1. HIV/AIDS continues to be a key global development issue in all regions of the world. The Caribbean Region has the highest HIV prevalence among adults outside Sub-Saharan Africa. Barbados has an estimated prevalence rate of 1.5% in 2007. Although Barbados has achieved significant results in the prevention and control of the epidemic, HIV/AIDS is one of the main causes of burden of disease in the country. While new AIDS cases and AIDS mortality significantly declined (46% and 85%, respectively) since the advent of anti-retroviral treatment in 2001, estimated HIV prevalence continues to increase. This is due to the increasing number of new and old cases, respectively, due to the lack of adoption of safer sexual practices, and the increasing survival of people under treatment.

2. The first case of HIV/AIDS was detected in Barbados in 1984, at a time when the epidemic was confined to men who have sex with men (MSM). However, the number of reported HIV cases continued to rise, particularly among self-reported heterosexual men and women of reproductive age. There are about 2,100 known people living with HIV (PLHIV) in Barbados, but recent estimates suggest that the total number of infected adults may be significantly higher. In 2006, over 75% of reported infections occurred in the age group 15-49 years. In addition, there has been rapidly increasing feminization of the epidemic, with a male to female ratio of 1 in 2006.
3. Despite the numerous achievements of the national program, much remains to be done regarding HIV/AIDS and other sexually-transmitted infections (STIs) in Barbados. The single greatest gap in the HIV/AIDS and STI program is the fact that the monitoring and evaluation (M&E) system is not fully functional. Outreach for key populations at higher risk needs to be improved. Evidence from the 2001, 2003 and 2005 youth KAP surveys indicate that educational messages have been successful in raising knowledge levels but less so in affecting behavior change. While the National AIDS Program has engaged in voluntary counseling and testing (VCT), further collaboration with community groups and NGOs will make VCT more available. Social care of People living with HIV (PLHIV) also needs strengthening. Finally, multi-sector institutional roles and relations have to be further strengthened, especially between NHAC and key ministries such as the Ministries of Health, Social Care, Constituency Empowerment and Urban Development, Education, Labor and Tourism.

4. **Government Strategy.** The Government of Barbados (GoB) is fully committed to containing the epidemic. The government specifically requested Bank assistance in 2001, and again now, to contain the HIV epidemic. Extensive work has been done to put in place the UN “Three Ones” principles: there is (i) one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; (ii) one national AIDS coordinating authority (NHAC), with a broad-based multisectoral mandate; and (iii) a monitoring and evaluation system has been designed. However, as mentioned before, the M&E system remains the element of the “Three Ones” that most needs additional work.

5. The Barbados HIV/AIDS Program is aligned with the Pan Caribbean Partnership against HIV/AIDS (PANCAP) and CARICOM’s Caribbean Regional Strategic Framework for HIV/AIDS. Barbados just completed its next five-year AIDS strategy, to which the Bank has contributed significant support. It reflects all the lessons of the past decade, including the need for greater programmatic focus and better surveillance, monitoring and evaluation. The National Strategic Plan of Barbados 2005-2025 (NSP) aims at continued reduction in the spread of HIV/AIDS and minimization of its negative impact, and full engagement of the national multi-sector HIV/AIDS Program by 2008. The second 5-year strategic plan to prevent and control HIV/AIDS is expected to be approved by the Cabinet of Ministers before project effectiveness. The proposed project would contribute to the implementation of this new strategic plan.

6. A National AIDS Coordinating Authority, with a broad-based multisectoral mandate, is fully functional. In 1988, the National Advisory Committee on AIDS (NACA) was formed, and in 1995 committed to a program designed to transfer ownership of the challenge of HIV/AIDS from government to the individual citizen. The program included Ministries other than health, civil society organizations (CSOs), and PLHIV - in sum, a multisectoral approach. The Prime Minister established the NHAC in his Office in 2001 with a mandate to coordinate the national expanded multisectoral response to the epidemic, and a Secretariat was established in 2001. Following the election of a new Government on January 2008, the NHAC was integrated intro the Ministry of Family, Youth Affairs, Sports and Environment. Of 18 Ministries, 15 report annually to NHAC on the respective HIV prevention programs. The number of AIDS-related civil society organizations reporting annually to NHAC increased from 4 in 2002 to 11 by November 2007. According to an ongoing ILO/US Department of Labor workplace education
project, the percentage of targeted enterprises which have HIV/AIDS policies and programs increased from 5% in 2003 to 75% in 2007.

7. **Bank Assistance.** Bank financial and technical assistance has been contributing to the achievement of these results. In 2001, the Bank prepared a horizontal APL to provide rapid support to Caribbean countries to combat the epidemic. Despite having graduated in 1993, Barbados was one of the first two countries to receive support under the APL, by virtue of its leadership role on HIV in the sub-region and the fear of a region-wide outbreak. The HIV/AIDS Prevention and Control Project was included in the 2001 Eastern Caribbean CAS due to the public good nature of this program. According to Bank policy, graduation reflects the achievements of a country in reaching a certain level of development, management capacity, and access to capital markets, but it does not prohibit the resumption of lending if necessary.

8. The first Barbados HIV/AIDS Prevention and Control Project ($23.65 million total cost, $15.15 million Bank loan) aimed at reducing the rate of new HIV infections; increasing the life expectancy, and improving the quality of life of PLHIV; and building sustainable arrangements for managing the epidemic. The project closed on December 31, 2007, after satisfactory implementation and full loan disbursement. Overall, the project had a dramatic impact on ultimate outcomes: as previously mentioned, annual deaths from AIDS have declined by more than 80%; and, among other results, the share of people reporting positive attitudes toward PLHIV has risen from less than 40% to nearly 80%.

**Project development objective and key indicators**

9. The project would support the implementation of the 2008-2013 Barbados National HIV/AIDS Strategic Plan, specifically to increase:

- Adoption of safe behaviors, in particular amongst the most vulnerable groups.
- Access to prevention, treatment and social care, in particular for the most vulnerable groups.
- Capacity of organizational and institutional structures that govern the NAP.
- Use of quality data for problem identification, strategy definition and measuring results.

**Project Development Indicators**

**Behavior change**

- Maintain the percentage of young people 15-24 years spontaneously indicating sexual relations as a way of transmitting HIV at least at 90% during 2008 to 2013.
- Increase in the percentage of
  - sex workers who report the use of a condom with their most recent client from 80% in 2008 to 95% in 2013.
  - men who have sex with men (MSM) reporting the use of a condom the last time they had sex from 65% in 2008 to 75% in 2013.
  - young men and women aged 15-24 years reporting the use of a condom the last time they had sex with a casual partner from 21% in 2008 to 31% in 2013.

**Access to prevention, treatment and social care**
• Increase in the number of people from key populations at higher risk (SW, MSM, PLHIV and youth) accessing preventive services from 250 in 2009 to 500 in 2013.
• Maintain the percentage of HIV-positive pregnant women receiving a complete course of AV prophylaxis to reduce the risk of mother to child transmission (MTCT) above 95% during 2008 to 2013.
• Maintain the percentage of PLHIV on ART achieving virologic success in the last 12 months above 70% during 2008 to 2013.

NAP Capacity
• Increase in the funds spent by civil society organizations under results-based agreements/contracts with the NHAC to facilitate the implementation of targeted program interventions for key populations at higher risk from zero in 2008 to 100% in 2013.

M&E
• Strategic Plan for the period of 2013-2018 prepared taking into account knowledge, attitudes and practices (KAP) and seroprevalence survey data, and BCC evaluation results.

A. Project components

Component 1: Prevention and Care (US$ 88.06 million)

10. This component would contribute to the implementation of the 2008-2013 Barbados National HIV/AIDS Strategy, specifically of the following three programs:

• National Program Coordination and Monitoring. This program aims at strengthening the ability of the public and private sectors and civil society to coordinate, monitor and evaluate their activities and use data to continually increase the quality of their programs. Specific activities would include (i) building capacity that would help the GOB and civil society increase their ability to formulate a vision, policies, strategies, and plans of action; mobilize financial resources; and conduct operations relevant to HIV/AIDS; (ii) strengthening surveillance; and (iii) addressing the critical issue of M&E within the HIV/AIDS Program. An existing Public-CSO Grant System (Annex 6) would be further developed under this program.

• Scaling up Prevention Efforts. This program aims at increasing access to preventive services, particularly (i) behavior change communication, (ii) HIV/AIDS and STI prevention and treatment, and (iii) condoms, with a special focus on key populations at higher risk. These activities are often difficult politically or culturally to start, but once started are relatively easy to maintain. Prevention activities would be implemented in close cooperation between public agencies and civil society organizations.

• Diagnosis, Treatment and Care. The goal of this program is to increase the length and quality of life of PLHIV. The program aims at increasing PLHIV access to diagnostic services, treatment services (ART and treatment for opportunistic infections) and social care and support (counseling, support groups, drug addiction therapy, and home care), as follows: (i) testing services would be expanded into community organizations, including those working with vulnerable groups; (ii) treatment would be decentralized on a phased
basis to the polyclinics that provide free government health services to the entire island; and (iii) referral systems to social care would be strengthened, including assigning each PLHIV to a social worker.

Component 2. Institutional Strengthening (US$ 4.39 million)

11. This component would finance training and technical assistance on M&E, management, surveillance, prevention, diagnosis, treatment and care of HIV/AIDS and other STIs, to support the implementation of the Strategic Plan. The objective of this component is to strengthen agencies and civil society organizations through training and technical assistance that cannot be funded under the regular program. While routine surveillance, seroprevalence and behavioral surveys, and quality audits would be carried out under Component 1, the second component would include non-routine training and technical assistance to review the surveillance system, and put in place sero- and behavior surveillance and quality audits and assist with standardization of data collection methodologies, particularly in the case of behavior surveillance. Component 2 would follow Bank procurement rules, and disburse over the life of the project against SOEs.

Safeguard policies that might apply

12. Only one safeguard policy, Environmental Assessment (OP/BP/GP 4.01), is triggered. Given that this is a follow on project, with no new construction envisaged, no new environmental assessment was required. The environmental assessment was updated in relation to ongoing health care waste management activities. Even though project activities would result in increases in health care waste, this added volume would be accommodated by the health care waste management system that was put in place with support from the first project. The second project would monitor the proper disposal of health care waste by health care providers supported by the new project.

Tentative financing

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