UNGASS COUNTRY PROGRESS REPORT

British Virgin Islands

Reporting period: January 1, 2007 – December 31, 2007

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1. **Status at a Glance**

(a) Stakeholder's Inclusiveness

In Order to ensure comprehensive coverage in terms of assessment of the status of HIV/AIDS in the British Virgin Islands, key stakeholders were identified by the National AIDS Programme, and contacted by the consultant who interviewed of the following persons :

Director of Health Services
Chief Executive Officer, BVI Health Services Authority
National AIDS Program Coordinator
Director of Primary Health Care
Chief Social Development Officer
Head of Gender Affairs
Manager Peebles Hospital Laboratory Services
Chairperson HIV/AIDS Foundation (NGO)*
Permanent Secretary, Ministry of Health & Social Development
Permanent Secretary Min. of Education
Red Cross HIV /AIDS Coordinator of Peer to Peer Program (NGO)
Director of Development Planning
Sr. Pharmacist/ Peebles Hospital Pharmacy

* A detailed written report was made available to the consultant

(b) Status of Epidemic :

The status of HIV/AIDS epidemic in the British Virgin Islands reflects the focused attempt to account for all persons living within the Territory with HIV/AIDS, and to place at their disposal, prevention, treatment, and care services coordinated by the National AIDS Programme.

Number of persons living in the BVI with AIDS - 28
Number of persons living in the BVI with HIV - 30

Total : 58

N.B. Of that total, some 27 persons choose to obtain treatment in the United States Virgin Islands (USVI) on account of the compelling need for anonymity and/or perceived confidentiality issues.

The status of the HIV/AIDS epidemic in the British Virgin Islands may be categorized as **very low**, given the region's overall prevalence rate of 2.3%.

CAREC's estimated prevalence rate of HIV infection in the British Virgin Islands is 1.5% . In actuality the prevalence rate for HIV/AIDS in this Territory is 0.23%.

(c) Policy and Programmatic Response

There are no written policies which have been formally adopted as a course and /or principles for action. However, a draft strategic plan exists for HIV/AIDS which will be revisited.

Meanwhile, in general terms, the provisions of the draft strategic plan form the basis for a programmatic response to HIV/AIDS treatment, behaviour change, education , care and prevention.

11. Overview of the AIDS epidemic

During the period January 1, 2007 – December 31, 2007, based on sentinel surveillance, there has been an observable increase of 3.5% in the infection rate over the previous year. (National AIDS Programme)

No specific studies upon which to rely, have been done in connection with the UNGASS impact indicators.

111. National response to the AIDS epidemic

A marked increase in terms of the national commitment, programme coordination and implementation, has been noted during the period under review (January 1, 2007 – December 31, 2007). The frequency and extent of involvement has deepened geographically, particularly in communities, schools and public sector agencies.

Prevention:

In 2007 condom distribution rose to 45,000 on account of increased demand and changes in behaviour. Condom distribution increased by 29% in 2007.

The paucity of data and absence of specific studies, limits the extent to which valid inferences may be drawn. It is possible for example, that an unknown percentage of condoms were used for family planning purposes, rather than disease prevention.

Treatment and Support:

All persons with HIV are known to be on treatment. Anyone who requires care and treatment is able to access those services through the HIV-AIDS Foundation and National AIDS Programme, in collaboration with the BVI Health Services Authority.

Knowledge and behaviour change :

The absence of reliable data precludes the verification of of behaviour change, resulting from increased knowledge.

Impact alleviation:

N/A

Care:

Care of persons living with AIDS, requiring nutritional supervision and support for their families to cope with the consequences of HIV/AIDS is available through the HIV-AIDS AIDS Foundation, the Social Development Dept., and the Nutritional Unit of Peebles Hospital.

There still remains the need to establish and maintain stronger and more effective multi-sector links through a central co-ordinating agency which requires the development and implementation of a National Strategic Plan for HIV/AIDS/STIs to mandate the establishment of a National AIDS Programme and a National AIDS Council. The **"Three Ones"** principles are instructive in this regard.

The emphasis to date has largely been on Care and Treatment, and Prevention Education Programs. While these emphases are valid, they should not overshadow the socio-economic implications of the disease, as the most active component of the labour force ages (15-45) are most at risk, and can thwart the development aspirations of a country, by high occurrences of morbidity and mortality.

IV. **Best Practices**

The BVI HIV-AIDS Foundation, provides excellent support for PLWH. As a Non Government Organization, it has been able to raise funds to assist in the purchase of ART drugs, and act as an advocate for PLWH. As the supply of antiretroviral medications are now available without cost to patients, under the Clinton Foundation initiative, the role of the organization could be further expanded to provide greater emphasis on areas such as prevention education, HIV testing and counselling and home care when required.

The political leadership is supportive of HIV/AIDS prevention and treatment programs, and publicly endorses the various activities of the National AIDS Programme, and other NGO's.

Prevention Education Programs have increased, and of particular note is the development and publication of Public Sector (HIV/AIDS) Workplace Policy Guidelines, promulgated throughout the Civil Service to over 3,000 employees.

Inter-denominational faith-based organizations have participated in several Prevention Education Programs and Workshops led by the NAP.

BVI has achieved universal access through the efforts and financial support from the HIV-AIDS Foundation. Therefore, every patient who needs care and treatment obtains it with minimal delays (if any). Perhaps this achievement is both a function of the geographic size of the Territory, as well as the

relatively small number of HIV/AIDS infected persons living in the country. It is also a function of the high level of commitment and activism of the NAP Coordinator.

V. Major Challenges and remedial actions :

Major challenges facing the HIV/AIDS program, are **financial**, **human** and **technical** resource constraints. These limitations severely limit the ability of the NAP to conduct field surveys to better assess its effectiveness, in terms of adequate data for purposes of monitoring and evaluation to plan programmes and develop a realistic budget.

The Programme has had ample success in terms of its Public prevention education programmes though it must be said that Life Skills Education, which focuses of HIV/AIDS in Primary and Secondary Schools is not implemented.

Voluntary Counseling and Testing, which is done from time to time, could be approached in a more pragmatic manner, focusing on specific populations, so that better estimates of persons who are actually in need of the service could be identified.

VI .Support from country's development partners.

The primary partners in assisting the Territory to achieve its HIV/AIDS objectives are:

DFID ; PAHO ; UNAIDS; E.U.; CAREC ; PANCAP.

Support from these agencies assumes various forms, but mainly in the area to technical support.

On account of current management structures from certain partners, difficulties have arisen in terms of catering to the specific differences and needs of partners. Consequently, there may be a case for a more responsive management structure to be put in place, to administer the needs of concerned partners.

V. Monitoring and evaluation environment

There is no monitoring and evaluation unit in the NAP, and consequently this important function remains unattended.

Given the size and scope of the NAP's activities, perhaps such services

could either be contracted out, or subsumed under an effective M&E unit which would assist the entire health sector to plan and budget effective programmes and services. Certainly this is an area where there is need for human and technical assistance to build capacity to ensure data is available to apply to measurable indicators.