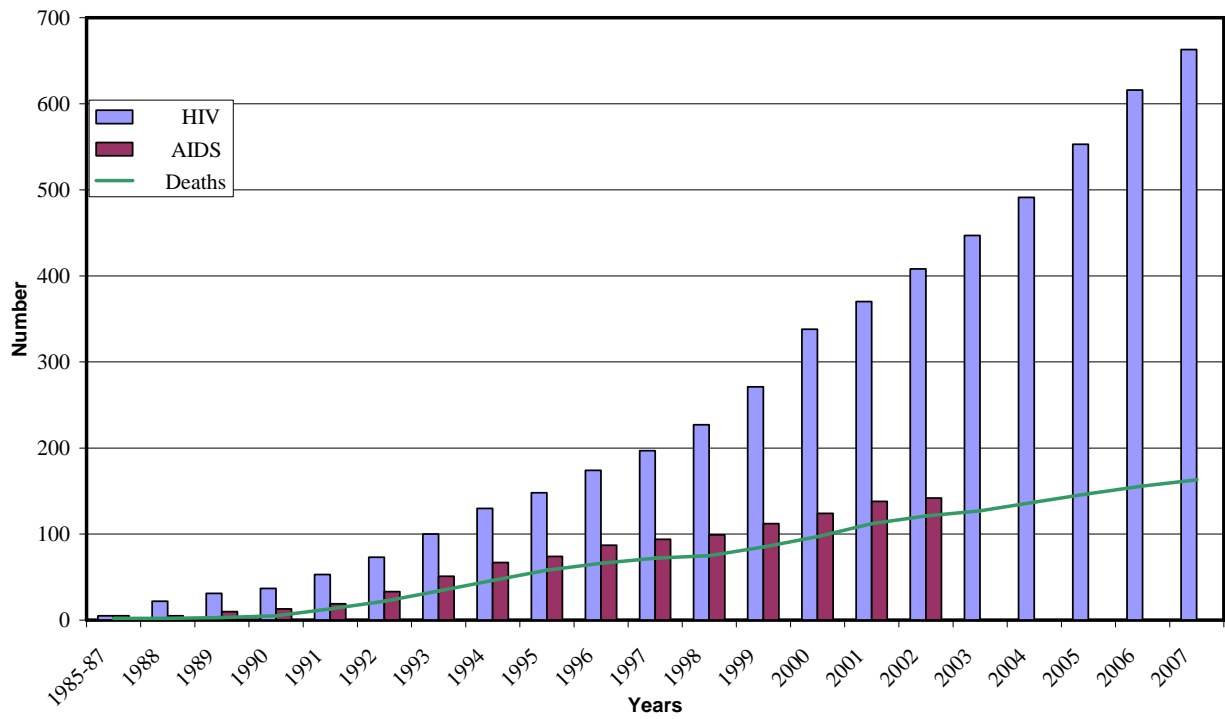
The available data indicate that the economically active population is most affected by the AIDS epidemic with the majority of notified cases of HIV occurring in persons between the ages of 20 and 54 years. In the age group 25-29 years, women out-number men among HIV-positive persons and among the reported cases of AIDS, there are more males compared to females. Anecdotal evidence suggests that the most at-risk groups are the youth, MSM and FSW. The total number of people dying from HIV-related causes was 163, giving a 65% case fatality rate.

Figure 1 below shows the cumulative total of HIV and AIDS cases as well as deaths since the first case was reported in 1985 and up to the end of September 2007. The total number of people dying from AIDS-related causes each year is shown below.

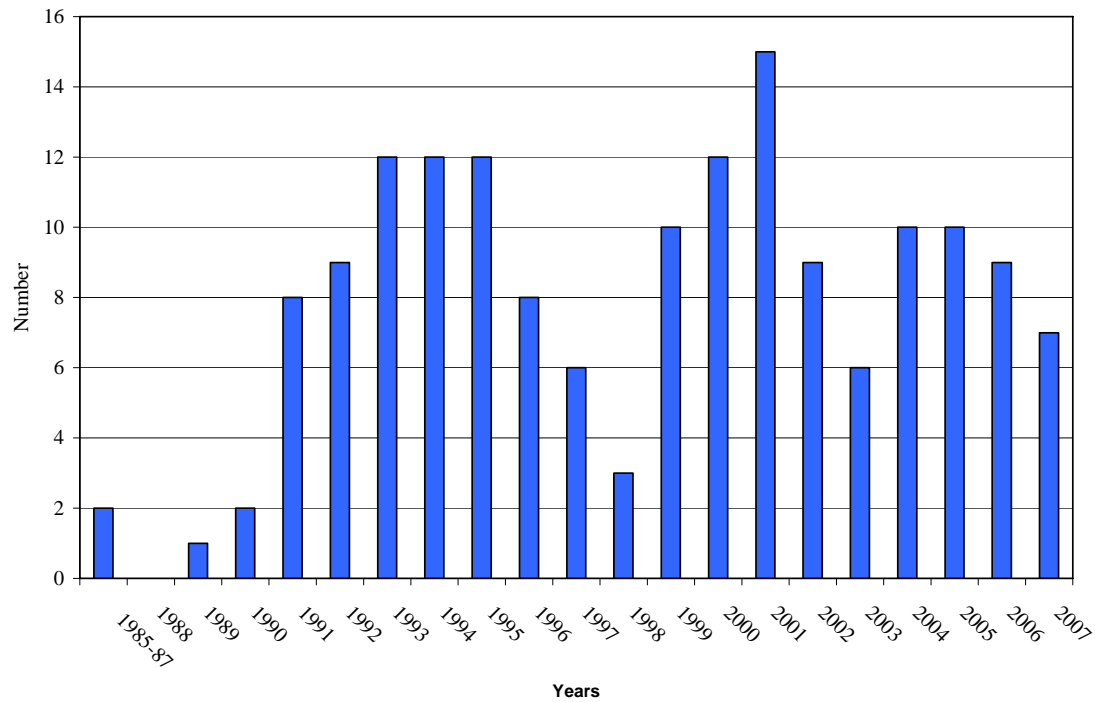
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<sup>6</sup> Extract from 2007 World AIDS Day message by the Minister of Health, Hon. John Maginley

**Fig. 1: Cumulative total of HIV and AIDS cases and Deaths 1985 - Sep. 2007**



**Fig. 2: Number of AIDS-related Deaths 1985 - Sep. 2007**



For the period 2006 -2007, there were 110 HIV cases and of these 46 were males and 62 were females. In 2 cases the sex was not stated. The majority of persons with HIV infection are in the age group 15-49. Of the 110 confirmed HIV cases for the period January 2006 to the end of September 2007, 86 persons were between the ages of 15 and 49 years and of these 33 persons were males and 53 persons were females; 17 persons were over the age of 49 years and there were two children in the age group 0-9 years. For four persons, the age was not stated. The data also show that the number of reported HIV cases is higher in women than in men.

#### **Distribution of HIV cases by age group, 2004 – Sept. 2007**

<b>Age group</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007*</b>
0 - 4 yrs	2	0	0	1
5 -14 yrs	0	1	1	1
15 - 49 yrs	33	46	49	37
50 and over	5	8	11	6
Not stated	4	7	2	2
<b>Total</b>	<b>44</b>	<b>62</b>	<b>63</b>	<b>47</b>

\* Jan. – Sep.

**Source:** AIDS Secretariat, Ministry of Health

Data for newly diagnosed cases of AIDS are not available. Information on hospitalisation of persons with advanced HIV infection indicates that 29 persons were hospitalised in 2006 and 31 persons in 2007. Of these persons hospitalised, there were 11 deaths in 2006 and seven deaths up to the end of September 2007. The one facility that offers ART maintains no records indicating the number of clients receiving ARV treatment and no formal reports are submitted routinely and on a regular basis for ART services. Information is available on request and the records in this facility showed that 161 persons have been seen and treated with ARV drugs. Of the 161 persons, 148 are alive and 60% are on ARV drugs.

Screening tests in 1998 indicated a sero-prevalence rate of 0.92% among pregnant women and between 1998 and 2002, based on voluntary testing, the average sero-prevalence rate among pregnant women who agreed to be tested was 0.6%.<sup>7</sup>

Persons attending ante-natal clinics, at which HIV screening is carried out routinely, represent the only sentinel population that has been monitored. The table below shows the percentage of HIV-positive persons attending ante-natal clinics.

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<sup>7</sup> CAREC. Status and Trends: Analysis of the Caribbean HIV/AIDS Epidemic 1982-2002: Antigua and Barbuda

### HIV among pregnant women

	2005	2006	2007*
No. tested	417	257	186
No. positive	1	5	3
HIV pos. %	0.24	1.9	1.6

\* Jan. – Sep.

**Source:** AIDS Secretariat, Ministry of Health

Since the last UNGASS report, there have been achievements in the areas of development and revision of policies and procedural manuals and in treatment, care and support of PLHIV. In spite of these achievements, the major challenge for the NAP is the HIV/AIDS Information System that does not permit easy access to data which are collected but not analysed. Documented comprehensive reports on the NAP, which could give a full picture of the epidemic, are not readily available. With the on-going scaling up of the NAP, and as more HIV-positive clients enter the system, it is important that a reliable and confidential procedure for record-keeping is established and reports submitted on a regular basis.

### III. National response to the AIDS epidemic

#### A. National Commitment and Action

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

The sources of funds for the NAP are the government, OECS Global Fund Project and DFID. For the period 2006-2007, a review of the Antigua and Barbuda's Estimates 2007 indicated that funds for the NAP were allocated as shown below.

#### Government financial commitment for the NAP

Year	Amt. allocated	Amt. spent
2006	EC \$929,845	EC \$499,162.63
2007	EC \$880,979	EC \$431,534.27

Rate of exchange: EC \$2.70 = US \$1

Source: AIDS Secretariat, Ministry of Health

Information on actual expenditure is not itemised into the categories recommended by UNAIDS and as requests are made to carry out activities of the NAP, funds are released from the Programme Sub-Head of the Annual Estimates of the Ministry of Health. A similar situation exists for funds from the OECS Global Fund Project and DFID. However arrangements have been made for providing periodic reports on expenditure by categories in the Global Fund Project. The funds from DFID represent a grant of US \$40,000 to the Government of Antigua and Barbuda as part of DFID's programme to scale up HIV/AIDS activities in the OECS. The table below shows the amount of funds from DFID and the Global Fund Project for the NAP.

#### Funds from International Agencies

Source of Funds	Amt. allocated	Amt. spent
DFID	US \$40,000	US \$29,766.36
OECS Global Fund Project	EC \$167,050	EC \$37,009

Rate of Exchange: US \$1 = EC \$2.70

Source: AIDS Secretariat, Ministry of Health

For the financial year March 1, 2006 to February 28, 2007, the Government of Antigua and Barbuda received EC \$167,050 from the Global Fund Grant for scaling up prevention, care and

treatment to fight the AIDS epidemic in the OECS. Of this amount EC \$37, 009 was spent in the areas outlined in the table below.<sup>8</sup>

**Expenditure by Programme areas March 1, 2006 to February 28, 2007**

<b>Category</b>	<b>Expenditure</b>
Outpatient primary/specialty medical care	EC \$12,360
Laboratory	EC \$5,884
Prevention and Education	EC \$8,252
Surveillance	EC \$9,966
Project support	EC \$547
<b>Total expenditure</b>	<b>EC \$37,009</b>

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

The completed questionnaire is attached in Annex 2.

***B. Prevention***

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

There is one public health laboratory (a department of the Holberton hospital, the only public hospital in Antigua) and four private laboratories. Screening of blood and blood products for HIV and other STI is carried out at the public and private laboratories and reports are submitted to the AIDS Secretariat on a regular basis. The report includes information on age, sex, reasons for requesting the test and the results of the test. The table below shows the number of units of blood collected and screened during 2006 and 2007.

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<sup>8</sup> Audit of the Global Fund Grant executed through the HIV/AIDS Programme Unit of the Organisation of Eastern Caribbean States (OECS).

**Number of blood units collected and screened – 2006 and 2007\***

Sources of Referral	2006		2007*	
	Blood screened	HIV pos.	Blood screened	HIV pos.
Blood donors	1,014	2	739	2
STI patients	239	10	157	3
Ante-natal clients	583	7	467	2
Insurance clients	1,257	42	955	39
<b>Total</b>	<b>3,093</b>		<b>2,318</b>	

\* Jan. – Sep.

**Source:** AIDS Secretariat, Ministry of Health

From the data collected the percentage of donated blood units screened for HIV for 2006 and 2007 was 32.8% and 31.9% respectively.

**Indicator 5: Percentage of HIV-positive pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission**

During the period 2001-2005, seven health facilities initiated Voluntary Counselling and Testing services - all health centres and the Holberton hospital in Antigua and the Hannah Thomas hospital in Barbuda.<sup>9</sup> Services for PMTCT are provided in conjunction with ante-natal services and delivery services and in Antigua these services are offered primarily through the ante-natal clinic and delivery ward at the Holberton hospital. The health centres offer some aspects of the PMTCT services which include pre-test and post-test counselling as well as testing pregnant women for HIV; providing HIV-positive pregnant women with counselling on infant feeding and the importance of family planning to prevent HIV transmission; and the provision of prophylactic ARV to the HIV-positive mother and to her newborn (within 72 hours of birth). The information presented is mainly from the hospital's records and is shown in the table below.

**HIV positive women receiving ARV drugs in the PMTCT programme**

	2006	2007*
No. of patients seen at Antenatal Clinics	982	1,072
No. of patients pre-test counselled for HIV	244	187
No. of patients tested for HIV	257	186
No. of patients testing positive for HIV	6	5
No. of patients on ART	5	3

\* Jan. – Sep.

**Source:** AIDS Secretariat, Ministry of Health

<sup>9</sup> Health in the Americas, 2007, Volume II - Countries

From the data collected, the percentage of HIV-positive pregnant women who received ART in 2006 and 2007 is 83% and 60% respectively.

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

A pilot Behavioural and HIV Sero-prevalence Survey (BSS) among 2 vulnerable populations – MSM and FSW which aimed at determining HIV prevalence and describing risk behaviours among MSM and FSW was not able to reach a sufficient number of participants because of the low level of networking among these populations; a high degree of stigma and discrimination; and the illegal aspects of MSM and FSW activities which result in a fear of identity disclosure and possible arrest, thus reducing their access to HIV prevention, treatment, care and support services.<sup>10</sup>

Although HIV prevention programmes have been developed for the entire population, there is no evidence that there are specific programmes which target FSW. Therefore, there is no information on this indicator.

***C. Treatment, care and support***

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

Data for newly diagnosed cases of AIDS are not available and information on hospitalisation of persons with advanced HIV infection indicates that 29 persons were hospitalised in 2006 and 31 persons in 2007. The one facility that offers ART maintains no records indicating the number of clients receiving ARV treatment and no formal reports for ART services are submitted on a regular basis. Information is available on request and the records in this facility showed that 161 persons have been seen and treated with ARV drugs. Of these 161 persons (adults and children), 148 are alive and 60% are on ART.

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

During the period 2001-2005, there were 16 cases of TB, 5 of which were in HIV-positive persons.<sup>11</sup> Two out of the nine facilities surveyed in 2006 provided TB services, none offered DOTS and one facility indicated that only follow-up treatment was performed. In the absence of additional information on TB and HIV co-infection, it is difficult to report on this indicator.

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<sup>10</sup> Behavioural and HIV Sero-prevalence Survey (BSS) among MSM and FSW, Nov. 2006 – Jan. 2007

<sup>11</sup> Health in the Americas, 2007, Volume II - Countries

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

Although there are reports that there are orphans and vulnerable children (OVC) as a result of the AIDS epidemic in Antigua and Barbuda, there are no records or official data to confirm these reports, neither are there programmes which specifically deal with these OVC.

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

The education system in Antigua and Barbuda comprises 54 public schools and 43 private schools. During the period 2005-2008 Antigua and Barbuda has been participating in a UNICEF-funded pilot project which aims to monitor and evaluate the effectiveness of the school curriculum in six schools. In these schools, Form I, II and III students between the ages of 11 and 14 years have been selected.

The project comprises two units: Self and Interpersonal Relationships (which incorporates violence prevention), and Sexuality and Sexual Health (which encompasses HIV/AIDS prevention). These two units aim to achieve measurable gains in students' knowledge, health-promoting attitudes and skills and, most importantly, reductions in risk behaviours related to HIV, sexually transmitted infections (STI), unintended pregnancy and violence. Findings of the project will identify areas for improving the Common Curriculum and its delivery.

Implementation of the new Health and Family Life Education (HFLE) Common Curriculum began with all Form I students during the 2005-2006 school year, and followed with all Form II students during the 2006-2007 school year and with all Form III students during the 2007-2008 school year.<sup>12</sup> Participation of public schools in this pilot project indicate that 13% of all schools provided life-skills based education in the 2005-2006 academic year.

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

In Antigua and Barbuda, education is free and compulsory for all children aged 5 to 16 years. Therefore, the indicator is not relevant for the country.

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<sup>12</sup> UNICEF-funded project: “Strengthening HFLE in the Region through Implementation, Monitoring and Evaluation of HFLE in 4 CARICOM countries, 2005-2008”.

### *C. Knowledge and behaviour change*

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

The Caribbean Region HIV and AIDS Service Provision Assessment Survey 2006 revealed that eight out of the nine public facilities have an HIV testing system (a facility offering pre-test and post-test counselling and HIV testing and which keeps records of having received test results) and at least one counsellor trained in pre-test and post-test counselling by the Caribbean HIV and AIDS Regional Training Initiative (CHART). Informed consent policy was available in most of the facilities and in 25% of them there are records for clients tested for HIV as well as registers with HIV test results. The existence of guidelines for pre-test and post-test counselling as well as a policy and guidelines on confidentiality for HIV test results indicate a high level of VCT coverage. Information from the BSS in six countries of the OECS indicate that 8% of the population in the age group 15-24 years and 17% in the age group 25-49 years was tested for HIV in the last 12 months and know their results.

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

There are no official records containing information on the use of the health services by most-at-risk populations (FSW) as they are included in the general population with respect to health care services. Data for this indicator are not available.

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

The information for this indicator is from a Behavioural Surveillance Survey (BSS) in Six Countries of the Organisation of Eastern Caribbean States (OECS) 2005-2006. Antigua and Barbuda is included in the six countries. The findings of the survey indicate that 48% of the population aged 15-24 years identified correctly ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.

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

The pilot Behavioural and HIV Sero-prevalence Surveillance (BSS) Survey among MSM and FSW in Antigua and Barbuda and St. Vincent and the Grenadines was not completed as the methodology used was not able to reach a sufficient number of participants.

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

Information from the BSS survey indicates that 25% of the respondents in the age group 15-24 years had sex (oral, vaginal or anal penetrative sex) before the age of 15 years.

**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**

Data from the BSS survey indicate that 41% of respondents in the age group 15-24 years and 14% in the age group 25-49 years had sexual intercourse with multiple (two or more) partners in the past 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**

The BSS survey (2005-2006) indicate that 60% of respondents in the age group 15-24 years and 53% in the age group 25-49 years reported using a condom the last time they had sexual intercourse.

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

Data for this indicator are not available because of the challenges experienced with surveys in these small at-risk populations and as outlined in the pilot BSS survey among MSM and FSW.

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

Information on this indicator is not available for reasons mentioned above.

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

Information on injecting drug users is not available.

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

As with Indicator 20, information on injecting drugs users is not available.

***D. Impact***

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

The guidelines recommended that data from pregnant women attending ante-natal clinics should be used to calculate this indicator. However, dis-aggregated data for pregnant women using ante-natal services is not collected and collated, thus it is not possible to calculate this indicator using data from these clinics. Calculation of the indicator used the numerator as the number of HIV-positive young persons aged 15-24 years in the general population and the denominator as the total number of persons aged 15-24 years in the general population. Based on the 2001 Census of Population and Housing, the projected estimated resident population for 2006 is 84,330 persons comprising 39,603 males and 44,727 females; for 2007 the estimated resident projected is 85,902 comprising 40,342 males and 45,560 females.

The estimated population in the age group 15-24 years for 2006 and 2007 is shown below.

**Projected Estimated Resident Population for 2006 and 2007**

Age group	2006			2007		
	Male	Female	Total	Male	Female	Total
All ages	39,603	44,727	84,330	40,342	45,560	85,902
15-24 yrs	6,467	7,119	13,586	6,589	7,252	13,841

**Source:** 2001 Census of Population and Housing

For the period 2006 to the end of September 2007, there were 110 HIV cases and of these 46 were males and 62 were females. During 2006 and 2007, the percentage of persons aged 15-24 years who were infected with HIV is 0.07% (9 persons) and 0.08% (11) respectively.

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

There is no information to report on this indicator

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

Information on hospitalisation of persons with advanced HIV infection indicates that 29 persons were hospitalised in 2006 and 31 persons in 2007. There are no official reports from the one facility that offers ART. Information is available on request and the records in this facility showed that 161 persons (adults and children) have been seen and treated with ARV drugs and of these, 148 are alive and 60% are on ARV drugs.

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

No data are available to report on this indicator.

#### **IV. Major challenges and actions required to achieve the UNGASS targets**

The previous UNGASS Report for Antigua and Barbuda identified the following challenges in carrying out activities of the NAP:

- An inadequate Monitoring and Evaluation system.
- A weak surveillance system and the need for training in surveillance, data management, including analysis and writing reports.
- Limited use of standardised codes for private laboratories and health care workers.
- Lack of HIV educational material for at-risk/high-risk groups.
- Limited involvement of most-at-risk populations in the NAP and the need to work closely with the relevant support groups to develop programmes.

For the years 2006 and 2007, additional challenges encountered in implementing activities of the NAP were as follows:

##### ***Programme Coordination and Management***

1. An out-dated Strategic Plan which was developed in 2001 for the period 2002-2005.
2. Lack of skilled and appropriately trained staff to manage the NAP efficiently and effectively.
3. Lack of empirical data on the HIV epidemic and dissemination of regular and timely reports on the NAP. Although information is submitted to the AIDS Secretariat, reports are not disseminated or shared with partners and relevant agencies on a regular basis resulting in limited knowledge about the NAP.
4. Fragmentation of services and limited collaboration between most partners in implementing activities of the NAP.

##### ***Policy and Legislation***

1. Unavailability of updated policies, guidelines and protocols on HIV and AIDS.
2. Lack of legislation to address deliberate and reckless transmission of HIV; access to medicines; disclosure of HIV status; and access to health services by youth.
3. Lack of anti-discriminatory legislation for the protection of PLHIV especially with respect to housing and employment.
4. Lack of knowledge about the monitoring mechanism to promote and protect human rights as it relates to HIV and AIDS.

##### ***HIV Education and Prevention***

1. Lack of information or the misconceptions related to drug use and risky sexual behaviour such as early sexual experience and multiple partners among the youth.

2. Lack of applying knowledge about HIV, and its link with substance abuse and sex, to personal life and behaviour especially among the youth.
3. Methods used to transmit preventive messages are viewed as inadequate and do not have the desired impact on youth.
4. Limited use of popular artistes and other art forms to disseminate information about HIV and AIDS.
5. Discomfort among some teachers in discussing sexual and reproductive health with students.
6. Limited promotion of the female condom as a barrier method for preventing HIV transmission and other STI among sexually active individuals.
7. Limited knowledge about the social marketing of condoms and limited collaboration between the agencies that distribute condoms.

### ***Treatment, care and support***

1. Fragmented treatment and care services for PLHIV especially in the areas of monitoring and follow-up care.
2. Breaches in confidentiality regarding disclosure of HIV status. This acts as a deterrent for HIV testing and for treating HIV-positive persons with ARV drugs.
3. Lack of youth-friendly services.
4. Low uptake of HIV testing, with more women than men being tested.
5. Unwillingness of male and female sex workers to attend clinics for VCT services.
6. Lack of knowledge about OVC.
7. Under-use of VCT services by nationals.
8. Limited number of trained staff to provide ART services and a low number of HIV-positive clients accessing available services.

### ***Monitoring and Evaluation (M&E)***

1. Lack of a Monitoring and Evaluation System which will provide technical assistance to ministries and agencies to maintain applications of Operational and Procedural manuals; as well as provide quality management of information.
2. Lack of evidence-based information.
3. Absence of progress reports of the NAP.
4. Lack of funds to conduct research associated with vulnerable and at-risk groups including orphans and vulnerable children in the population.

## **Recommendations**

In an effort to implement effectively activities of the NAP and achieve Universal Access to HIV prevention, treatment, care and support services, the following is recommended:

### ***Programme Coordination and Management***

1. Re-examine and strengthen the structure of governance of the NAP.
2. Develop a new five-year National Strategic Plan for the period 2008-2012.
3. Ensure that human resource capacity in the public sector is sustained.
4. Strengthen collaboration and coordination of services between partners in the public and private sectors with greater involvement of civil society in the design and implementation of the NAP.
5. Integrate gender issues into the HIV/AIDS policies and programmes (all components of the NAP).

### ***Policy and Legislation***

1. Build an enabling framework of legislation and rights by reviewing and revising existing policies and laws relating to insurance and HIV testing; immigration and HIV positive persons; and the protection of human rights including those of prisoners.
2. Revise and update the existing Policy Framework on HIV/AIDS and disseminate widely to all stakeholders involved in the response to AIDS.
3. Review and revise existing policies and programmes which relate to access to health services by youth; the deliberate and reckless transmission of HIV; access to medicines; and disclosure of HIV status.
4. Revise the Labour Code to include policies on HIV and AIDS.
5. Implement the HIV/AIDS Workplace policy in the public and private sectors.
6. Develop anti-discriminatory legislation by revising existing legislation and policies that promote or reinforce stigma and discrimination.
7. Promote the existence of a Human Rights desk.

### ***Education and Prevention***

1. Develop an effective behaviour change programme for the population through a comprehensive BCC Strategy which aims to bring about lifestyle changes in the population.
2. Design and disseminate age-appropriate messages using various art forms; involving target populations and popular artistes (especially in the music industry) in the design of these messages.
3. Ensure that messages (posters and brochures) are displayed in non-traditional outlets and places frequently used by the population.

4. Train teachers in sexual and reproductive health so that they can discuss these topics comfortably with students.
5. Improve the coverage of PMTCT by meeting the minimum requirements for facilities providing PMTCT services. The components of routine PMTCT for a facility include:
  - HIV testing with pre- and post-test counselling;
  - ARV prophylaxis for the mother and new-born;
  - Infant feeding counselling; and
  - Provision of family planning services.
6. Provide standardised VCT services at easily identifiable sites.
7. Improve collaboration between the agencies involved in the distribution of condoms.
8. Increase the number of sites for the distribution of condoms using non-traditional outlets.

### ***Treatment, care and support***

1. Establish a comprehensive treatment, care and support unit for PLHIV.
2. Establish a system for follow-up care for PLHIV on ARV drugs.
3. Re-establish services for adolescents and youth in a user-friendly environment.
4. Provide standardised services for inaccessible vulnerable groups in a more comfortable environment.
5. Conduct an island-wide assessment of OVC as well as develop and implement policies on the management of OVC.
6. Strengthen and coordinate services for OVC involving relevant agencies e.g. Big Brother/Big Sister Association and the Child and Family Guidance Centre.
7. Develop systems and train staff to ensure high-quality HIV testing and counselling services.

### ***Monitoring and Evaluation***

1. Establish a Monitoring and Evaluation Framework and System to track the performance and impact of the NAP as well as provide evidence-based information to local stakeholders for decision-making and to international donors for funding. There is need to:
  2. Improve M&E skills (capacity building);
  3. Develop procedures and guidelines for the M&E Framework so that the efficiency and effectiveness of interventions of the NAP can be documented and reported;
  4. Request technical support to develop the M&E Framework and System;
  5. Strengthen the data collection process of the NAP - ensure that information is collected, collated and disseminated on a timely basis to local, regional and international partners/stakeholders involved in the response to AIDS.

## **V. Support from the country's development partners**

International, non-governmental and national agencies continue to provide support to the Government of Antigua and Barbuda for the NAP through grants, loans and technical cooperation in the health sector. These agencies are as listed:

### **International agencies**

- The United Kingdom's Department for International Development (DFID)
- Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
- The British High Commission
- The Canadian International Development Agency (CIDA)
- Pan American Health Organisation (PAHO)
- The United Nations Children's Fund (UNICEF)
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- The United Nations Assessment Assistance Program
- The Clinton Foundation HIV/AIDS Initiative (CHAI)
- United States Agency for International Development (USAID)
- Centers for Disease Control and Prevention (CDC)
- International Labour Organisation (ILO)

### **Regional health institutions**

- CAREC/PAHO
- Caribbean Health Research Council (CHRC)
- UWI-CHART.

### **National groups**

- Other government ministries
- NGOs
- FBOs
- Civil Society
- The Antigua and Barbuda Red Cross
- Special interest groups
- Service clubs.

Technical and financial support is required in the following areas:

1. Development of a new 5-year National Strategic Plan for the period 2008-2012.
2. Capacity building to strengthen programme management and coordination, clinical care services and the HIV/AIDS Information System.
3. Development of policies and procedural manuals.

4. Development of a Behaviour Change Communication Strategy.
5. Develop a Monitoring and Evaluation System.
6. Conduct research to provide base-line information on several population groups, especially the most-at-risk and OVC.

## **VI. Monitoring and Evaluation environment**

In Antigua and Barbuda, monitoring and evaluation of the NAP is limited and inadequate as there is no comprehensive M&E system in place. There is therefore an urgent need for technical assistance:

1. To develop a comprehensive M&E system;
2. To train staff in all aspects of monitoring and evaluation such as use of M&E tools; data analysis; understanding indicators and data sources and the use of relevant software (CRIS and SPSS).

## **ANNEXES**

1. Consultation/preparation process for the country progress report on the implementation of the Declaration of Commitment on HIV/AIDS.
2. National Composite Policy Index questionnaire
3. List of Stakeholders interviewed and who participated in the workshop on developing targets for achieving Universal Access to HIV prevention, treatment, care and support services.
4. Documents reviewed.

**Work Plan to prepare the UNGASS Country Progress Report, 2006– 2007  
Antigua and Barbuda**

**Goal:**

Preparation of the UNGASS Country Progress Report 2006-2007 incorporating targets developed for achieving Universal Access to HIV prevention, treatment, care and support services for all those who need them by 2010.

**Objectives:**

1. To support the development of targets for Universal Access to HIV/AIDS prevention, treatment care and support for all those who need it and involving the participation of Civil Society.
2. To assist with developing the UNGASS Report for 2007 for Antigua and Barbuda.

<b>Activity</b>	<b>Resource persons</b>	<b>Dates</b>
1. Meet with the Minister of Health, Permanent Secretary, Chief Medical Officer, AIDS Programme Manager and the UNAIDS consultant to discuss <ul style="list-style-type: none"> <li>• the TOR for the consultant</li> <li>• progress in the NAP – achievements and challenges</li> </ul>	Minister of Health Perm. Secy. C.M.O. AIDS Prog. Mgr. UNAIDS Consultant	Nov. 12, 2007
2. Obtain information from civil society through discussions with key persons about the NAP and identify achievable UA targets	APM CMO Civil Society Reps UNAIDS Consultant	Nov. 12-16, 2007
3. Review relevant reports and documents.	UNAIDS Consultant	Nov. 12-16, 2007
4. Prepare for Workshop on developing Universal Access targets with representatives from civil society organisations, PLHIV and Government Ministries.	Perm. Secy. CMO APM UNAIDS Consultant	Nov. 12-16, 2007
5. Conduct workshop to review and refine targets from information obtained discussions with stakeholders and reviews of relevant documents.	Perm. Secy. CMO APM Stakeholders UNAIDS Consultant	Nov. 26-28, 2007

<b>Activity</b>	<b>Resource persons</b>	<b>Dates</b>
6. Assist with the development of the framework of action using the Universal Access targets identified.	APM CMO UCC UNAIDS Consultant	By Dec. 03, 2007
7. Meeting with the CMO, APM and Statistician from the Health Information Division, Ministry of Health to discuss the preparation of the UNGASS Report 2006-2007 based on data collected at discussions and the workshop.	APM UNAIDS Consultant	Dec. 12-17, 2007
8. Analyse data and prepare draft report	APM UNAIDS Consultant	Dec. 18 onwards
9. Disseminate draft UNGASS Report for comments and feedback from stakeholders.	CMO APM Minister's Pers. Asst. UNAIDS Consultant	
10. Assist with the preparation of the final UNGASS Report.	APM. UCC UNAIDS Consultant	By Jan. 15, 2008
11. Submit final UNGASS Report to UNAIDS	APM UNAIDS Consultant	

**National Composite Policy Index Questionnaire**

## List of Stakeholders

Name	Organisation
Hon. John Maginely	Minister of Health
Ms. Clara Emanuel	Permanent Secretary, Ministry of Health
Ms. Machado Reyes	Principal Assistant Secretary, Ministry of Health
Dr. Rhonda Sealey-Thomas	Chief Medical Officer
Mrs. Janet Weston	AIDS Programme Manager
Ms. Delcora Williams	Deputy AIDS Programme Manager
Mr. Oswald Hannays	HIV Counsellor and Educator
Mr. Sinclair Williams and members	Health, Hope and HIV Network
Ms. Joan Gomes	Red Cross Peer Education Project
Ms. Alex. Wong	Antigua Planned Parenthood Assoc/PSI/SFH
Mrs. Smithen	Caribbean Council of Churches
Mr. Elvis Watkins	PSI/SFH
Ms. Gwyneth Walcott	Health, Hope and HIV Network
Mrs. Felicity Aymer	Former AIDS Programme Mgr.
Dr. Prince Ramsey	Clinical Care Coordinator
Mrs Maureen Lewis	HFLE Coordinator – Ministry of Education
Dr. Maria Pereira	Medical Officer, Clare Hall Clinic
Mr. Colin O’Keiffe	Statistician, Health Information Division
Ms. Jarvis	Holberton Hosp. - Laboratory
Mr. Dave Bridgewater	Pharmacist, Holberton Hosp.
Ms. Cleon Athill	Director, Dept. of Youth Affairs
Ms. Sheila Roseau	Director, Gender Affairs
Ms. Labrechia Hesse	Gender Affairs
Mr. Norville Simon	Ministry of Youth Affairs
Mr. Casford King	Director, Pharm. Services
Ms. Janet Samuel	Nurse Epidemiologist
Ms. Eulany Roberts	Dep. Supt. Public Health Nurses
Ms. Cecily Dorsett	Principal Nursing Officer
Dr. Oritta Zachariah	Medical Officer of Health
Ms. Keida Nicholas	
Ms. Teju Alakija	Advisor to Minister of Health

**Documents reviewed**

1. Strategic Plan for the National Response to HIV/AIDS, Antigua and Barbuda, 2002-2005
2. UNGASS Country Report 2005, Antigua and Barbuda
3. Health in the Americas, 2007, Volume II – Countries
4. Guidelines on Construction of Core Indicators, 2008 Reporting
5. Behavioural Surveillance Surveys (BSS) in Six Countries of the Organisation of Eastern Caribbean States (OECS), 2005-2006.
6. Pilot Behavioural and HIV Sero-prevalence Surveillance Surveys among Men who have Sex with Men (MSM) and Female Sex Workers (FSW) in Antigua and Barbuda and St. Vincent and the Grenadines, November 2006 to January 2007.
7. The Link between Drug Use and HIV/AIDS among Young People in Antigua and Barbuda: A Semi-Qualitative Research Study.
8. Antigua and Barbuda Census 2001.
9. A Female Condom Study in Antigua and Barbuda, 2007.
10. Caribbean Region HIV and AIDS Service Provision Assessment (HSPA) Survey, 2006.