NATIONAL STRATEGIC PLAN

ON

HIV/AIDS & Other STIs

FOR

THE BRITISHVIRGIN ISLANDS

2015- 2019

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"Strengthening the Integration of the British & Dutch OCTs in the Regional Response to HIV/AIDS within the PANCAP Framework"

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List of Abbreviations

Abbreviation	Definition
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Anti-retroviral
BVI	British Virgin Islands
BVIHSA	British Virgin Island Health Services Authority
CARICOM	Caribbean Community
CRSF	Caribbean Regional Strategic Framework (PANCAP)
CSW	Commercial Sex Workers
DARE	Drug Education Programme
DFID	Department for International Development
E.U.	European Union
HIV	Human Immunodeficiency Virus
M&E	Monitoring and Evaluation
MARPs	Most-At-Risk-Populations
MTCT	Mother-to-Child-Transmission
NAP	National AIDS Programme
NAPC	National AIDS Programme Coordinator
OCT	Overseas Caribbean Territory
OECS	Organization of Eastern Caribbean States
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PEP	Post Exposure Prophylaxis
PHCO	PAHO HIV/AIDS Caribbean Office
PLHIV	Persons Living with HIV
SITAN	Situational Analysis
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities & Threats Analysis
TB	Tuberculosis
UNGASS	United Nations General Assembly Special Session (HIV)
VCT	Voluntary Counseling and Testing

BACKGROUND

In 2008, approximately 240,000 people in the Caribbean sub-region were living with HIV. With 20,000 new infections and 12,000 deaths because of AIDS-related illnesses (UNAIDS 2010), adult HIV prevalence in the Caribbean continues to be estimated at 1% [0.9%–1.1].

The HIV burden varies considerably between and within countries in the Caribbean. Cuba, for example, has a very low HIV prevalence of 0.1%, ranging between 0.08% and 0.13%, while the Bahamas has the highest HIV adult prevalence in the region, at 3.1%, ranging between 1.2% and 5.4%.[1]

Although the Caribbean accounts for a relatively small share of the global epidemic, its HIV prevalence among adults is about 1.0% which is higher than in all other regions outside sub-Saharan Africa. Aside from sub-Saharan Africa, it is also the only region where the proportion of women and girls living with HIV (53%) is higher than that of men and boys.

In the British Virgin Islands (BVI), at the end of 2012, there was a cumulative total of 103 reported cases of HIV/AIDS with a total of 35 deaths (18 males and 17 females) recorded. The prevalence rate since 2006 has been estimated by CAREC to be at 1.5%.[2]

In 2008, the ECOCT Project "Strengthening the Integration of the British & Dutch OCTs in the Regional Response to HIV/AIDS within the PANCAP Framework" was initiated. The project covers eleven overseas territories in the Dutch and British Caribbean, with the PAHO HIV Caribbean Office (PHCO) being designated coordinating responsibilities.

A key deliverable of the ECOCT project is the availability of a National Strategic Plan (NSP) for HIV for all territories by the end of the project implementation period in 2013. Within this context the Consultant, was contracted to develop the NSP for The British Virgin Islands.

[1] UNAIDS Global Report Fact Sheet 2010
[2] Situation Analysis of the Virgin Islands Response to HIV/AIDS, Focus on Sexual and Reproductive Health and HIV Linkages, 2009 (Revised) 2010

METHODOLOGY

The methodology for the development of the national Strategic Plan included primary and secondary data gathering techniques. In the case of the former, the consultant engaged in interviews with key stakeholders from the National HIV/AIDS Programme and wider Ministry of Health and Social Development.

A key component of this approach was executed via stakeholders' input at the Strategic Planning Workshop. This forum provided a rich source of information that ultimately is captured in the key priority areas and strategies upon which the Strategic Plan is based.

Equally as important was secondary data gathering, which entailed the review of reports, studies and relevant papers, as well as the review of data that contained information that was relevant to the development of the Plan. A key aspect of this phase was a review of the recently finalised Situational & Response Analysis and the Draft Health Sector Work Plan for Strengthening HIV/STIs in BVI.

The health sector plan to strengthen the HIV response was developed through a consultative process with members of the health sector and other stakeholders. Key activities were integrated into the current NSP. This allowed for a comprehensive NSP that supports HIV prevention, care, treatment and support at the community level and is aligned to the health sector services.

The process of developing the NSP included capacity-building of health professionals to undertake strategic and operational planning as an integral aspect of their managerial functions. In this context, the process of developing the strategic plan was linked to a training component which was done through the workshop. Participants were therefore able to understand the key areas involved in the Strategic Planning process.

The approach used for this project was highly participatory, with the consultant facilitating the strategic planning workshop. The report on the National Strategic Plan for HIV/AIDS details the information collected from individual and group discussions coupled with current reports, plans and critical data which were reviewed over this period.

Rational for the National Strategic Plan

As the Territory embarks on the strengthening of the HIV response, it is essential that a blue print to guide the process is identified. The Strategic Plan for the BVI details the priority actions to be undertaken utilising a multi-sectoral approach which includes the health sector's response.

REVIEW OF THE SITUATION

POPULATION PROFILE

The population of the BVI was estimated to be 30,616 in 2012 and of this total, 47.8% comprised of women (PAHO, 2006). In addition, the tables below illustrate a population pattern which is consistent with that of global trends; that of an aging population. This is reflected in increases in the 65 years and older age-group, a fall in the under 15 years age-group and a resulting increase in the mean population age. The projections to 2015, while suggesting an increase in the 0-14 years age group, also suggest an accelerated growth in the 65 and over age group. This changing population profile is further reflected in the country's population pyramids below.

Table 1 Selected Population Indicators

Year	1999	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Young (0-14 years)%	26.87	26.71	26.50	23.73	24.44	24.44	24.53	24.73	25.06	25.27	25.29
Active (15-64 years)%	68.21	68.43	68.66	70.78	70.35	70.40	70.32	70.08	69.69	69.36	69.17
Old (65+ years)%	4.93	4.86	4.83	5.48	5.21	5.16	5.16	5.18	5.25	5.37	5.54
Mean Age Population	29.76	30.00	30.27	31.28	30.96	31.12	31.26	31.34	31.40	31.49	31.65

Source: Development Planning Unit (DPU), Ministry of Finance, 2010.

Table 2 Population Projections to 2015

	2009	2010	2011	2012	2013	2014	2015
0–14	7,018	7,127	7,251	7,361	7,538	7,764	8,005
15–64	20,101	20,506	20,895	21,201	21,489	21,780	22,099
65+	1,726	1,839	1,952	2,054	2,167	2,297	2,445
Total	28,845	29,472	30,098	30,616	31,194	31,841	32,549

POPULATION PYRAMID

Figure 1

Predicted age and sex distribution for the year 2010

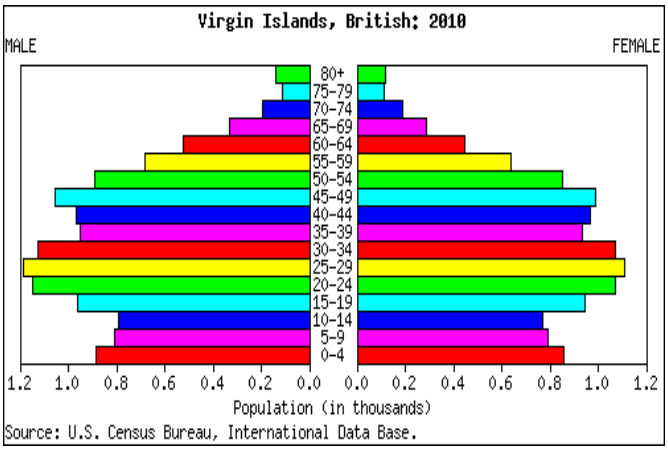
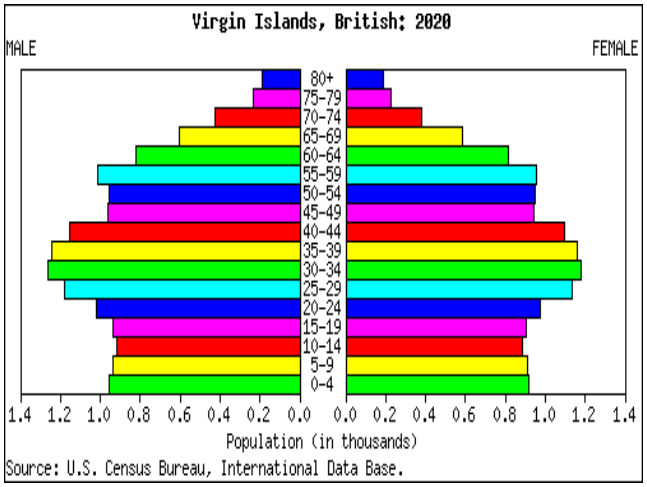


Figure 2

Predicted age and sex distribution for the year 2020:



HEALTH PROFILE

Chronic Non Communicable Diseases (CNCDs)

A profile of the health situation in the BVI reveals CNCDs as among the leading causes of morbidity and mortality in the country, with cancer being the leading cause of deaths followed by Hypertension and Diabetes Mellitus. This pattern is driven by a series of risk factors including inadequate physical activity, unhealthy diet, obesity and abuse of alcohol. These risk factors were further verified by the 2009 STEPS Risk Factor Survey[3] . According to the survey findings, 41.4% of respondents aged 25-44 had three or more of the risk factors identified with non-communicable diseases, while among those 45-64 the percentage stood at 51.5%.

HIV/AIDS

HIV continues to be a major feature of the Caribbean's as well as the local landscape. Since its first diagnosed case in 1985, the BVI has recorded a total of 103 cases of HIV and AIDS as of December, 2012. A total of 35 AIDS-related deaths has been reported up to December 2012. As of January 2011, there were an estimated total of 61 persons living with HIV. The split along gender lines is evenly divided (30 females and 31 males), with all individuals falling within the age group 19 – 67 years of age.

Of the 61 PLHIV, twenty-eight (28) are reported to be accessing HIV treatment and care in the BVI, while thirty-three (33) access care overseas. The large quantity of individuals who explore treatment overseas is a reflection of both the resource and capacity constraints in the BVI as well as an indication of an environment for PLHIV which is perceived as not enabling and reflected in unacceptable levels of stigma and discrimination against those infected and affected by the virus.

HIV incidence have been fairly consistent over the last four years with 9, 9, 7,6 and 5 new cases reported over the years 2008, 2009, 2010, 2011 and 2012 respectively. (PAHO/PHCO, DFID & AID Inc. 2010)

[3]Survey conducted by the Ministry of Health and Social Development in collaboration with the BVI Social Security Board

MOST AT RISK POPULATIONS

The DFID project initiated formative research focusing on the Most-at-Risk-Populations (MARPs) in the United Kingdom Overseas Territories (UKOTs). As part of this process, a mapping exercise conducted in November 2009, in the BVI, identified five priority-at-risk groups:

- Out of School Youth;
- Sex Workers;
- Migrant workers;
- Men who have sex with Men; and
- Drug Users.

The research methodology utilised in the study of these groups focused on more qualitative approaches (focus groups and key informant interviews). This approach, while providing insights into the risk profile of these groups, does not provide key baselines which can form the basis of any strong quantitative projections or key indicators. A summary of the findings on these at-risk groups, as reported in the BVI Situational Analysis of HIV/AIDS (1985 - 2009), are captured in the boxes that follow.

Summary of At-risk groups in British Virgin Islands

Box 1 Out-of-School Youth

Out-of-school youth find themselves in a culture that requires them to 'fit in'. This environment is therefore driven and characterized by peer pressure, negative media images on television and the internet. This often manifests itself in young males who aspire to have multiple sexual partners and young females who gravitate toward older, affluent males.

Condom use is inconsistent, while alcohol use is widespread with marijuana used to a lesser extent.

Lack of confidentiality coupled with the stigma that is associated with going for a test acts as a deterrent to young persons presenting themselves for testing. This is reinforced by a legislative system that denies health services to an unaccompanied young person under the age of 16.

Box 2. Men who have Sex with Men (MSM)

The size of the MSM population in the BVI is reported to be small, and traversing all age groups, socio-economic profiles and nationalities. Close proximity and easy access to neighboring St. Thomas and Puerto Rico make these countries key sites for meeting other MSM. In the presence of an environment that is far from accepting or enabling, these countries also serve as destinations where MSM will seek their HIV tests and seek treatment for HIV and other STIs.

Box 3 Drug Users

Drug users were found to be generally between the ages of 30 - 45 years old and predominantly males. Alcohol and crack cocaine were identified as the drugs of choice while some were found to be multi-drug users. Drug users were classified into alcohol, marijuana and crack users, with males more likely to be alcoholics and women more likely to use crack.

The study on this risk group identified areas that drug users tended to frequent, these included such areas as Crab Tree Lot, Comedy Corner located at Sea Cow's Bay, and the Tree located at Long Look.

All drug users were reported to generally engage in unprotected sex with females likely to engage in transactional sex to support their addiction. Several drug users were also reported to have contracted other STIs.

Peer pressure, dysfunctional home environments, and introduction to marijuana use at school were identified as the key factors that facilitated the introduction to heavy drug use and addiction in the Virgin Islands.

Box 4 Sex Workers

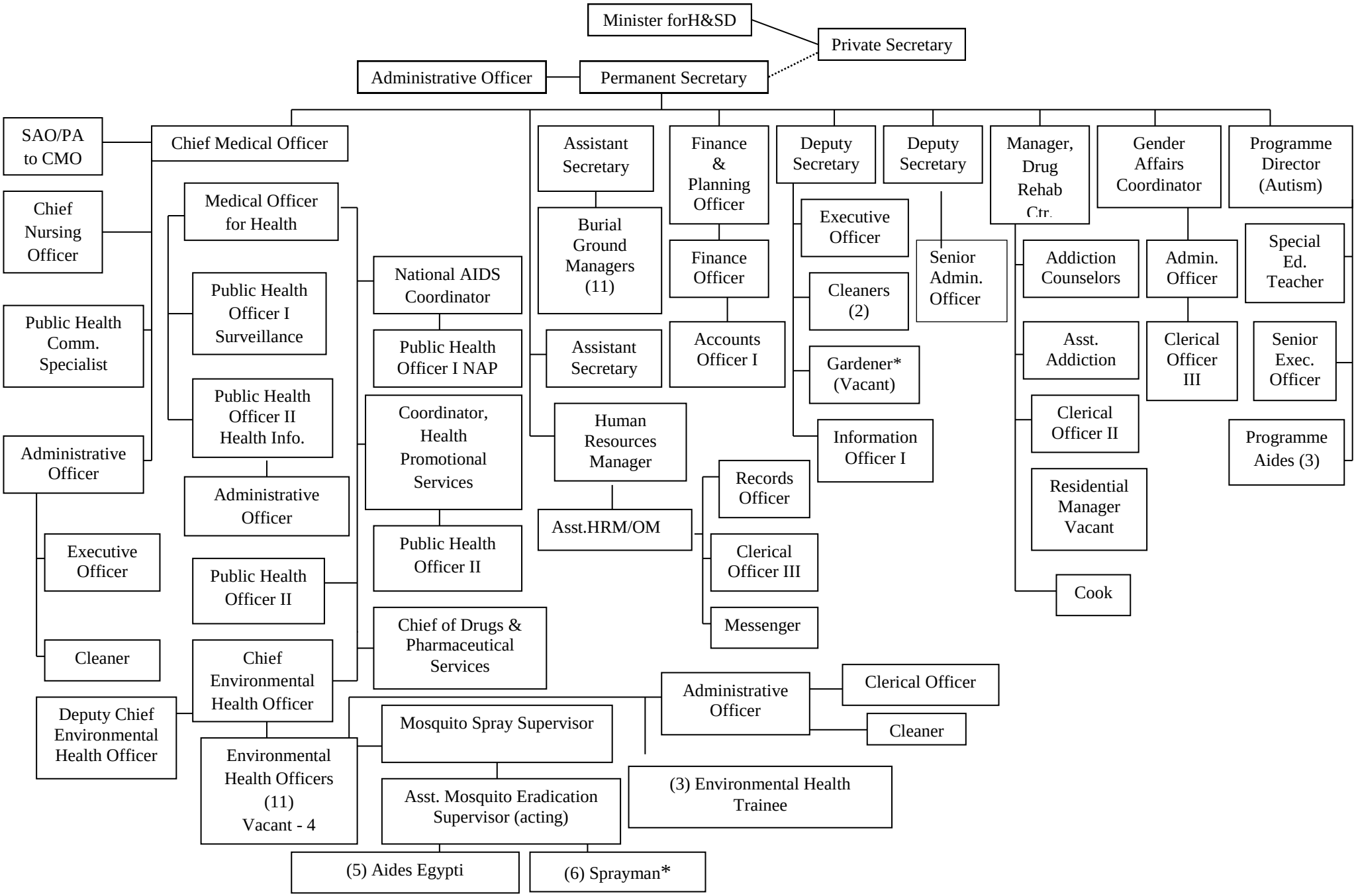
Sex workers mainly comprise of women from neighboring Caribbean islands. They are reported to stay for short periods of time and are employed mainly in bars and strip clubs and brothels. Condom use is generally found to be high among female sex workers. While no cases of HIV have been reported, medical services for other STIs have been reported by some doctors.

HEALTH SYSTEMS RESPONSE

Under the Public Health Ordinance 1977 (Cap. 194) the Ministry of Health and Social Development is charged with the responsibility for the promotion and preservation of the nation's health. Within this context, the Minister of Health has the responsibility for developing and enacting policies and legislation; planning and development of public health and social services; and the monitoring and regulation of all health care providers.

Since 2005 the delivery of health care has been devolved to the BVI Health Services Authority in keeping with the BVI Health Services Authority Act (2004). Primary care is provided through a network of clinics the Community Health Services and Peebles Hospital which provides secondary care and some tertiary care. Care not available in the Territory is provided through overseas providers on referral from Peebles Hospital.

ORGANISATIONAL CHART, MINISTRY OF HEALTH AND SOCIAL DEVELOPMENT



THE HIV/AIDS RESPONSE

The National HIV/AIDS response is coordinated by the National AIDS Programme in the Ministry of Health and Social Development. The National AIDS Programme works together with various sectors in planning, implementing, monitoring, and evaluating the national HIV/AIDS response.

In 2006, the HIV/AIDS Foundation (HAF) a non-profit government organisation was formed which focused on raising awareness, training and enabling patients to access care and support. The Foundation receives an annual subvention from Government and engaged in several fundraising activities to fund its programme.

The HAF annual programme of work included:

1. Annual Artists Against AIDS Concerts
2. Bi-weekly radio & TV show "Let's Talk About Sex"
3. World AIDS Day activities
4. Sexual health promotion through videos and movies for TV
5. Distribution of sexual health literature and commodities in the community
6. "FREE" HIV screening for pregnant women
7. Sexual Health "HOTLINE" for information and referral

The national response also receives support from a number of key external partners. They include DFID, PAHO, UNAIDS, E.U. (particularly through the project, "Strengthening the Integration of the British and Dutch OCTs in the Regional Response to HIV/AIDS within the Wider PANCAP Framework") and PANCAP. Support from these agencies typically comes in the form of technical support to the programme response. Some direct funding is also provided.

PERCEPTIONS OF THE RESPONSE (SWOT)

An overview of the situation and response was largely captured from secondary sources particularly the report on the Situation and Response Analysis which is an assessment of the HIV/AIDS response in the BVI. Additional information to support the strategic planning process included an analysis of the overall health and non-health mechanism and response in the BVI. Participants were therefore asked to highlight what they determined as the areas of strengths, weaknesses as well as the opportunities and threats in its response to the HIV epidemic. The following is a summary of this Analysis:

STRENGTHS

Among the strong points highlighted in the local response was access to technical support from both local and overseas sources, coupled with a significant degree of government support. One by-product of this, also identified as a strength, was the opportunities for key personnel to be trained in key aspects linked to the response. The presence of a Workplace Policy was also cited as positive.

WEAKNESSES

An environment that is prone to stigma and discrimination against persons on the basis of their sexual orientation and HIV status, as well as a culture of denial were identified among the key weaknesses of the system. Despite training opportunities provided, the lack of continuity in these initiatives was also cited as a weakness in the system.

OPPORTUNITIES

A great deal of opportunities continued to be seen in training initiatives being explored across all sectors. Buy-in from senior managers across key sectors and an interest in adopting more of a territorial approach to addressing HIV/AIDS was also identified as opportunities that can impact positively on the national response.

THREATS

Key threats were however flagged by stakeholders at the consultation and these were in large part systemic in nature. They focused on the volatile Economic environment in which the country found itself. Also highlighted was the reduction in population and as a result the workforce, a direct result of migration by this age group to other countries. Rising health care costs was also identified as threat facing PLHIV.

RECOMMENDATIONS FROM THE BVI SITAN

Box 5. The Key Recommendations coming from the SITAN

- A policy on Provider Initiated Testing and Counselling (PITC) should be developed to ensure that key populations have access to routine HIV testing.
- Increase access to HIV testing utilizing the use of rapid HIV testing at clinics.
- Confirmatory HIV serology algorithm and rapid HIV testing algorithm need to be developed.
- The development of a national health plan is critical for the strengthening of the health sector's response to HIV.
- Continue to integrate HIV services into other chronic disease clinics and generally into primary health care.
- A second clinic public clinic should be used to implement HIV testing and counselling and other HIV services at the primary care level.
- Further enhance the private-public partnership in HIV care and treatment.
- Financing to provide fee care at point of services must be reviewed. The proposed National Health Insurance provides an opportunity for this to happen.
- Explore the possibility of reducing cost for diagnostic testing abroad. These tests are provided cheaper in some Caribbean Countries.
- Strengthen SRH services to support and implement HIV testing and counselling.
- Review and update appropriate guidelines such as PMTCT including congenital syphilis, HIV testing and counselling, care and treatment, HIV/TB co-infections, PEP and STIs based on newly developed recommendations is urgent.
- Counseling within the public health services should also be linked to the mental health nurses and should be seen as part of the essential package of services provided to persons with HIV. Referrals to psychologists/mental health nurses should be made for persons accessing HIV care and treatment.
- Capacity building of health care providers to deliver HIV care should be continued.
- Develop/adapt regional STI management guidelines and train health care providers to enhance the diagnosis and management of STI cases.
- Develop mechanism for quality of care monitoring.
- System for HIV/STI surveillance needs to be strengthened, including case-based surveillance with information such as patient tracking information, and HIV Drug Resistance (HIV DR).
- There is a need for a patient monitoring system that can adapted from other Caribbean countries.
- Strengthen the reporting of HIV/STI through surveillance. This reporting should also be linked to lab reporting system
- Strengthen HIV prevention at the community level is critical putting emphasis on accessing to services by the vulnerable populations.
- With the development of a work place policy, efforts should be place on implementing a work place program in order to strengthen HIV prevention at the community level.
- Strengthen the capacity of the existing support group to better provide support.

THE STRATEGIC PLAN

A Strategic Plan is essentially a framework for changing a specific situation by delineating priority action areas and utilizing the basic steps of going from one point in time; the present to another time in the future. A HIV/AIDS strategic plan takes into account the underlying determinants of the epidemic and how they affect different social groups according to situations that change over time. As a result, the consultant drew on the findings of the Situational Analysis report, together with the outcome of the consultation exercise, in addressing the key aspects of the plan.

Formulation of the plan also takes into account, and where necessary draws on, other reports, plans and studies conducted either directly in the areas of HIV or in the broader field of health. Key among this list was the BVI Operational Plan for a Sustainable Health Sector Response to HIV 2011-2012 completed by the PAHO/PHCO in consultation with the Ministry of Health and Social Development (2011). Other documents include the Assessment of the Health System, Services and Situation, done by the HEU, Centre for Health Economics (2009) and the Strategy for the Prevention of Chronic Non Communicable Diseases, a report compiled by Mary Collins of Amarok Holdings Ltd. Vancouver BC Canada for the Ministry of Health and Social Development.

GUIDING PRINCIPLES

The NSP on HIV/AIDS for the BVI 2015-2019 is founded upon the following:

- Human Rights – Health is a fundamental human right that should be accessible to all regardless of sexual orientation, sex, race, age or disease status;
- Integration – An integrated approach allows for engagement of scarce resources across chief implementing sectors and ensures a sustainable response;
- Political/Leadership - Support to the planning process and its outcome ensures widespread endorsement by the wider population, buy-in from those charged as key implementers of the plan and legitimizes the outcome of the exercise;
- Sustainability – Given the spread and reach of the epidemic and its known potential to seriously compromise both health and non-health systems over the immediate to long term, it is imperative that the plan be grounded in programmes that can be sustained over the long term.
- Universal Access to comprehensive care for HIV/AIDS & STI - This includes the continuum of care, including ART, etc. which should be easily accessible.

VISION AND MISSION STATEMENTS

The Vision describes where one is headed, or where one wishes to be. The Mission describes what is being attempted or how is the vision to be achieved. The vision and mission statements which are to inform the strategic plan were identified as follows:

Vision Statement

> *We are committed to a BVI where everyone knows their (HIV) status, stigma and discrimination is reduced, safe sex is practiced and affordable integrated holistic health care is available to all in a supportive environment*

Mission Statement

> *We are a multi-sectoral organisation working in the BVI whose aim is to reduce the incidence of HIV in the territory by providing an affordable, sustainable, broad-based integrated approach to services to all persons (residents) in a supportive environment*

OVERARCHING GOAL

The overarching goal of the National Strategic Plan is stated as follows:

> ***"To improve the quality of life of the population of the BVI"***

PRIORITY AREAS

In order to achieve this overall goal outlined above, the strategies and approaches outlined in the plan are captured under four key priority areas, they are:

> ***Priority Area 1: Prevention of new HIV infections***
>
> ***Priority Area 2: Integrated treatment, care and support***
>
> ***Priority Area 3: Enabling environment***
>
> ***Priority Area 4: Sustainable funding***

Underlying & Cross-Cutting Themes

Capacity building and strategic information systems have been identified as key to the achievement of the key expected outcomes identified in the plan. These two key areas will therefore be referenced throughout the plan.

The Role of Capacity Building

Training is recognized as a key component of this plan and one that is central to the sustainability of the National Response. This is particularly important given the challenges of the small population, which is also reflected in the size of the labour force and restrictions across all the key sectors, but more so likely to be felt among the more labour intensive sectors such as Health.

This situation is exacerbated by the migration of the labour force out of the island in search of opportunities in other larger territories. It is within this context that it is critical that the response programme be built on a platform of capacity building that will ensure the presence of a cadre of labour that is capable of ensuring the effective and efficient delivery of the services required to achieve the goal of the National Strategic Plan across all the key sectors on a sustained basis.

The Role of Strategic Information Systems

Strategic information is defined as the set of essential health data that makes it possible to monitor a range of clinical and other determining factors, as well as the impact of interventions, in order to make decisions that improved the national health response (PAHO 2012). In the context of HIV/AIDS, strategic information systems refer to activities that aim to strengthen HIV/AIDS surveillance, Health Management Information Systems, Monitoring and Evaluation.

The need for capacity building in these key aspects of strategic information systems is also seen here as key to the sustainability of the national HIV and broader health response.A detailed breakdown of the strategies associated with the priority areas is outlined below.

MONITORING AND EVALUATION FRAMEWORK

The monitoring and evaluation framework which is in Annex 1 is the responsibility of the Surveillance Unit who will provide support for the ongoing collection of the data.

PRIORITY AREAS, EXPECTED OUTCOMES AND OBJECTIVES

Priority Area 1:	**Prevention of new HIV infections**

Expected Outcome: **Reduction of new HIV reported infections by at least 25% by 2017**

Strategic Objective 1. To increase the number of persons tested for HIV for the first time.

Expected Outcome: *The number of persons who tested for HIV for the first time increased by 25% by 2017*

The approaches that are geared toward achieving the expected outcome are centered around two major strategies: the first focuses on raising public awareness on the importance of knowing one's status and the second on a scaling up of the testing initiative. Efforts at raising awareness will involve the development of media campaigns drawing on both the traditional media, as well as the new media in designing messages specific to the targeted age group. This initiative is not to be restricted to the area of HIV, but will addressed other STIs and health related issues.

Sensitization campaigns at the sectoral level will build upon an HIV in the Workplace initiative facilitated through The Pan American Health Organization HIV Caribbean Office (PHCO) and ILO. This five-year European Union funded project involving the Ministry of Health and Social Development (MHSD) focused on enhanced prevention efforts to reduce the spread of HIV/AIDS through workplace policies and programmes. The MHSD will work closely with the Department of Labour to coordinate activities.

The second strategy under this objective focuses on a scaling up of the HIV testing initiative. Activities aligned with this include the development of an outreach testing initiative that is targeted toward key groups and communities that are deemed to be high risk. A key aspect to the success of this strategy is an expansion in the number of persons trained in the area of testing and counseling. The strategy will therefore include the training of health care providers in Provider Initiated Testing and Counseling (PITC) building on initiatives that have begun in this area and members of the HIV/AIDS Foundation; representing key points of contact to reach out to the at-risk population.

Strategic Objective 2. To increase interventions to promote safe sex practices among the general populations.

Expected Outcome: *The number of persons engaging in safe sex practices increase at least by 25% by 2017*

Raising the present level of awareness among key population groups is seen as an important approach towards this objective. It is proposed that this can be operationalized through the development of safer sex campaigns drawing on both the traditional as well as the new media based on the group that the campaign is targeted to. The key groups to be targeted include sex workers, men who have sex with men, and youth. The inclusion and focus of youth among the traditional key population is based on recognition of the population dynamics and the noted behaviour practices by cross sections of youth that put them at risk of exposure to HIV and other STIs. Buy-in by the media will greatly facilitate the dissemination of the campaign and related messages in a timely and more focused manner.

The setting of baselines, as well as monitoring the shifts in behaviour in response to this and other programmes in general, is important in tracking the output of the strategy. To this end, Knowledge, Attitudes, Practices and Behaviour studies are to form an integral part of this strategy. This quantitative survey provides an opportunity to not only providing key baselines, but also facilitates the tracking of progress of the programmes being implemented to guide and inform its refinement in an objective manner. The key agencies that will lead this programme are the Ministry of Health and Social Development, The HIV/AIDS Foundation, Ministry of Education and Culture and the Ministry of Communications & Works. Support from key regional technical agencies including universities will also be critical in the conduct of these studies.

Priority Area 2:	**Integrated Treatment, Care and Support**

Expected Outcome: **Universal Access to Care, treatment and support to persons with HIV infection in the public health sector by 2018**

Strategic Objective 1. To increase the number of public health facilities providing care, treatment and support.

Expected Outcomes: *Access to care and treatment in Public Health Facilities increase by at least 1 by 2017*

A cadre of health care providers providing HIV services and support in an integrated care setting increase by 25% by 2017

The BVI is presently divided into five health-care districts or zones. These districts are: Zone 1 – East Tortola; Zone 2 – Central Tortola; Zone 3 – West Tortola; Zone 4 – Virgin Gorda; and Zone 5 – Anegada. It is proposed that the number of public health facilities providing HIV care and treatment be increased to have one such facility in each of the health-care zones. This will involve a process of dialoguing that involves all key players in health and related fields, so that adequate buy-in is received for this planned activity.

The proposed expansion will also be implemented within the context of an integrated approach to HIV service delivery into the broader health system. This provides an opportunity for the expansion of treatment, care and support towards the goal of universal access, in a more sustainable context. The integrated approach also provides the opportunity for the implementation of new initiatives for HIV (treatment as prevention and treatment 2.0) and the strengthening of the associated or linked health services, specifically in the areas of STIs and the related areas linked to Family Health.

The proposed expansion to wider health zones will entail upgrading and adjustments at the physical, as well as systemic levels. While in the former, this will involve physical infrastructure evaluation and upgrade where necessary, in the latter, this will entail such activities as pilot testing of HIV Rapid testing in SRH services such as family planning, pap smears, prostate screening, etc. as well as broader revisions to the Family Health Strategy to ensure that it easily accommodates the provision of HIV services that can be readily be linked to primary health care settings.

Also required will be the necessary management framework outlining such aspects as lines of authority and protocols to ensure that there is smooth integration of HIV programmes into the broader health systems. Essential to this activity is the information systems platform which will provide the basis for informing the decisions made and monitoring the key outcomes of the interventions proposed. This includes inclusion of Early Warning Indicators (EWIs) to monitor and minimize antiretroviral resistance.

Human resource shortages have been identified as one of the key challenges of the HIV response within the health sector as well as other sectors in the BVI. It is therefore critical that efforts at capacity building among health care workers seek to do so within the integrated care model that will see a wider cadre of workers exposed to core training, resulting in a larger pool of health care practitioners providing care and treatment to a larger number of patients.

A key aspect of the strategy is to increase access to treatment, care and support with on-going training for staff in areas such as contact tracing, partner notification, clinical care and issues of stigma and discrimination. Two key initiatives that have been conducted in this respect are:

1. A two-day meeting was convened with health care workers from the public and private sectors to standardize the types of treatments available and to identify the most effective treatment regimen and intervention strategies for persons living with HIV/AIDS. This was done by The Ministry of Health and Social Development, in collaboration with PHCO.

2. A capacity building workshop on the Clinical Management of HIV/AIDS and other STIs for health providers was hosted in February by the Office of the Chief of Drugs and Pharmaceutical Services, Ministry of Health and Social Development, in collaboration with the Organization of Eastern Caribbean States/Pharmaceutical Procurement Services (OECS/PPS). The workshop presented the findings and recommendations of a Drug Utilization Review of Anti-Retroviral Medicines prescribed in the Virgin Islands and provided an update on the Clinical Management of HIV/AIDS and other STIs for health professionals.

The Ministry, in its drive to achieve the universal access objective, will be required to build on the above initiatives and formalize training programmes in Clinical Management drawing on opportunities for in-service and pre-service training through programmes offered through the Caribbean HIV/AIDS Regional Training Network (CHART), University of Washington, (TREE - Treatment, Research, Educational, Evaluation)as well as those offered by other Caribbean Universities and International Universities.

Priority Area 3:	**Enabling Environment**

Expected Outcome: **Create an enabling environment to support persons with HIV and their families by 2017**

Strategic Objective 1: To create a system for the monitoring of stigma and discrimination progress

This priority area seeks to create a more enabling environment focused on a marked reduction in reported incidence of stigma and discrimination by PLHIV. Recognition of this is based on the acknowledgement of the importance of an enabling environment and supporting systems to ensure its sustainability toward the achievement of the universal access goal, as well as the prevention and management of HIV.

The first objective focuses on the creation of a system for monitoring the progress toward the stated outcome of the priority area, a key aspect of which involves the approaches to adequately track its progress. The first of these approaches involve the strengthening of the National Sexual Health Hotline to address issues related to HIV and other Sexual and Reproductive Health subject areas. The second approach builds on the KAPB survey, earlier identified, as the instrument for monitoring and tracking the "pulse" of the general population on HIV in general and PLHIV specifically.

Strategic Objective2: To increase the utilization of the legislative environment and public education systems to better address Stigma and Discrimination.

Expected Outcome: *Increase in public awareness initiatives that addresses human rights by 2018.*

The second objective seeks to address the legislative environment as a means towards the achievement of a more enabling environment. Drawing on the findings of the Policy Analysis and Legislative Review on the Impact of Stigma and Discrimination in BVI (Pargass, 2011), the activities identified will aim to address some of the key gaps identified in this review.

These activities involve:

1. A capacity building element which is geared to conducting a programme of legal literacy among key populations as a means of increasing their general awareness of rights under the major international conventions which would have been signed onto by the Government of the BVI.
2. The establishment of a Human Rights desk. This is expected to work closely with the Hotline.
3. The re-establishment of the coordinating reporting committee. This committee has been charged with the responsibility of reviewing existing laws and policies that can assist in guaranteeing the rights of PLHIV and other groups that are susceptible to abuse and rights violation.

Strategic Objective 3: To reduce cases of stigma and discrimination against PLHIV using education as the tool

Expected Outcome: *Increase stigma-reduction education by 50% by 2017*

The third objective focuses on capacity building approaches as a means toward achieving the outcome of the broader priority area. One of the activities outlined speaks to a public education campaign, building on the above mention initiative, which focuses on key groups. The aim of this activity is that of awareness building across the wider population on those rights that are protected under the law in the country.

The next key activity builds on the legal literacy programme mentioned above, expanding it to include areas that will better guide leaders across the key populations to inform policy development at both the local and wider national level. This activity will take the form of a training of trainers, as a means of ensuring the programme reaches key population groups. This training initiative also ensures the sustainability of the capacity building component of this plan.

Priority Area 4	**A Sustainable HIV Response**

Expected Outcome: **To create a sustainable national HIV/STI response to the National HIV/AIDS response by 2015**

Strategic Objective 1: To integrate HIV/STI into national services and programmes

Expected Outcome: *An integrated approach for HIV/STI implemented by 2018*

The resource mobilization strategy is a priority in light of the prevailing economic climate and the projection for the international economy. Recognizing the open nature of the region and its susceptibility to the effects of the global economic situation, it is imperative that sustainability of the response be rooted in exploring new, while sustaining and strengthening present arrangements with state and non-state actors.

The strategy of increasing non-governmental funding is routed in the establishment of partnerships with key non-state actors, drawing on the significant contribution they can provide based on their areas of strengths. Increased funding from this sector will come in the form of direct as well as indirect funding through technical support. The private sector is identified as a key partner in this respect, bringing their experience to bear in collaborating with the Ministry in its media campaign as part of the prevention strategy.

The role of the BVICCHA is key as a leading partner, for advancing sensitization campaigns, as well as outreach testing initiatives among their constituencies. It is anticipated that the HAF will work collaboratively with the BVICCHA and the Ministry of Health on these activities. Another aspect of the objective to increase funding from non-governmental sources involves the continued engagement with the donor community.

This is expected to be accomplished by building on established relationships with such agencies as EU, PAHO, ILO, OECS, PANCAP and the Caribbean Public Health Agency. Given the global economic environment, it is expected that support from external donors will be easier accessed in the form of technical support. The capacity building agenda can therefore be targeted for support in achieving the outcomes of the NSP.

Strategic Objective 2: To increase the allocation of funding to support the national response for HIV/STIs

Expected Outcome: *National donor funds for HIV/STI increased by 10% by 2017*

Aspects of the sustainable funding strategy will be centered on the direct engagement with the Government. The objective is to lobby the Government for an increased subvention towards the National Response. This is to be approached through engagement with members of the House of Assembly to highlight the present epidemic, the present trends and potential benefits of increased support to interventions in health in general and the HIV response specifically.

The benefits to be derived from the integrated approach to the response, through a strengthening of key related programmes and systems both within and around the Health Sector, will be critical at this juncture. An outline of the proposed new integrated structure is also geared toward illustrating the potential savings to be derived through increased efficiencies and the potential for a more sustainable response to the epidemic.

PLATFORM FOR THE PROPOSED STRUCTURE OF THE HIV RESPONSE

The proposed repositioning of the national response in line with the goals of a more integrated structure seeks to locate the response programme within the broader area of Family Health. This is in line with the BVI's Family Health Strategy which is being adopted from the Caribbean Community Family Health Strategy by the MHSD. The objective of this strategy is to provide comprehensive care and treatment of individuals by health care providers that addresses the needs of individuals and their families, throughout **a life cycle approach**.

The strategy focuses on the family as a unit, with emphasis placed on health promotion, epidemiologic trends, disease prevention and other health related issues **throughout the lifespan of an individual**. This initiative seeks to standardise the care and treatment provided to patients around the Primary Health Care model, allowing for strengthening of the integration of health care across key divisions within and outside the sector.

A detailed breakdown of key aspects of the NSP, outlining the strategies, and broad activities for each of the strategic objectives is provided in the section that follows.

Also listed in the matrix are the proposed lead agencies, organizations and government departments for each of the activities identified.

BVI NATIONAL STRATEGIC PLAN ON HIV/STI 2015– 2019 MATRIX

Priority Area 1: Prevention of new HIV infections			
Expected Outcome: Reduction of new HIV infections by at least 50% by 2017			
Strategic Objectives	**Strategies**	**Key Activities**	**Lead Agencies**
To increase the number of persons tested for the first time.	Increase Public Awareness on the importance of knowing one's status	Embark on media campaigns using both traditional and new media channels	MHSD, NPOs, BVICCHA
		Engage in Sensitization Campaigns at the Community and Sector Level	MHSD, NPOs
	Scale up testing in health facilities and at the community level	Identification of variable to collect data and include into Cellma for utilization in all clinics and hospital	MHSD, BVIHSA

Priority Area 1: Prevention of new HIV infections			
Expected Outcome: Reduction of new HIV infections by at least 50% by 2017			
		Support provided for the Red Cross to implement HIV rapid test, with emphasis on key populations Outreach Testing Initiative targeting communities and key groups	MHSD, NPOs
		Train non-health persons in HIV counseling and testing	MHSD ,Health Services Authority
		Facilitate pilot testing of HIV Rapid Testing in key services such as SRH services (family planning; OCPs, annual Pap Smears, prostate cancer screening, antenatal services) at two clinics (Iris O'Neal and Road Town) in order to link HIV prevention with other services in the primary care setting	MHSD ,Health Services Authority
		Assess and implement appropriate strategy so as to scale up HIV prevention (testing and counseling in all public clinics in the health sector	MHSD ,Health Services Authority
		Train Heath Care Providers in PITC Policy, Counseling and Testing to support the implementation in the health sector	
		Identify alternative diagnostic laboratories in the region that provides quality, cost- effective follow-up diagnostic HIV care	MHSD, Health Services Authority
		Review, develop and implement in-country lab confirmatory algorithm for HIV	
Increase Interventions to promote safe sex among the general populations		Develop and implement combination prevention programmes for HIV/STIs at the community level	MHSD, NPOs
		Integrate and implement and HIV/STI prevention programme within a comprehensive health and wellness programme (implement within 3 businesses)	MHSD, NPOs
		Develop campaign drawing on social media to target youth (using Facebook, twitter ,etc)	MHSD, MC&W, NPOs
		Increase sensitization of key media on the impact and importance of HIV programming via workshops	MHSD, MC&W, NPOs
		Conduct assessment on knowledge, attitudes, Behaviors and Practices around HIV/STIs and related health issues	MHSD, MC&W, NPOs

Priority Area 2: Integrated treatment, and support care			
Expected Outcome: Access Universal Assess goal to PHLIV in the health system by 2017			
Strategic Objectives	**Strategies**	**Key Activities**	**Lead Agencies**
To increase the number of public health facilities providing care, treatment & support	Increase the number of public health facilities providing care, treatment and support to PLHIV to at least 1 by 2017	Conduct Assessment of Sites for provision of T,C&S Services	MHSD
		Integrate HIV care and treatment into 2 appropriate Health Clinics	MHSD, Health Services Authority
		Develop and implement strategy to support partner notification for communicable infections	MHSD, Health Services Authority
		Adopt the draft Caribbean Family Health Strategy to ensure it captures the provision of HIV services	MHSD, Health Services Authority
	Increase the cadre of health care providers who can provide treatment, care and support in an integrated care setting by 50% by 2017	Implement on-going training for health care providers in areas including Partner Notification, Clinical care approaches, stigma & discrimination within the context of the integrated model of care for HIV in primary care	MHSD, Health Services Authority
		Strengthen care for HIV co-morbidity including TB, Hepatitis and other STIs in the public health facilities.	MHSD, Health Services Authority
		Training for health care providers on the integrated management of chronic conditions including HIV	MHSD, Health Services Authority
		Train health care providers on the newly developed guidelines for the clinical management of HIV in the Public Clinics.	MHSD, Health Services Authority
Strengthen mechanisms to collect strategic information to guide HIV care and treatment		Assess surveillance needs to include Early Warning Indicators, patient tracking information and strengthening of case-based surveillance	MHSD, Surveillance Unit

Priority Area 2: Integrated treatment, and support care			
Expected Outcome: Access Universal Assess goal to PHLIV in the health system by 2017			
		Systematic collection of data to monitor EI, and the continuum of care	MHSD, Surveillance Unit
		Develop and disseminate an epidemiological report on HIV/STI for BVI to support the monitoring and planning of the national response.	MHSD, Surveillance Unit
		Facilitate mapping and implement mechanism/structure for data flow from private sector to Epidemiology	MHSD, Surveillance Unit
		Acquire software to support data collection in 3 care and treatment sites and at Peebles Hospital Pharmacy	MHSD, Surveillance Unit

Priority Area 3: Enabling environment			
Expected Outcome: To create an enabling environment that supports persons with HIV and their families			
Strategic Objectives	**Strategies**	**Key Activities**	**Lead Agencies**
To create a system for the monitoring of stigma and discrimination	Establish approaches to monitor stigma and discrimination	Conduct formative assessment to determine the type of stigma and discrimination experience in BVI	MHSD, NDF, NPOs
		Promote the use of the Legal Advisor of the BVI New Day Foundation among persons with HIV to capture and address violations in a meaningful manner	MHSD, Attorney General Chambers, NDF
		At least one case of stigma and discrimination against a person with HIV review and address within the legal framework	MHSD, New Day Foundation
To improve the enabling environment to better address stigma and discrimination		Provide E-counseling for persons with HIV and their families with linkages to appropriate professional counseling	MHSD, New Day Foundation
		Peer support provided to persons with HIV through local support Group Structure	MHSD, New Day Foundation
		Socialization of the E-Counseling site through the promotion of brochures to attract users	MHSD, New Day Foundation

Priority Area 3: Enabling environment			
Expected Outcome: To create an enabling environment that supports persons with HIV and their families			
To reduce cases of stigma and discrimination against PLHIV using Education as the tool and to increase stigma-reduction education by 50% by 2017	Create and implement training programmes aimed at Knowledge enhancement	Provide training on human rights and advocacy for the local support group	MHSD,NPOs
		Ongoing peer support(Meetings) for persons with HIV in BVI	New Day Foundation
		Conduct training programme for the community and general population on understanding the legislations which supports HIV	MHSD,NPOs
		Implement training for health care providers on the right to health	MHSD
		Training for health care providers on the provision of services for the sexually diverse populations	MHSD
		Develop and implement a national Public Education programme on stigma and discrimination	MHSD, AG's Chambers

Priority Area 4 : A Sustainable HIV response for HIV/STI			
Goal: To create a sustainable national response for HIV/STI by 2016			
Strategic Objectives	**Strategies**	**Key Activities**	**Lead Agencies**
Integrate HIV/STI services into the national response	Establish partnerships	Collaborate with Private sector & NGOs in the development of media campaigns for the prevention of HIV/STI strategy	MHSD, BVICCHA
		Establish an inter-sectoral coordinating committee to support the implementation, monitoring and evaluation of this NSP	MHSD
		Strengthen established relationships with DFID, PAHO/PHCO, ILO, and establish new regional/international partnerships (CARPHA) for ongoing technical support to the HIV response and broader Health response	MHSD
National and donor funding increase to support the national response by 10% by 2017	Resource mobilization locally and internationally	Develop resource mobilization strategy and proposals aligned to the NSP to be submitted to donors, NGOs & Government so as to increase the national budget for HIV the response	MHSD

Priority Area 4 : A Sustainable HIV response for HIV/STI			
Goal: To create a sustainable national response for HIV/STI by 2016			
		Engage in a sensitization session with Parliament so as to advocate for increase in funds to support the national response within the integrated approach	MHSD, NPOs
	Present the proposed new structure of the National Response to Gov't	Outline the proposed integrated programme and resource requirement and benefits of the revised structure	MHSD

Annex 1: MONITROING AND EVALUATION FRAMEWORK

INDICATIOR MATRIX

Priority Area	Indicators	Source of Information	Frequency	Responsible Person/Unit	Baseline		Target	
					Value	Year	Value	Year
Priority Area 1: To increase the number of persons tested for the first time	• 25%reduction of new reported HIV infections by 2017	Surveillance Reports	Annually	Surveillance Unit		2012		2017
Priority Area 2: Integrated Treatment, Care and Support	• 80%of PLHIV access to care, treatment and support in the health system by 2015	Surveillance Reports	Annually	Surveillance Unit		2012		2014
Priority Area 3: Enabling Environment	• 50% reduction in the reported incidence of stigma and discrimination by PLHIV by 2017	Reports made on stigma and discrimination to the Human Rights Help Desk	Annually	National AIDS Programme		2012		2017
Priority Area 4: Sustainable Funding	• 10% increase of mobilization of resources to the National HIV/AIDS Response by 2017	Donors, NGO and Government Financial Reports	Annually	National AIDS Programme		2012		2015

Priority Set of Indicators for the Strategic Objectives

Priority Area 1. **Prevention of New HIV infections**			
Strategic Objectives	**Indicators**	**Source of Information**	**Assumptions**
1.1 Reduction of newly reported HIV infection	1. The number of newly reported infection reduced by at least by 25% by 2017.	Surveillance Reports	Critical data is collected at all point of testing and submitted to the Surveillance Office.
	2. The number of work places (at least 3) implementing HIV/STI prevention within a comprehensive health and wellness programme by 2018	Reports from the work places and programmes implemented	Private and public workplaces willing to implement workplace health and wellness programmes
	3. Number of health care facilities implementing HIV testing linked to other key services increased by at least 3 by 2018	Report from the public health centres and number of persons access HIV testing in clinics	Health care facilities are willing to provide HIV tests in the clinic settings

Priority Area 2. **Integrated Treatment, care and support**			
Strategic Objectives	**Indicators**	**Source of Information**	**Assumptions**
2.1 **To increase the number of public health facilities providing care and treatment**	1. Access to care, treatment and support services in the public sector increased by 1 health facility by 2017. 2. The cadre of health care providers who can provide treatment, care and support in an integrated care setting increased by 25% by 2017.	Facility Records Clinic Records	The health facilities will be willing to embrace and continue the integration and decentralization of HIV services.

Priority Area 3. **Enabling Environment**			
Strategic Objectives	**Indicators**	**Source of Information**	**Assumptions**
3.1 To improve the enabling environment to better address stigma and discrimination.	1. Number of reports received at the human rights desk increased by 10% by 2017. 2. Increase in the number of public awareness initiatives and training on humans rights implemented by 2018	Reports Reports on number of users	Persons with HIV are accessing the reporting options available and the use of the Human Rights Desk
3.2 To reduce cases of stigma and discrimination against PLHIV using education as the tool	3. Increase stigma reduction education by50% by 2019. 4. Number of health care providers trained on human rights and health increased by 25% by December 2019 5. Number of the community members receiving training in human rights and advocacy increased by 20% by 2019	Training tool & training plans Training plan, reports and list of participants Training plan, reports& list of participants	Health care providers and community members are willing to participate in the training programmes

Priority Area 4. **Sustainable National Response for HIV/STI**			
Strategic Objectives	**Indicators**	**Source of Information**	**Assumption**
4.1 HIV services integrated into national services and programmes	1. Number of HIV services that have been integrated into national programmes and services increased by 20% by 2019	Reports on the integration of services	Willingness of the key partners to mainstream HIV programme of work into their ongoing services
4.2 To increase the allocation of finding for the national response	2. Funding for the National HIV/STIs response increased from donors, government and NGOs by at least 10% by 2017.	Ministry of Finance budget report/allocation	Funding available from Government and private sectors to increase the budget allocation for HIV

Logical Framework for National Strategic Plan

	PREVENTION	TREATMENT,CARE and SUPPORT	ENABLING ENVIRONMENT	SUSTAINABILITY
GOAL	To reduce sexual transmission of HIV by 25% by 2017 Indicators • Percentage of young people 15-24 who are living with HIV • Percentage of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother-to-child-transmission • Percentage of HIV positive infants born to HIV positive pregnant mothers	To reduce the number of newly reported HIV Infections by at least 25% by 2017 Indicators • Percentage of eligible adults and children currently receiving ART • Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART • Percentage of HIV+ who have been screened for TB	To reduce reported incidence of stigma and discrimination by PLHIV by 50% by 2017 Indicator • Percentage of people 15-49 years expressing accepting attitudes towards PLHIV	To create a sustainable national response for HIV/STI by 2016 Indicator • Percentage of increase of resources to the National HIV Response • Percentage of national services and programmes that have integrated HIV services
PURPOSE	To achieve universal access to prevention with emphasis on key populations Indicators • Percentage of adults aged 15-49 who had more than one sexual partner in the last 12 months who report the use of a condom during their last intercourse	To achieve universal access to quality, comprehensive treatment, care and support through the integration of services in the public health sector Indicators • Percentage of adults and children with HIV known to be on treatment 24 months after initiation of ART	To decrease stigma and discrimination towards PLHIV Indicator • Percentage of reported cases of HIV related discrimination receiving redress by setting	To create a sustainable national response for HIV/STI Indicator • Number of HIV services that have been integrated into national programmes and services increased by 20% by 2018

	• Percentage of sex workers reporting the use of a condom with their most recent client • Percentage of sex workers who received and HIV test in the past 12 months and know their HIV results • Percentage of pregnant mothers who know their HIV status (tested for HIV and received their results- during pregnancy, during labour and delivery and during the post-partum (<72 hours), including those with previously known HIV status)	• Percentage of HIV positive persons with first CD4cell count <200 cells/uL • Switching Rate: % of change of ART of 1st line to 2nd line per year • Percentage of persons on ART with at least 2 VL tests per year • Percentage of patients retained on first line at 12 months • Percentage of PLHIV with undetectable VL at 12 months of ART		• Funding for the National HIV/STI response increased from donors, government and NGOs by at least 10% by 2017.
OBJECTIVES	• To increase the number of persons who tested for the first time • To increase the interventions to promote safe sex practices among the general population	• To increase access by at least 1 to health facilities providing care, treatment and support to persons with HIV infection in the public health sector • Strengthen mechanisms to collect strategic information to guide HIV care and treatment	• To create a system for the monitoring of stigma and discrimination progress • To improve the enabling environment to better address S&D	• To integrate HIV services into national programmes and services • Increase national funds through donor, Government & private budget allocations

	Indicators • Number of men and women aged 15 and older who receive HIV testing and counseling in the last 12 months and know their results • Number of pregnant women attending ANC at least once during the reporting period • Number of media campaigns conducted • Number of sensitization campaigns conducted • Number of persons trained in conducting testing and counseling , including PITC • Number of HIV tests conducted in the reporting period • Number of Businesses implementing HIV/STI prevention within a comprehensive health and wellness programme	Indicators • Number of eligible adults and children who newly initiated ART during the reporting period • Number of health facilities that offer ART • Number of adults newly enrolled in pre-ART (HIV Care) during the reporting period • Number of adults newly enrolled in HIV Care (pre-ART) and Treatment (ART) during the reporting period • Number of PLHIV on ART by line of treatment (1st, 2nd ,3rd) • Number of healthcare providers trained and providing HIV Care and Treatment • Number of health care providers trained in the integrated management of chronic care	• To reduce cases of stigma and discrimination against PLHIV using Education as the tool Indicators • Number of cases of HIV related discrimination reported to the Human Rights Desks • Number of reported cases of HIV related discrimination receiving legal redress • Number of persons of the HIV community population who have received capacity building related human rights	Indicators • Inter-sectoral committee to monitor and evaluate the integration/mainstreaming of HIV/STI into national services and programmes • New structure of the National Response presented to Government • Resource mobilization strategy developed (including donor community, key non-state actors, private sector • Sensitization session conducted with Parliament

	• Number of Media persons trained on the Impact and Importance of HIV Programming	• Surveillance System assessed • Structure to collect data for EI and continuum of care and report to the Surveillance Unit developed • HIV Epidemiological Profile developed • Utilization of software to support HIV Database	Numbers of training programmes implemented for health care providers and the wider community on health and human rights	

LIST OF INDICATORS

PRIORITY AREA 1: PREVENTION	
IMPACT	
Target 1: Reduction in the newly HIV reported infection by 25% by 2017	
GARPR2013 (1.6)	Percentage of young people 15-24 who are living with HIV
GARPR2013, UA2013 (1.10)	Percentage of sex workers who are living with HIV
GARPR2013, UA2013 (1.14)	Percentage of men who have sex with men who are living with HIV
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths	
GARPR2013, UA2013 (3.1) (EC/OCT Indicator)	Percentage of HIV-positive pregnant women who receive anti-retrovirals to reduce the risk of mother-to-child-transmission
(EC/OCT Indicator)	Percentage of HIV positive infants born to HIV positive pregnant mothers
OUTCOME	
GARPR2013 (1.4)	Percentage of adults aged 15-49 who had more than one sexual partner in the last 12 months who report the use of a condom during their last intercourse
GARPR2013 (1.5)	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results
GARPR2013, UA2013 (1.8)	Percentage of sex workers reporting the use of a condom with their most recent client
GARPR2013, UA2013 (1.9)	Percentage of sex workers who received an HIV test in the past 12 months and know their results
GARPR2013, UA2013 (1.12)	Percentage of men who have sex with men reporting the use of a condom the last time they had anal sex with a male partner
GARPR2013, UA2013 (1.13)	Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results
UA2013 (3.4)	Percentage of pregnant mothers who know their HIV status (tested for HIV and received their results-during pregnancy, during labour and delivery and during the post-partum (<72 hours), including those with previously known HIV status)
OUTPUT & PROCESS	
UA2013 (1.16) NSP	Number of men and women aged 15 and older who receive HIV testing and counseling in the last 12 months and know their results
UA2013 (1.11)	Number of pregnant women attending ANC at least once during the reporting period
NSP	Number of media campaigns conducted
NSP	Number of sensitization campaigns conducted

NSP	Number of persons trained in conducting testing and counseling
NSP	Number of HIV tests conducted in the reporting period
NSP	Number of health care providers trained in PITC
NSP	Number of Media persons trained on the Impact and Importance of HIV Programming
PRIORITY AREA 2: TREATMENT, CARE AND SUPPORT	
IMPACT	
Target 4: Have 15 million people living with HIV on antiretroviral therapy by 2015	
GARPR2013, UA2013 (4.1)	Percentage of eligible adults and children currently receiving ART
GARPR2013, UA2013 (4.2) (EC/OCT Indicator)	Percentage of adults and children with HIV known to be on treatment 12 (24, 36, 60) months after initiation of ART
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015	
GARPR2013, UA2013 (5.1)	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV
TB/HIV Reporting	Percentage of HIV+ who have been screened for TB
OUTCOME	
UA2013 (4.2b)	Percentage of adults and children with HIV known to be on treatment 24 months after initiation of ART
UA2013 (4.4)	Percentage of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months
UA2013 (4.5)	Percentage of HIV positive persons with first CD4cell count <200 cells/uL
AMDS Survey on ARV Use & Laboratory Use	Switching Rate: % of change of ART of 1st line to 2nd line per year
UA2013 (4.5)	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 Testing
AMDS Survey on ARV Use & Laboratory Use	Percentage of persons on ART with at least 2 VL tests per year
Treatment as Prevention, 2012	Percentage of patients that continue in care in last year (proxy: % of patients with ≥ 2 CD4/year or 2 VL or drug pick up)
WHO Global Strategy for Surveillance & HIVDR Monitoring	Percentage of patients retained on first line at 12 months
Treatment as Prevention, 2012	Percentage of PLHIV with undetectable VL
Treatment as Prevention, 2012	Percentage of PLHIV on ART with undetectable VL (≥6 months of ART)
WHO Global Strategy for Surveillance and Monitoring of HIVDR	Percentage of PLHIV with undetectable VL at 12 months of ART

OUTPUT & PROCESS	
GARPR2013, UA2013 (4.1)	Number of eligible adults and children who newly initiated ART during the reporting period
UA2013 (4.3a)	Number of health facilities that offer ART
UA2013 (4.6a)	Number of adults newly enrolled in pre-ART (HIV Care) during the reporting period
UA2013 (4.6b)	Number of adults newly enrolled in HIV Care (pre-ART) and Treatment (ART) during the reporting period
AMDS Survey on ARV Use & Laboratory Use	Number of PLHIV on ART by line of treatment (1^{st}, 2^{nd} ,3^{rd})
NSP	Number of healthcare providers trained in HIV Care and Treatment
NSP	Number of healthcare providers trained and providing HIV Care and Treatment in an integrated approach
NSP	Surveillance System assessed
NSP	HIV Epidemiological Profile developed
	Structure to collect data for EI and continuum of care and report to the Surveillance Unit developed
NSP	Utilization of software to support HIV Database

PRIORITY AREA 3: ENABLING ENVIRONMENT	
IMPACT	
Target: Reduce reported incidence of stigma and discrimination by PLHIV by 50% by 2015	
NSP Percentage of people 15-49 years expressing accepting attitudes towards PLHIV	
OUTCOME	
NSP	Percentage of reported cases of HIV related discrimination receiving redress by setting
OUTPUT & PROCESS	
NSP	Number of cases of HIV discrimination reported to the Human Rights Desk
NSP	Number of reported cases of HIV related discrimination addressed within the legal framework/environment
NSP	Number of persons with HIV who have received capacity building related to human rights and right to health
	Number of health care providers who have received capacity building related to human rights and right to health and provision of services to the sexually diverse population

PRIORITY AREA 4: SUSTAINABILITY OF THE NATIONAL RESPONSE	
IMPACT	
Target: Create a sustainable national response for HIV/STI by 2016	
NSP Percentage of increase of resources to the National HIV Response	
OUTCOME	
NSP	Number of services that integrates HIV services into their national programmes and services increased by 20% by 2018
NSP	Funding for the National HIV/STI response increased from donors, government and NGOs by at least 10 % by 2017.
OUTPUT & PROCESS	
NSP	Resource mobilization strategy developed (including donor community, key non-state actors, private sector
	Sensitization session conducted with Parliament
	New structure of the National Response presented to Government

ANNEX 2: IMPLEMENTATION PLAN

First year implementation activities were selected by the NAP and key stakeholders through a process of focus group discussions. This section of the report presents the cost of activities and programmes earmarked for implementation in the first year of this strategic plan.

The table below provides the implementation plan for year one.

National Strategic Plan for HIV/AIDS: Implementation Plan - Year One

NSP Priority Area 1:				**Implementation Month**											
Prevention of Newly Contracted HIV Infection				**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Strategic Objectives:	**Strategies:**	**Activities**	**Responsible Agency**												
To reduce the number of new HIV reported infections	1.Increase public awareness on the importance of knowing one's status	**1. Embark on media campaigns using both traditional and new media channels**													
		• Radio advertisements - Aired twice daily, 3 times a week	GIS MOH	√	√	√	√	√	√	√	√	√	√	√	√
		• Television advertisements – Aired 4 times weekly	GIS MOH	√	√	√	√	√	√	√	√	√	√	√	√
		• Advertise online local news sites	GIS MOH	√			√			√			√		
		• Advertise on social media (Face Book)	MHSD	√	√	√	√	√	√	√	√	√	√	√	√
		2. Engage in sensitization campaigns at the community and sector level													
		• Sensitization seminars at private businesses, public institutions and FBOs – one per/month	MHSD	√	√	√	√	√	√	√	√	√	√	√	√

	2. Scale up testing initiatives	**3. Strengthen HIV testing in the health facilities and at the community level**													
		• Counselling and testing at health fairs – At least 3 annually	MHSD, Red Cross, Leo Club, etc.												
		• Counselling and testing at public health facilities and NAP office	MHSD, BVIHSA												
		• Train health care providers in Provider Initiative Testing &Counselling (PITC)	MHSD												
		• Collect data and include into Celma for utilization in all clinics and hospital	MHSD, BVIHSA	√					√						√
		• Review, develop and implement in-country lab confirmatory algorithm for HIV diagnosis	MHSD, Health Services Authority												
		4. Combination Prevention package for HIV/STIs													
		• Develop and implement a comprehensive wellness programme which integrates HIV/STI prevention in work places	MHSD and Labour Department	√					√						√
2. To increase interventions to promote safe sex	3. Raise awareness of safer sex with emphasis on key populations	**5. Develop campaign drawing on social media to target youth (using Facebook, twitter, etc.)**													

		• Create a BVI-HIV Facebook page and twitter	MHSD	√	√	√	√	√	√	√	√	√	√	√	√
		• Increase availability of condoms at clubs, health centres, Red Cross and other relevant places	MHSD, BVIHSA, Rotaract Club	√	√	√	√	√	√	√	√	√	√	√	√
		• Conduct workshop to sensitize media on HIV/AIDS annually	MHSD CPMB					√							
NSP Priority Area 2:				**Implementation Month**											
Integrated Treatment, Care and Support				**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Strategic Objectives:	**Strategies:**	**Activities**	**Responsible Agency**												
1. To increase access to sites providing care and treatment to PLWH in the health system	1. Strengthen the capacity of health facilities to provide care, treatment, support	**1. Conduct assessment of services and provide support to strengthen public facilities to provide HIV care, treatment and Support services**	MHSD												
		• Integrate HIV care and treatment into two public health clinics	MHSD, BVIHSA	√	√	√									
		• Strengthen care for HIV-co-morbidity including TB, Hepatitis and other STIs in the public health facilities	MHSD, Health Services Authority						√	√	√				
		Develop and implement strategy for partner notification of sexually communicable infections	MHSD, Health Services Authority										√	√	√

	2. Increase the cadre of health care providers who can provide treatment, care and support within integrated services	**4. Capacity building for health care providers in both private and public health institutions**		√	√	√										
		Implement training for health care providers in areas including contact tracing and notification, clinical care approaches, stigma and discrimination	MHSD, Health Services Authority				√						√	√	√	
		Train health care providers on the newly developed guidelines for the clinical management of HIV in the Public Facilities	MHSD, Health Services Authority													
		Training for health care providers on the integrated management of chronic conditions including HIV	MHSD, Health Services Authority									√				
Strategic Information strengthen to collect data to		**5.Improve data collection and reporting in the public health facilities**														

guide monitoring and planning of the national response															
		Assess surveillance needs to include early Warning Indicators, patient tracking system and case-based surveillance	MHSD, Surveillance Department												
		Develop tool and implement for the systematic collection of data to monitor EI and the continuum for care (from lab and various service point)	MHSD, Surveillance Department	√	√	√	√	√	√	√	√	√	√	√	√
		Develop and disseminate Epidemiological profile for HIV	MHSD, Surveillance Department												
		Finalize report on Elimination Strategy	MHSD, Surveillance Department												

NSP Priority Area 3: Enabling Environment				Implementation Month											
				1	2	3	4	5	6	7	8	9	10	11	12
Strategic Objectives:	**Strategies:**	**Activities**	**Responsible Agency**												
1. Create a system for monitoring of stigma and discrimination progress	1. Establish approaches to create and track key S&D indicators	**1. Utilization of services to monitor stigma &discrimination**													
		Conduct formative assessment to determine the type of S&D experienced	MHSD, BVIHSA, NDF	√											√
2. To improve the enabling environment to better address S&D	2. Support for persons with HIV and their families	**2. Supportive environment created for persons with HIV and their families**													
		Provide E-Counseling for PLWH and families linked to professional counseling	MHSD, NDF												
		Socialize the E-counseling site for wide utilization in BVI	MHSD, NDF	√											
		Peer support for persons with HIV through support group	MHSD, NDF	√	√	√	√	√	√	√	√	√	√	√	√
3. To reduce cases of S&D against PLWH using education tools	3. Create programmes for knowledge enhancement	**3. Capacity in the understanding of human rights and health to address stigma and discrimination**													
		Training for the members of the community on human rights and advocacy	MHSD, SCF												

NSP Priority Area 4: A Sustainable National Response for HIV				Implementation Month											
				1	2	3	4	5	6	7	8	9	10	11	12
Strategic Objectives:	**Strategies:**	**Activities**	**Responsible Agency**												
1. Integrate HIV/STI services into the national response	Establish partnerships	**1. Collaboration strengthen with key local and regional partners to support the integration of HIV services**													
		Collaborate with private sector in media campaigns for the prevention strategy and in building and upgrading activities of treatment and care facilities	MHSD, BVIHSA	√											
		Strengthened relationships with DFID, PAHO/PHCO, ILO and establish new regional/international partnerships (CARPHA) for support to the HIV and broader health response	MHSD												
		Establish an inter-sectoral coordinating committee to support the monitoring of the HIV programme of work which are integrated into national services	MHSD	√	√	√	√	√	√	√	√	√	√	√	√

2. National and donor funding increase by 10% to support the national response by 2017	Resource mobilization	**2.Embarke on resource mobilization campaign**													
		Facilitate sensitization sessions with Cabinet in order to raise awareness and address the need for a national sustainable response implanted in an integrated manner	MHSD, NDF						√						
		Develop resource mobilization strategy and proposal aligned to the NSP	MHSD, NDF	√											

ANNEX 3: COST OF THE IMPLEMENTATIONS PLAN

The cost of implementing the activities outlined in Table 1 were derived using the OCT costing tool which was developed by PAHO specifically for the costing of HIV/AIDS activities in overseas territories. This is an Excel based spreadsheet which allows for the standardization of costs categories across the various types of activities. Costs for each of category were estimated using local prices, where available, and the intensity with which the activity were intended to be carried out.

COST CATEGORY DEFINITIONS	
Cost Category	**Details**
Communication Material	Printed material and communication costs associated with program-related campaigns, TV spots, radio programmes, advertising, media events, education, dissemination, promotional items.
Health Products and Health Equipment	Health products such as bed nets, condoms, lubricants, diagnostics, reagents, test kits, syringes, spraying materials and other consumables. Health equipment such as microscopes, x-ray machines and testing machines (including the Total Cost of Ownership' of this equipment such as reagents, and maintenance costs). Does not include other types of non-health equipment, as these costs should be included under the Infrastructure and Other Equipment category below.
Human Resources	Salaries, wages and related costs (pensions, incentives and other employee benefits, etc.) relating to all employees (including field personnel), and employee recruitment cost5s, as well as stipends, expense reimbursement and related costs for non-employees such as volunteers.
Infrastructure and Other Equipment	This includes health infrastructure rehabilitation and renovation and enhancement costs, non-health equipment such as generators and beds, information technology (IT) systems and software, website creation and development. Office equipment, furniture, audio-visual equipment, vehicles, motorcycles, bicycles, related maintenance, spare parts and repair costs.
Living Support to Clients/Other Populations	Monetary or in-kind support given to clients and patients e.g. school fees for orphans, assistance to foster families, transport allowances, patient incentives, grants for revenue-generating activities, food and care packages, costs associated with supporting patients charters for care.
Monitoring and Evaluation	Data collection, surveys, research analysis, travel, field supervision and oversight visits, and any other costs associated with monitoring and evaluation. Do not include personnel, management or technical assistance or IT systems costs, as these costs should be included in the categories above.
Other Costs	Significant costs which do not fall under the above-defined categories. The applicant is encouraged to avoid using this category unless it is deemed necessary in order to meet national budget planning categories.
Overheads	Overhead costs such as office rent, utilities, internal communication costs (mail, telephone, internet), insurance, fuel security, cleaning. Management or overhead fees.
Pharmaceutical Products (Medicines)	Cost of antiretroviral therapy, medicines for opportunistic infections, anti-tuberculosis medicines, anti-malarial medicines and other medicines. Do not include insurance, transportation, storage, distribution or other like costs. These costs should be included in Procurement and Supply Management costs below.
Planning and Administration	Office supplies, travel, field visits and other costs relating to programme planning and administration (including in respect o managing sub-recipient relationships). Legal, translation, accounting and auditing costs, bank charges etc. Green Light Committee contributions (refer to question 6.6). Do not include human resources costs, as these costs should be included under the Human Resources category above.

Procurement and Supply Management (Diagnostics)	Transportation costs for all purchases (equipment, commodities, products, medicines) including packaging, shipping and handling. Warehouse, PSM office facilities, and other logistics requirements. Procurements agent fees. Costs for quality assurance (including laboratory testing of samples), and any other costs associated with the purchase, storage and delivery of items. Costs associated with pharmaceutical management systems, especially costs associated with: -Pharmaco-vigilance -Drug resistance surveillance -Quality assurance (including laboratory testing of samples) -National Regulatory Authorities strengthening Do not include staff, management or technical assistance, IT systems, health products or health equipment costs, as these costs should be included in categories above.
Technical and Management Assistance	Costs of all consultants (short or long term) providing technical or management assistance, including consulting fees, travel and per-diems, field visits and other costs relating to program planning, supervision and administration (including in respect of managing Sub-recipient relationships, monitoring and evaluation, and procurement and supply management).
Training and Capacity Building	Workshops, meetings, training publications, training-related travel, including training per-diems. Do not include human resources costs related to training which should be included under the Human Resources category.
Travel and Subsistence	Any travel or subsistence costs associated with travel away from home. Applicable per diem for the Caribbean Territories are included in the Per Diem Worksheet.

BREAKDOWN OF COST OF IMPLEMENTATION PLAN: YEAR 1

The cost to implement HIV/AIDS activities in the first year is estimated at US$12,000. This cost does not include the cost of staff and non-staff expenses at the NAP that is already borne by the Government.

Prevention activities account for approximately 88% of the total costs or US$1320. While Treatment, Care, Support and Sustainable Funding account for 5% and 7% respectfully. The costs of activities to be implemented under Priority Area 3, Enabling Environment are subsumed under activities in other priority areas.

With respect to Prevention, activities geared towards public awareness and the dissemination of HIV/AIDS knowledge and information account for the majority of costs with television, radio and print media together accounting for 56% of prevention activities ($7500) and 49% of total costs.

Radio advertisements were quoted at approximately US$300 every other month with airing on two (2) local radio stations. The use of social media such as Facebook and Twitter attracts no cost and is an attractive form of disseminating information targeted to the younger population.

The development and implementation of a combination prevention to reduce new infection is also targeted to be conducted in year 1 at a cost of US$3600. This will provide valuable information to the general population by increasing HIV/AIDS awareness with emphasis on vulnerable populations.

Table 5 provides a breakdown of cost for prevention activities.

CASH FLOW PLAN FOR HIV/AIDS: IMPLEMENTATION PLAN – YEAR ONE

Table 5: Cost to Prevent New Infections June 2015 – May 2016

Inflows	**June**	**July**	**Aug.**	**Sept.**	**Oct.**	**Nov.**	**Dec.**	**Jan.**	**Feb.**	**March**	**April**	**May**	**Total**
National AIDS Programme	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$12000
Total	**$1000**	**$1000**	**$1000**	**$1000**	**$1000**	**$1000**	**$1000**	**$1000**	**$1000**	**$1000**	**$1000**	**$1000**	**$12000**
Outflows	**June**	**July**	**Aug.**	**Sept.**	**Oct.**	**Nov.**	**Dec.**	**Jan.**	**Feb.**	**March**	**April**	**May**	
Radio Ads	$300		$300		$300		$300		$300		$300		$1800
Online Ads (News sites)	$300		$300		$300		$300		$300		$300		$1800
Condom Procurement	$800								$800				$1600
Purchase of HIV Test Kits	$1000								$1000				$2000
Medical Supplies	$300												$300
Total	**$2300**		**$500**		**$500**		**$500**		**$2300**		**$500**		**$7500**

Treatment, Care and Support activities in the first year were estimated to cost US$6000 or approximately 40% of total cost. This cost is made up primarily of the cost for on-going training of health care providers. Table 6 refers.

COST OF TREATMENT, CARE AND SUPPORT ACTIVITIES

Table 6: Cost of Treatment, Care and Support Activities

			Cost Category						
Prevention of Newly HIV Infections	**Total**	**% of Costs**	**Communication Materials**	**Health Products and Health Equipment**	**Human Resources**	**Monitoring and Evaluation**	**Pharmaceutical Products (Medicines)**	**Training and Capacity Building**	**Travel and Subsistence**
• Conduct assessment of services and provide support to strengthen public facilities for HIV care, treatment and support	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0
• Integrate HIV care, treatment and support into two appropriate public health clinics	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0
• Develop and implement strategy for partner notification of sexually communicable infections	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0
• Upgrade facilities	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0
• Provide ARV at public health facilities	**$0**	**0.00%**	$0	$0	$0	$0	$4,161	$0	$0
• Implement training for health care providers in areas including	**$1800**	**30.00%**	$0	$0	$0	$0	$0	**$1800**	$0

			Cost Category						
Prevention of Newly HIV Infections	**Total**	**% of Costs**	**Communication Materials**	**Health Products and Health Equipment**	**Human Resources**	**Monitoring and Evaluation**	**Pharmaceutical Products (Medicines)**	**Training and Capacity Building**	**Travel and Subsistence**
contact tracing and notification, clinical care approaches, stigma and discrimination									
• Train health care providers on the newly developed guidelines for the clinical management of HIV in the public facilities	**$2800**	**0.00%**	$0	$0	$1600	$0	$0	$1200	$0
• Training for health care providers on the integrated management of chronic conditions including HIV	**$3200**	**0.00%**	$0	$0	$1400	$0	$0	$1800	$0
• Assess surveillance needs to include early warning indicators patient tracking system and case-based surveillance	**$0**	**%**	$0	$0	$0	$0	$0	$0	$0
• Develop tool and implement for the systematic collection of	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0

			Cost Category						
Prevention of Newly HIV Infections	**Total**	**% of Costs**	**Communication Materials**	**Health Products and Health Equipment**	**Human Resources**	**Monitoring and Evaluation**	**Pharmaceutical Products (Medicines)**	**Training and Capacity Building**	**Travel and Subsistence**
data to monitor EI and the continuum for care (from lab and various service point)									
• Develop and disseminate Epi profile for HIV	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0
• Finalize report on elimination strategy	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0
Subtotal NSP Priority Area 2:	**$6000**	**%**	**$0**	**$0**	**$3000**	**$0**	**$**	**$3000**	**$0**

Table 7: Cost to Sustain the National Response

			Cost Category						
Sustainable Funding	**Total**	**% of Costs**	**Communication Materials**	**Health Products and Health Equipment**	**Human Resources**	**Monitoring and Evaluation**	**Pharmaceutical Products (Medicines)**	**Training and Capacity Building**	**Travel and Subsistence**
• Collaborate with private sector in media campaigns for the prevention strategy and in building and upgrading activities of treatment and care facilities	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0
• Build on established relationships DFID, PAHO/PHCO, ILO and establish new regional/internatio nal partnerships (CARPHA) for support to the HIV and broader health response	**$**	**%**	$0	$0	$0	$0	$0	$0	$12,000
• Engage in a sensitization session with Members of the	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0

			Cost Category						
Sustainable Funding	**Total**	**% of Costs**	**Communication Materials**	**Health Products and Health Equipment**	**Human Resources**	**Monitoring and Evaluation**	**Pharmaceutical Products (Medicines)**	**Training and Capacity Building**	**Travel and Subsistence**
House of Assembly									
• Outline the proposed integrated programme and resource requirement and benefits of the revised structure	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0
• Establish an inter-sectoral coordinating committee to support the monitoring of the HIV programme of work which are integrated into national services	**$0**	**0.00%**	$0	$0	$0	$0	$0	$0	$0
• Develop resource mobilization strategy and proposal aligned to the NSP	**$5,000**	**29.41%**	$0	$0	$5,000	$0	$0	$0	$0
Subtotal NSP Priority Area 3:	**$5,000**	**100.00%**	**$0**	**$0**	**$5,000**	**$0**	**$0**	**$0**	**$12,000**

CONCLUSION

The costs estimated for activities included in the first year of implementation are a based on the intensity of these activities. The costing tool used provides the flexibility needed to increase or decrease activities and programmes based on resource availability. It is also recommended that costs for subsequent years of implementation be estimated in order to plan and mobilise resources which contribute to the sustainability of programmes. Following December 2019 with achievement of strategic objectives of this plan, a new Situation Analysis is to be conducted on HIV/AIDS and other Sexually Transmitted Infections within the Territory with a new five-year National Strategic Plan developed accordingly.

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