NATIONAL STRATEGIC PLAN

Expanded Response to HIV/AIDS for Aruba
2003 - 2007

Government of Aruba
November 15, 2002

Preface

This National Strategic Plan for an Expanded Response to HIV/AIDS for Aruba was prepared by an independent consultant, Stewart Smith. The Consultant, in consultation with the Government and people of Aruba, after extensive dialogue, document review and national consultation. The document as the *National Strategic Plan for an Expanded Response to HIV/AIDS for Aruba 2003 –2007* which will guide the national strategic response to HIV/AIDS in Aruba for the period 2003 – 2007.

The Consultant acknowledges The Governemnt of Aruba, His Excellency, The Governor, The Members of Parliament, The Prime Minister, The Minister of Health and The Minister of Finance and Economic Affairs. officials of the different Ministries, the United Nations Development Programme (UNDP) Trinidad and Tobago Country Office and the UN AIDS Theme Group for their invaluable support and commitment to the successful completion of this project.

The National Strategic Plan was presented to The Prime Minister and Parliament of Aruba on November 25, 2002.

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Acronyms and Abbreviations

ABC	Aruba, Bonaire and Curacao
ACP	Association of Caribbean and Pacific States
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
ASGS	AIDS Support Group Saba
ASNA	AIDS Society of the Netherlands Antilles
ATFA	AIDS Task Force of Aruba
AZT	Azidothymidine (now called Zidovudine)
BSA	Broad Strategic Areas
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CARIFORUM	Caribbean Forum of ACP States
CBO	Community Based Organization
CCF	Country Cooperation Framework
CCM	Country Coordinating Mechanism
CDB	Caribbean Development Bank
CDC	Centre for Disease Control
CIDA	Canadian International Development Agency
CMC	CAREC Member Country
CMO	Chief Medical Officer
CRN+	Caribbean Regional Network of People Living with HIV/AIDS
CSW	Commercial Sex Worker
DFID	Department For International Development
EC	European Commission
EDF	8th European Development Fund
EU	European Union
FBO	Faith Based Organization
FTC	French Technical Cooperation
FTE	Full Time Equivalent
GDP	Gross Domestic Product
GTZ	German Technical Cooperation
HCP	Health Care Professionals (Workers)
HEU	Health Economics Unit (UWI)
HFLE	Health and Family Life Education Programme
HIV	Human Immunodeficiency Virus
HSRP	Health Sector Reform Programme
IEC	Information, Education and Communication
ISP	Insular Strategic Plan
KAPB	Knowledge, Attitude, Perception and Behaviour
MOH	Ministry of Health
MSM	Men who have Sex with Men
MTCT	Mother To Child Transmission
NAC	National AIDS Committee
NAN	Netherlands Antilles
NAO	National Authorizing Officers
NAP	National AIDS Programme
NAPC	National AIDS Programme Coordinator
NCC	Net Contributor Countries
NGO	Nongovernmental Organization
NSP	National Strategic Plans
NXA	National Executing Agreement
OCT	Non-independent Overseas Countries and Territories

Acronyms and Abbreviations (Continued)

OECD	Organization for Economic Cooperation Development
PAF	Programme Acceleration Funds
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership
PHLIS	Public Health Laboratory Information System
PIT	Island's Project Implementation Teams
PLWHA	Person Living with HIV/AIDS
PMG	Project Management Group
PSC	Project Steering Committee
SARA	Situation and Response Analysis
SBA	Standard Basic Agreement
SSS	St. Maarten, Saba and St. Eustatius
SPTI	Special Programme for Sexually Transmitted Diseases
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UWI	University of the West Indies
VRG	Vulnerable Risk Groups
VTC	Voluntary Testing and Counselling
WHO	World Health Organization

1.0 Summary

A truly vibrant economy matched with positive economic growth and expansion has attracted a large number of immigrants to the island shores of Aruba in the last decade. This migration phenomenon coupled with its youthful population (50% below the age of 50), its relaxed atmosphere, cool tropical climate, inviting white sand and engaging blue water creates the ideal environment for romantic exchanges between visitor and national alike.

A review of the available Caribbean literature show that there is a paucity of documentation on HIV/AIDS in the Dutch Caribbean territories. Life expectancy at birth for both men and women continues to be above average of the rest of the Caribbean with 70 for males and 76 for females, indicating that the impact of the number of death from HIV/AIDS over the past 20 years have not had a negative or even a significant impact on mortality. Also it is interesting to note that the mortality data does not include a category for AIDS deaths as it appears not to be significant enough to be included among the major cause of mortality. However, this is not to suggest that HIV/AIDS is not a problem for Aruba.

As at October 2002 the cumulative number of HIV seropositive reported cases over the period 1987 to October was 372, giving a point prevalence rate of 0.4%. This figure compares favourably to the Caribbean prevalence statistic of 2% in the adult population. An estimated 2.8 million people in the Americas are currently living with AIDS – including the 235,000 people who contracted the virus last year. However, significant differences are clearly visible in the intensity of the HIV/AIDS epidemic and its transmission trends. Thus, in Latin America there are 1.4 million people living with HIV/AIDS; in the Caribbean, 420,000; and in North America, 940,000. The relative increase in the number of new infections is higher in the Caribbean (16%), followed by Latin America (10%) and North America (5%).

Statistical figures that are available on the HIV/AIDS epidemiology are based on reported seropositive cases. The true number of HIV infected people, and people living with AIDS in Aruba are not known. The reported HIV cases are yearly cumulative totals. Since some of these persons may have left the country, have developed AIDS, or have deceased, the HIV prevalence in any given year cannot be established accurately. The cumulative number of reported HIV seropositive cases over the period 1987 to 2000 is 334. Between the first diagnosed case and 1993, the average annual growth in new cases per annum was about 13 persons. For the period 1993 to 2001 the average number of new cases per year has been 30. The HIV incidence over the year 2000 was of 28.9 per 100,000 inhabitants. However, the incidence of HIV+ cases over the last years has stabilized; the incidence of the age group 0-4, 49-59 and 60+ is decreasing, whereas the incidence of the age group 15-39 has stabilized.

Most of the reported HIV cases (65%) have been in the age group 20 to 39 years at the time the seropositive status became known to the infected person. 10 cases were reported in the age bracket 0 to 4 years. The male to female ratio is 1.5 to 1 with the predominant transmission mode being heterosexual. There is no data to suggest the transmission of HIV by blood transfusion, or by the use of infected needles in intravenous drug use. The figures show a very low rate of mother to child transmission. One third (34%) of the reported seropositive persons are from Aruba, 55% are from abroad, including those applying for working permits, and 12% are unknown.

Over the period 1987 to 2000, 47 cases of AIDS (33 male) have been reported. Besides age and gender, there is no additional statistical information available that could serve to compose a socio-economic profile of the infected population. Most practitioners seem to think that if such a profile were to be composed it would indicate *"people from all walks of life."* The perception of medical practitioners regarding the stage of the epidemic therefore is that it is spread across the community.

With a total prevalence of over 2% in the adult population, the Caribbean is the second most affected region after sub–Saharan Africa. Aruba therefore by comparisons would appear to be doing well. The countries with the highest prevalence rates in the Caribbean are The Bahamas and Haiti, where the rates in the adult populations are above 4% approaching 5% respectively.

The perinatal mortality data from as late as 1999 does not indicate a problem of vertical transmission of HIV/AIDS from mother to child. Again, suggesting that HIV/AIDS may not be a problem for Aruba. The positive side of this analysis is that the problem is not as significant as in other countries in the region where general prevalence is estimated at 2%. However, what the data does suggest is that it is important that the necessary steps be taken at this time to ensure that the situation does not worsen and paint a different statistical picture five or ten years from now.

The most vulnerable group in Aruba continues to be young people and young women of childbearing age. Also at risk are commercial sex workers (CSW), men who have sex with men (MSM) and immigrant workers who do not belong in stable family relationships.

Five broad strategic areas (BSA) have been identified to inform the strategic response to HIV/AIDS in Aruba. The five BSA identified were:

- Health Promotion for Behaviour Change
- Diagnosis, Treatment, Care and Support
- Surveillance and Epidemiology
- Advocacy and Partnerships
- Institutional Strengthening and Resource Mobilization

2.0 Introduction

2.1 The Caribbean Perspective on HIV/AIDS

Coming out of the October 2002 Pan Caribbean Partnership Meeting held in Guyana, it was noted that after 20 plus years of evolvement that the HIV/AIDS epidemic has impacted negatively on all Caribbean countries and that trends of the epidemic, success stories which can be replicated and lessons learnt by other Caribbean countries should be used to strengthen the regional responses to the epidemic.

The Nassau Declaration – "The Health of the Region is the wealth of the Region", which was issued during the 22nd Meeting of CARICOM Conference of Heads of Governments held in Nassau, The Bahamas in July 2001 placed HIV/AIDS firmly on the political agenda of the Governments of CARICOM. This declaration emphasizes the critical role of health in development and the importance of strategies designed to reduce the spread of HIV/AIDS that is fast eroding the regions human capital. These strategies include: *Strategic Planning*; *Management; Resource Mobilization, Institutional Strengthening and Sustainability*, including the strengthening of PANCAP as the all-inclusive HIV/AIDS network of Caribbean countries and partners.

Two key document guide the direction of the work of PANCAP, namely

- *The Caribbean Regional Strategic Framework on HIV/AIDS 2002 –2006*, which is based on the Regional Strategic Plan prepared by the Caribbean Task Force on HIV/AIDS; and
- The CARICOM Secretariat Plan of Action for the fight against HIV/AIDS, which is intended to guide the PANCAP Secretariat and the CARICOM Secretariat in coordinating the regional response to HIV/AIDS.

The foregoing information is provided in the context that at the discussions at the Guyana meeting with respect to the structure and function of PANCAP, delegates considered the need for PANCAP to be more inclusive and broader than CARICOM so that it can truly represent the Caribbean and become the forum for all partners to interact, with the result being grater collaboration and co-ordination between and among all Caribbean countries and territories.

It is noted that Aruba is not a member of CARICOM, however it is hoped that by spring 2003 PANCAP would have amended and broadened its structure to include all partners and that Aruba will accept to be part of this wider HIV/AIDS Caribbean initiative.

2.2 Macro Caribbean HIV/AIDS Context

During the past year, renewed concern about the HIV/AIDS pandemic has resulted in the significant new opportunities to improve national and regional responses in the Caribbean region for HIV/AIDS prevention and control. Initiatives such as the Declaration of the United Nations General Assembly Special Session; the establishment of the Global Fund to fight HIV/AIDS, Tuberculosis, and Malaria; as well as the growing interest of the World Bank, the Inter-American Development Bank and other bilateral and multilateral agencies in this issue, as well as the sub regional approaches and technical cooperation among countries, provide the framework of political-financial and scientific programmatic support that will make it possible to step up prevention and care activities for HIV/AIDS in every country in the region.

With a total prevalence of over 2% in the adult population, the Caribbean is the second most affected region on the planet, after sub –Saharan Africa. The countries with the highest prevalence rates are The Bahamas and Haiti, where the rates in the adult populations are above 4%.

Heterosexual transmission of HIV continues to be responsible for the almost three quarters of the cases in the Caribbean. In the United States for example, transmission among men who have sex with men is responsible for roughly 50% of the cases. The emergence of the pandemic and recognition of the gravity of the impact of other sexually transmitted infections has heightened awareness of the urgent need for activities designed to change behaviour and sexual practices. There is a move towards comprehensive care programs, which should include clinical management, nursing care, counselling and emotional and social support.

2.3 HIV/AIDS Planning in Aruba

Consequent upon the completion of an HIV/AIDS Situation and Response Analysis for Aruba and the Netherlands Antilles in September 2001 which has taken place with the support of the United Nations Development Program, Trinidad and Tobago Country Office, a National Consultation was held on September 26 and 27, 2002 in preparation for the development of a National Strategic Plan for an Expanded Response to HIV/AIDS in Aruba. Following this two-day (2) National Consultation a Sensitization and Advocacy Session with the Prime Minister, Minister of Health, Minister of Finance and Economic Affairs and Minister of Labour, Culture and Sports and Members of Parliament was conducted on Monday September 29, 2002.

The following proposal represent the outcome of those investigations and consultations and represents the collective wisdom of a cross section of Aruban nationals who have contributed to the information contained in this national response for HIV/AIDS in Aruba.

3.0 Country Overview

3.1 Aruba Island Profile

The island of Aruba is part of the West Indies in the Caribbean Sea, and lies approximately 30 kilometers (18 miles) off the Paraguaná Peninsula of Venezuela. It is the smallest and most western island of a group of three Dutch Leeward Islands, the so-called ABC-islands (Aruba, Bonaire, Curaçao). Aruba is about 30 kilometers long and 8 kilometers wide, and encompasses an area of 194 km. The capital is Oranjestad, named after the Dutch House of Orange. Aruba is geographically divided into 6 districts, which are Noord, Oranjestad, Paradera, Santa Cruz, Savaneta and San Nicolas.

The climate is tropical but not extreme. The temperatures range between 24 -29 ºC (75-85 º F), with trade winds cooling the island. Rainfall averages about eighteen inches a year, with October, November, December and January accounting for most of it. Aruba lies outside the hurricane belt and usually only experiences fringe effects of nearby heavy tropical storms, if at all.

Dutch is the official language. It is used both in education and in the civil service. The native language is Papiamento, which is spoken exclusively on the ABC-islands. It is used in Parliament as well as in the media. English and Spanish are compulsory in the last grades of primary school and are spoken by a large part of the population.

3.2 Political Structure

Historically, Aruba has been part of the Netherlands Antilles, a six-island federation, which also included Bonaire, Curaçao, St. Maarten, Saba and St. Eustatius. On January 1, 1986, Aruba became a separate entity within the Kingdom of the Netherlands. The Kingdom now consists of three constituents: the Netherlands, the Netherlands Antilles (5 islands), and Aruba.

Aruba has its own constitution, based on Western democratic principles. The Queen of the Netherlands appoints the governor of Aruba who holds office for a 6-year term, and acts as her representative. Legislative and judicial powers are vested in parliament, which is housed in Aruba's capital, Oranjestad. The Aruban parliament consists of 21 members elected by universal suffrage. The cabinet thus formed consists of a maximum of nine ministers and is headed by the Prime Minister.

The last elections were held in September 2001. The present Parliament is formed by: a Social-Democratic party, M.E.P. (12 seats), two Christian-democratic parties A.V.P. (6 seats) and P.P.A. (2 seats) and a liberal party, O.L.A. (1 seat). Although the government of Aruba can be considered as a stable one, during the last decade no administration period has fulfilled the 4-year term.

Aruba is responsible for its own administration and its policy, except for defense, foreign affairs, and the Supreme Court, which are cared for by the Netherlands. Although Aruba has a separate status, it still retains strong economic, cultural, and political ties with Holland and her "sister" islands.

3.3 Socioeconomic Profile

In 1998 the proportion of Government expenditures on health was about 5.3% and 1.6% on social affairs. During the period 1986-1990 the average growth rate of the real Gross Domestic Product (GDP) in Aruba was 13.83 % per annum whereas during the period 1991-2001 this growth rate decelerated to 4.65 %. Real GDP per capita reached the level of US$ 17,303 per person in 2001.

Gross Domestic Product 1992-2001

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
GDP (in US$M)										
Nominal GDP	959	1083	1,246	1,321	1,380	1,532	1,665	1,725	1,858	1,884
Nominal Growth	9.9	13.0	15.0	6.0	4.5	11.0	8.7	3.6	7.8	1.4
Real GDP	1110	1191	1288	1321	1337	1441	1537	1556	1,612	1,589
Real Growth (%)	5.9	7.3	8.2	2.5	1.3	7.8	6.7	1.2	3.6	-1.4
Inflation (Avg.)	3.8	5.3	6.3	3.4	3.2	3.0	1.9	2.3	4.0	2.9

Source: Dept. of Economic Affairs, Commerce and Industry, Central Bank Aruba & Central Bureau of Statistics.

The rapid growth of the economy in the early nineties resulted in relatively high inflationary pressures. The annual inflation rate was approximately 6.3% in 1994. However, Government succeeded in decreasing inflation to 2.9 % in 2001[i] The total population increased from 66,687 in 1997 to 90,506 in 2000, which is a 36% increase, most of which is to be attributed to domiciliation of immigrants (refer to table of vital statistics).

Vital Statistics 1994- 2000

Description	1994	1995	1996	1997	1998	1999	2000
Live births	1315	1419	1452	1457	1315	1225	1294
Deaths	431	504	469	497	505	554	531
Natural increase	884	915	983	960	810	671	763
Domiciliation	3287	4094	4950	4007	3416	3345	3535
Departures	1811	1690	1625	1566	2031	2265	2580
Net migration	1476	2404	3325	2441	1385	1080	955
Total population change	2360	3319	4308	3401	2195	1773	1718

Source: Central Bureau of Statistics and Registry Office

The main economic activity in Aruba is the service sector, in which the tourism industry is the major player and contributor. Tourism worldwide is very competitive, especially in the Caribbean, where

most islands have the same limitations for economic development and have basically the same natural resource base, with the exception of a few, i.e., sun, sea and sand. Caribbean islands have become more dependent on tourism as the main contributor to social and economic development. Aruba's market share of the Caribbean tourism market increased from 2.1% in 1986, to 4.3% in 1997. The main market sources are the USA with almost 61.8% of total arrivals, Venezuela with 15.2% and the Netherlands with 4.7%. Other emerging markets are Brazil, Argentina, Canada, and the Netherlands Antilles. From 1986 to 1997, the number of hotel rooms increased from 2,524 to 6,687. The number of stay-over visitors increased from 181,012 to 649,893. The average occupancy rates of the hotels were in excess of 70%.[ii]

In the last three decades, the highest unemployment experienced by Aruba was in 1985 (28.0%), when the oil refinery LAGO closed down. This was a hard blow to the economy. Accelerated investment in the labour intensive hotel sector and the construction sector in the late eighties and the first half of the nineties, and the re-opening of the oil refinery have put enormous pressures on the local labour market. Therefore many of the newly created jobs in the economy had to be filled by foreign workers. Statistics show that in 1988, the total population census was approximately 61,045 inhabitants of which 14,044 were immigrants (23.1%), while in 1995 the total population had grown to 83,652 inhabitants of which 26,919 immigrants (32.2%), mostly from Colombia, Dominican Republic and Venezuela.[iii] In 1997 the non-Aruban population represented 27% of the working age population.

With the increase in population, employment also increased from 29,127 in 1991 to 41,501 in 1997. The unemployment rate has increased as well, from 6.1% in 1991 to 7.4% in 1997. Before 1990, the participation rate of women in the labour market was at a very low level, though slowly increasing. From 1991 onwards, a greater number of working women, especially in the age group 30-44 years has been noted.

Percentage of Unemployment by Gender

Year	Male	Female	Total
1991	5.9	6.3	6.1
1994	5.7	8.0	6.4
1997	6.7	8.4	7.4

Labour Force Survey, 1997

The unemployment rates for the age category 15-24 have increased significantly from 1994 to 1997. This can be attributed to the number of persons graduating from secondary school and have made themselves available for employment to the labour market. In the over 65 age group category the employment rate has decreased. This is due to the fact that most of the people are retired and receive a pension from the Social Insurance Bank (S.V.B.).

Employment and Unemployment Rate by Age group 1994-1997 (/1000 inhabitants)

Age group	Employed rate 1994	Employed rate 1997	Unemployed rate 1994	Unemployed rate 1997
15-24	377.7	326.6	48.6	83.9
25-64	712.2	702.2	44.4	43.8
>65	91.0	67.8	0	0

Labour Force Survey, 1997

People from South America and the Caribbean islands have the highest percentage of employment compared with the other foreign nationalities. However, they also have the highest percentage point unemployment rate and non-activity. This could have social consequences such as isolation of individuals, poverty and spur criminal activity.

Labour Dynamics by Nationality (1997)

Nationality	Employed %	Unemployed %	Non-active %
Dutch	49.3	3.6	34.6
North America	0.3	0.0	0.2
Central America	0.1	0.0	0.1
South America	4.7	0.5	1.4
Caribbean islands	3.0	0.4	0.6
Europe	0.3	0.0	0.2
Asia	0.4	0.0	0.1
Africa	0.0	0.0	0.0
Oceania	0.0	0.0	0.1

Labour Force Survey, 1997

At present, the tourism sector is the largest single employer in Aruba. Tourism also contributes to indirect employment in restaurants and casino's, transport and water sports as well as spin off employment generated in construction, trade, services and other sectors. Of total jobs in 1997, approximately 17% are directly created in the hotel industry.

3.4 Socio-Demographic Profile

The total population of Aruba in 2000 was 90,506, of which 48.0% were males and 52.0% were females. The density of population has increased steadily from 341 inhabitants/km² in 1985 to 502.8 inhabitants/km² in 2000.

The fertility rates for the years 1995-1999 decreased steadily from 68.2 (1995) to 48.4 (2000) per 1,000 women 14-44 years of age. The crude birth rate also decreased from 17.4 in 1995 to 13.8 in 2000 for 1,000 inhabitants. In the year 2000 life expectancy at birth were 70 years for males and 76 years for females.

Fertility Rates, Birth Rates, 1995-2000

Year	Female population 14-44 years	Live Births	Fertility rates/1000 (Women15-44 years)	Birth rates/1000
1995	20,806	1,419	68.2	17.4
1996	21,789	1,452	66.6	16.9
1997	22,788	1,457	63.9	16.3
1998	22,957	1,315	57.3	14.2
1999	23,262	1,225	52.7	13.0
2000	25,858	1,252	48.4	13.8

Source: Central Bureau for Statistics

The population of Aruba can be considered young, since 52.7% is below 35 years. Though this might be true, there is an increase in the ageing population as people continue to live longer, a phenomenon that will have to be addressed both at the health and social services sector level. The percentage of the population older than 65 years was 6.6% in 1995; in 1999 it increased slightly to 7.1%. The population increase in Aruba has been as a result of an increase in the number of immigrants, who belong to the working class age group. Between 1991 and 1999 the absolute number of 65-plussers has increased with 43.2%. In 1999, as could be expected considering the higher life expectancy for women, the 65-plus population has a higher percentage of women (57.6%) then men (42.4%).

3.5 Mortality

Between 1995 and 1999 the mortality rate ranged between 6.2 and 5.3 per 1,000 inhabitants. The mortality data have been coded since 1996 using the International Classification of Diseases 10th edition (ICD-10). In 1999, there were a total of 548 deaths: 37.1% were attributed to diseases of the circulatory system, 19.2% to malignant neoplasms, 8.2% to external causes and poisoning, 8.0% to communicable diseases and 1.1% to certain conditions originating in the perinatal period. Between 1996 and 1999, diseases of the circulatory system and malignant neoplasms have occupied consistently, in that order, the first and second place of the leading causes of death while communicable diseases, external causes and poisoning have been alternating for the third and fourth positions. The category of Certain Conditions Originating in perinatal period has been constant over the years at an average of 1% of the total mortality.

Raw Mortality Rate, 1995-1999

Year	Population	Deaths	Deaths/1000
1995	83,652	513	6.2
1996	87,971	464	5.3
1997	92,026	492	5.4
1998	93,428	497	5.4
1999	95,201	548	5.8

Source: Central Bureau for Statistics

Like with developed western nations Aruba's mortality is primarily due to the so-called diseases of civilization (heart disease, cancer etc.), mainly as a result of unhealthy lifestyles. Communicable diseases have been brought under control.

Proportional Death Rate (%)

Causes of Death 1996-1999	1996	1997	1998	1999
Symptoms, Signs and Ill-defined Conditions	4.3	7.1	5.2	7.3
Communicable Diseases	5.4	10.6	10.1	8.0
Neoplasms	19.8	17.3	22.1	19.2
Diseases of Circulatory System	36.2	33.7	34.2	37.1
Certain Conditions Originating in perinatal period	1.3	1.0	1.2	1.1
External Causes and Poisoning	8.0	9.6	9.7	8.2
All other Diseases	25	20.7	17.5	19.0

Source: Department of Public Health, Epidemiology & Research

The more detailed data for the causes of death for 1999 show some differences between the sexes. Diseases of Circulatory System and Neoplasms constitute the leading causes of death for both male and female. For the males the next leading causes of death are external causes and poisoning, which represent 13.2% of all causes of death, while in females, this represent 2.4%. For the female population communicable diseases are the third leading cause of death (9.1%) while in males it is the fourth leading cause of death, accounting for 7.1%.

Cause of Death by Gender 1999
Proportional Death Rate (%)

Causes of Death	Male	Female	Total
Symptoms, Signs and Ill-defined Conditions	7.5	7.1	7.3
Communicable Diseases	7.1	9.1	8.0
Neoplasms	19.0	19.4	19.2
Diseases of Circulatory System	36.6	37.7	37.1
Certain Conditions Originating in perinatal period	0.7	1.6	1.1
External Causes and Poisoning	13.2	2.4	8.2
All other Diseases	15.9	22.6	19.0

Source: Department of Public Health, Epidemiology & Research

Conditions originating in the perinatal period account for the highest mortality among children under 1 year old. For the age categories 1-4 and 5-9 years, the causes of death are communicable diseases and external causes and poisoning. The leading cause of death in the age category 10-19 years is external causes and poisoning. All the cases were male. Diseases of the circulatory system and neoplasms are the most important causes of death in the age category 20-64 years. External causes and poisoning take the third position in this age category. In this age category, causes of death due to diseases of circulatory system and external causes and poisoning are more common in males than in females, while neoplasms are more frequent in females. In the highest age category diseases of the circulatory system and neoplasms are the main causes of death while communicable come in third place.

4.0 Situation and Response Analysis - Aruba

The Situation and Response Analysis was commissioned by the United Nations Development Programme (UNDP) Trinidad & Tobago Country Office and carried out in the Netherlands Antilles and Aruba in the period July 15 to August 20, 2001.

In September 2001 a consultant, retained by the UNDP Trinidad and Tobago Country Office, presented a report on the Situation and Response Analysis for Aruba and the Netherlands Antilles to the United Nations Development Programme, Trinidad & Tobago. The review revealed that there was a gap between desired and actual state of the response to HIV/AIDS and that the gap appeared large. The report stated however that there appeared to be no paucity of relevant HIV/AIDS guiding policy in Aruba. What was offered as an explanation for this gap was insufficient attention being given to the implementation of policy reform, i.e., how policy change should be accomplished. The problem has been diagnosed as one of implementation and not one of policy direction.

Prevalence, incidence and the infected population in Aruba

Statistical figures that are available on the HIV/AIDS epidemiology are based on reported seropositive cases. The true number of HIV infected people, and people living with AIDS in Aruba are not known. The Epidemiology & Research Division of the Department of Public Health of Aruba obtains these figures from the Public Laboratory. There are also private laboratories where blood samples are tested for the presence of the HIV virus that do not report at all times to the Department of Public Health. For these reasons and the fact that there are cases tested abroad, which are not reported, the figures reflect only part of the total infected population.

Immigrants who apply for a work permit must follow a number of procedures. One such procedure is a medical test, which includes a blood sample test for the presence of the HIV virus. These tests are done at the Public laboratory. In the interest of public health the seropositive applicants who do not pass the medical test are denied a work permit. The policy of the Department of Public Health is to guide and encourage these applicants to return to their supportive family environment. For the purpose of surveillance these seropositive cases are reported to the Epidemiology & Research Division, where they are added to the other cases. The proportion of these cases relative to the cumulative total of cases is estimated at a little over 40%. The majority of these immigrants do return to their countries, making it impossible to determine how many developed AIDS or died of AIDS.

The reported HIV cases are yearly cumulative totals. Since some of these persons may have left the country, have developed AIDS, or have deceased, the HIV prevalence in any given year cannot be established accurately. The following picture emerges from available figures.

- The cumulative number of reported HIV seropositive cases over the period 1987 to 2000 is 334.
- Between the first diagnosed case and 1993 the average annual growth in new cases per annum was about 13 persons. For the period 1993 to 2001 the average number of new cases a year is 30. The HIV incidence over the year 2000 was of 28.9 per 100,000 inhabitants.
- The HIV + incidence of the last years has stabilized; though the incidence of the age group 0-4, 49-59 and 60+ is diminishing and of the age group 15-39 has stabilized.
- Most of the reported cases (65%) were in the age bracket 20 to 39 years at the time the seropositive status became known to the infected person. 10 cases were reported in the age bracket 0 to 4 years.
- The male to female ratio is 1.5 to 1.
- The predominant transmission mode is heterosexual. There seems to be no indication of transmission by blood transfusion, or by the use of infected needles in intravenous drug use. The figures show a very low rate of mother to child transmission.

- One third (34%) of the reported seropositive persons are from Aruba, 55% are from abroad, including those applying for working permits, and 12% are unknown.
- Over the period 1987 to 2000, 47 cases of AIDS (33 male) have been reported.
- Besides age and gender, there is no additional statistical information available that could serve to compose a socio-economic profile of the infected population. Most practitioners seem to think that if such a profile were to be composed it would indicate *"people from all walks of life."*
- The perception of practitioners regarding the stage of the epidemic therefore is that it is spread across the community.

Institutional framework and the response in Aruba

Sero-positivity screening is performed by the Public Laboratory of Aruba using ELISA-test and the LIATEK for confirmatory testing. Most of the screening done by private laboratories using ELISA is being confirmed by the Public Laboratory. Pre-test and post-test counselling is available through the Division of Contagious Diseases of the Department of Public Health, which is part of the Voluntary Testing and Counselling Programme (VTC). Contact tracing is also done on reported cases. Specialized Laboratory tests such as CD4, CD8 and viral load are done outside of Aruba, e.g. Curacao, Netherlands, Colombia and Venezuela. Most of the HIV/AIDS patients are under control of an Internist.

Once the infected person knows of their HIV seropositive status, clinical care and counselling is made available to the client. Patients receiving medical treatment (ART) obtain their supply of "triple therapy" through the Division of Contagious Diseases once they have a prescription from their doctor. This is done in order to guarantee continuity in treatment and counselling. The therapy is available to all infected residents of Aruba and is covered by the General Medical Insurance. AZT is used in cases of HIV infected pregnant women and the newborn child. The General Medical Insurance also covers AZT.

Aruba has one Hospital, the Dr. Horacio Oduber Hospital, which is a private and non-profit hospital, administered by a foundation. It is considered an average size hospital, having 264 inpatient beds and admits HIV/AIDS patients who require inpatient treatment and care. Nurses have received training in the management and care of HIV/AIDS patients, but there is still a fear and anxiety with respect to the risk of HIV infection through contact with patients. This is due to the stigmatization and discrimination that comes along with the disease.

HIV/AIDS Country Coordinating Structure in Aruba

There are three HIV/AIDS focused organizations in Aruba. A Commission of the Department of Public Health, AIDS Task Force Aruba (ATFA), Women's Club of Aruba and the UNAIDS Theme Group.

ATFA is a working group, consisting of government officials of the Department of Public Health charged with the specific responsibility of providing technical advice to the Minister of Public Health on policy regarding HIV/AIDS issues**.** The Women's Club of Aruba is an NGO that has worked in the area of HIV/AIDS prevention from the beginning of the epidemic until now and was instrumental in the creation of the first National AIDS Committee Aruba (NACA). This NGO is active in AIDS awareness and education and in community mobilization.

The UNAIDS Theme Group is a multi-sectoral group that consists of representatives of government departments, non-government organizations and the private sector. The chairman of the group is the UNDP Residents Representative in Trinidad and Tobago. A strategic plan was developed by the UNAIDS Theme Group for the period 1999-2001 which presented a comprehensive program for prevention and control of HIV/AIDS in Aruba. The plan was developed by the UNAIDS Theme Group and implemented by a sub-working group of that planning committee. The UNAIDS working group consists of the same Theme Group representatives, but without UN participation. ATFA and the Women's Club of Aruba are also represented in the UNAIDS Theme Group. A UNAIDS focal point has been appointed and has a coordination function.

Information, education and other preventive services are also provided by:

- Department of Public Health, Division of Contagious Diseases and ATFA;
- Women's Club of Aruba;
- UNAIDS Theme Group;

For the purpose of surveillance, physicians are requested to report the results of their seropositive patients to the Department of Public Health through the Division of Contagious Diseases. Physician compliance and cooperation in this area are still lacking. Reasons quoted for their non-compliance include the absence of patient privacy and confidentiality being ensured once the results are released to the government department and doctor patient confidentiality. Most doctors are still not optimistic and therefore continue not to fully comply.

Information collected however by the Department of Public Health through the Division of Epidemiology and Research and from the Division of Contagious Diseases is analyzed to provide statistical information about the epidemiology of the disease on the island.

Areas identified for further Development

Information relevant for policy planning

- Available statistics on HIV/AIDS do give a clear picture of the magnitude of the epidemic. However, more information is needed to provide a more focused insight into the prevalence of HIV

infected persons, persons living with AIDS, as well as AIDS mortality. In Aruba the reporting and communication system between physicians and the Department of Public Health needs to be improved.

- There is little insight into the socio-economic and demographic dynamics of the epidemic. Existing data collection sources include a very limited number of variables (primarily gender and age). This may also contribute to the absence of information projecting the future path of the epidemic. The absence of this type of information compromises the ability of the Department of public Health to determine the longer-term impact on both the society and the economy.

- Information on the precise estimates for the demand for care of the HIV infected population is insufficient. This data is a function of the foregoing two points.

- Vulnerable groups such as CSW have been identified as high priority groups to be targeted for preventative policy actions. However, specific data on these groups is not available. There are two groups of CSW, the legal and the illegal CSW. The legal CSW do get regularly medical check-up, however the illegal CSW and escort services need to get attention and policy needs to be in place. There is need for special research studies in this area and other vulnerable risk group (VRG).

- Information on the effectiveness and efficacy of policy interventions is very limited, if not non-existent. The last evaluation study of HIV/AIDS information and education programs has reportedly been conducted in the early nineties**.** Knowledge Attitude Beliefs Practice (KABP) research has been done in the early nineties. The age group was >18 years. It is recommended to repeat this study and include also teenagers younger than 18 years.

Treatment, Care, Support, Information, Education and Prevention

- AIDS patients receive inpatient care in the hospital whenever this is clinically indicated. One organization, The White Yellow Cross Foundation provides home nursing services to HIV/AIDS patients. However, it has been observed that that no AIDS patient has requested their services.

- Counselling is available to PLWHA and their families from the Department of Public Health at the request of the patient. The Government of Aruba has employed counsellors, through the Department of Public Health, Division of Contagious Diseases, to give counselling to PLWHA.

- HIV/AIDS taboo is still a major obstacle in the testing, treatment and care of PLWHA and contributes to the stigma and discrimination of PLWHA. This taboo is rooted in a complex set of

social and cultural factors that have not yet been fully explored and understood. Some of these factors are believed to be a false sense of shame coming from being connected to something that is perceived as a moral sin, fear of social isolation, fear of contamination, and strong skepticism about the ability of "the system" to maintain confidentiality about client status. The problems arising from this taboo can cause unnecessary suffering and can have far reaching consequences for both those infected and affected by HIV/AIDS. In Aruba the discrimination and stigmatization of the HIV/AIDS patients is still evident.

- Being HIV infected and/or living with AIDS brings about a great number of issues that influence ones living conditions and various environments. It remains unclear to what extent HIV/AIDS from the point of view of the infected, is incorporated into information, education and prevention policy. Because of the fear of being discriminated against and stigmatized, it is very difficult to get PLWHA in Aruba to participate and contribute to national information, education and prevention policy response.

- Several information, education and prevention programs have been implemented in the past, targeting both the collective population, as well as specific groups. Also, several organizations have been involved in these activities in some way and at some time or other. However there is a need to finance appropriate research and to keep up the campaigns on a continuous basis, and to recruit more personell to suport the National AIDS Progamme. There appears to be a quantity of goodwill and expertise regarding efforts to slow down the epidemic. The programme is supported by a multi-sectoral group. There is need however for more volunteers with skill in some specific areas.

- Aruba's SPDF-plan that was implemented in 1999-2001 was a systematic, continuous and targeted prevention plan, with specific objectives. An evaluation of the success of this plan is recommended.

- Key areas that are considered high priority for policy interventions are: clandestine commercial sex work, illegal immigrants, persons infected with HIV who consciously attempt to infect others, HIV on the work floor, the school-attending population, the school drop-out population, and an ethical/legal framework for HIV testing.

There is insufficient data to support the notion that the effective HIV/AIDS growth rate is constant or decreasing, which could be interpreted to mean that the epidemic may very well be growing at an accelerating pace.

Almost as many women as men are infected through predominantly heterosexual contact and most of these are young people in the productive and reproductive stages of their lives. The infection spreads fastest among these young people. These features of the epidemic are reasons for concern, given the now well-known potential socio-economic and demographic impact it may have in countries if left unchecked, in addition to human suffering that is already occurring. This concern may intensify in the years ahead. HIV/AIDS medical practitioners expect the effectiveness of triple therapy medication to decrease over time as resistance in patient's bodies to the medication may increase.

In Aruba, the scope of the HIV/AIDS response has been limited to mostly medical treatment, counselling, and basic informational prevention activities. A comprehensive and expanded response is now required as there are still too many "unknowns" regarding the magnitude and nature of the epidemic. Available data are not adequate to allow for a sufficiently sharp epidemiological image and for an understanding of the socio-economic and demographic dynamics of the epidemic and its potential future impact.

In Aruba, the HIV/AIDS professional community is generally as aware as can be expected of the state of the epidemic, the strengths and the shortcomings of the response to date, the constraints practitioners are facing, and what needs to be done better. In Aruba although less policy documentation is available, the awareness has increased in the last years. In addition, there appears to be significant of good will and expertise relative to the required efforts to curb the epidemic.

5.0 The Context of Strategic Planning

5.1 Methodology

The strategic planning methodology employed in the development of this National Strategic Plan is consistent with that designed and proposed by UNAIDS in its planning cycle. The planning process recognizes and builds upon the SPDF Action Plan and Time Line for Aruba for 2000/2001 as well as the Situation and Response Analysis conducted by an independent consultant for the UNDP Trinidad and Tobago Country Office. It is noted that no primary research was done in the compilation of information and/or data for this proposal. The process was also informed by an earlier National Consultation on HIV/AIDS for Aruba and the Netherlands Antilles in March 2002 in Aruba, again under the auspices of the UNDP Trinidad and Tobago Country Office, in preparation of a joint country-funding proposal for HIV/AIDS to the European Commission for funding under the 8th EDF. The Logical Framework developed during that process is used therefore to inform the strategic orientation of this document. The September 2002 National Consultation and the subsequent Sensitization and Advocacy session with the Parliament of Aruba were the final two inputs into the planning process.

a) National Consultation

A two-day (2) National Consultation on HIV/AIDS for the development of a national strategic expanded response to HIV/AIDS in Aruba was conducted on September 26 and 27, 2002. The primary objective of the workshop was to conduct a pre planning exercise with a wide cross section of key players and stakeholders with a view to soliciting the views of the stakeholders as to the direction of the HIV/AIDS response in Aruba, while at the same time seeking to solicit support for HIV/AIDS action through sensitization and information sharing.

The 2-day consultation consisted of formal presentations by the Hon Minister of Finance, the Acting Director of the Department of Public Health, the presentation of the Situation and Response Analysis and a full 2 day facilitated workshop that included experiential learning through the "Wildfire" exercise which simulated the spread of the HIV virus as a well as presentations on the *Strategic Planning Process*, the *Expanded Response concept* and the issues to consider in developing a *Country Coordinating Mechanism* for the expanded response to HIV/AIDS.

b) Sensitization and Advocacy Workshop

The Sensitization and Advocacy session with the Members of Parliament and Ministers, sought to sensitize the parliamentarians and the Government of Aruba on the importance of a national and expanded response to HIV/AIDS, as well as to brief the Honourable House as to the proposed agenda for the development of the National Strategic Plan. This session was both useful and successful.

5.2 Strategic Planning Framework

The national HIV/AIDS expanded response for Aruba has been designed to address and acknowledge the following: the current HIV/AIDS situation in Aruba; the response to date in terms of surveillance, education, control and treatment; the five year and ten year projection for the disease; identification of future strategies as well as defining the role of key stakeholders in an expanded response to HIV/AIDS. In defining possible strategies the following factors have been taken into consideration: the organizational maturity and readiness of the national HIV/AIDS program, the organizational capability and capacity in terms of institutional structure and resources, external support, executive commitment, internal commitment and buy-in, and the organizational need and impetus for change.

5.3 The Strategic Planning Structure

A situation and response analysis was conducted as an integral part of the strategic planning process, which would have included:

- An evaluation of the economic political, social, and cultural factors that impact on and is affected by HIV/AIDS
- A review of the epidemiology of STI and HIV/AIDS in the country
- Identification of the most vulnerable groups to infection
- Review of the organization structure and management of the program
- Review of the responses to date and factors which influenced success
- Identification of obstacles and opportunities in an expanded response
- Recommendation of areas for broad strategic action
- Development of a strategic framework for the development of annual work plans and action plans
- Wide dissemination of the results of the assessment and recommendations

5.4 Critical Success Factors

A number of critical success factors have been identified to ensure the functional success of the process and the implementation of the national strategic plan:

- Commitment at executive, senior managerial and technical levels
- Multi-sectoral approach to program planning
- Implementation and evaluation of the plan
- Government, NGO, CBO, FBO and business sector involvement in the process
- Involvement of people living with HIV/AIDS (PLWHA)
- Availability of resources (human and financial) to focus on HIV/AIDS prevention, care and support
- Development and promotion of a supportive environment as evident in the formulation of policies and programs that recognize the rights of people living with HIVAIDS
- Reduction in stigma and discrimination
- Ownership for the process and its outputs

5.5 Expanded Response to HIV/AIDS

A key feature of the September national consultation was the presentation of the Expanded Response Initiative to HIV/AIDS. Over the years a number of different approaches have been implemented in an attempt to slow the spread of HIV/AIDS and minimize its impact. However, the HIV/AIDS epidemic exists in an environment that has changed rapidly over a short period of time and is influenced by behaviours that are deeply rooted in social, cultural, political and economic circumstances. The epidemic is therefore more than just a health problem. It is a development problem with far reaching implications for governance of both society and economy. Most effective national responses to the HIV/AIDS epidemic have been those that are designed to meet the specific needs of the country, while embracing and addressing the circumstances that make people vulnerable to HIV/AIDS infection. But critical to the success of such programmes have been treatment, i.e., through the availability of

antiretroviral drugs, including triple therapy and vertical transmission reduction strategies as well as an expanded response that seeks to include both the public sector and the business community as well as NGO, media FBO and CBO in the battle against and response to HIV/AIDS. The principles of inclusion and collaboration continue to remain the cornerstone of a successful expanded response programme.

An effective response mechanism requires for strong political leadership, participation from all sectors (public and private), the creation of a supportive environment free from stigma and discrimination of people living with HIV/AIDS and of other vulnerable groups.

5.6 Mission, Vision and Philosophy

One key element of the planning process was defining the purpose of the organization challenged with the responsibility for providing leadership in the battle against HIV/AIDS in Aruba. This statement is commonly referred to as the mission of the organization. This statement should be an all-embracing embodiment of the purpose of the organization, which should provide overall direction to the organization and allow for the development of broad goals and specific objectives, as well as the development of strategies to achieve these goals and objectives.

Coming out of the workshop the following **mission statement** was adopted:

> *"To equip the Government and the people of Aruba with information and support services, designed to reduce the transmission and spread of HIV in Aruba through the promotion of behaviour change strategies and the development of clinical protocols for the management of the HIV/AIDS patients."*

The goal of the NSP is:

> *"To reduce the spread of HIV/AIDS and minimize the impact of the epidemic on individuals and communities in Aruba and to strengthen the capacity of National AIDS Programmes of Aruba so as to manage and provide sustainable programming for the mitigation, prevention and control of HIV/AIDS/STIs and care of people living with HIV/AIDS."*

The Vision statement is:

> *"That Aruba will be included in the wider Caribbean HIV/AIDS initiatives to fight against HIV/AIDS therefore benefiting from the wider experience, broader information base, resources and lessons learnt in the region and contribute to the regions knowledge and experiential base*

through it's own expertise and experience gained in mitigating the impact of HIV/AIDS in Aruba."

Philosophy/Statements of Beliefs:

- A zero tolerance policy on stigma and discrimination against PLWHA
- Inclusion of PLWHA in main stream society
- Safe non threatening work environments
- HIV/AIDS as a chronic disease

5.7 Statements of Expectations

The following statements represent the expectations of the new thrust of the National AIDS Programme coming out of the two day National Consultation and Sensitization Session with Parliament as articulated by the various participants. This statement is an embodiment of the sentiments and commitments expressed at both the national consultation participant level as well as the commitment expressed at the political level during the Sensitization and Advocacy Session. The statement speaks to an expectation that significantly exceeds the current capacity of the National AIDS Programme. The collective wisdom coming from the various audiences have expressed the following:

- To create a resource center designed to increase public information and public awareness about HIV/AIDS
- To sensitize the Aruban population about HIV/AIDS
- To promote behaviour change in the Aruban population both towards HIV/AIDS and more specifically toward people living with HIV/AIDS: the issue of stigma and discrimination
- To reduce the stigma and discrimination of PLWHA
- The empowerment of PLWHA
- To ensure the sustainability and expansion of equitable access to quality treatment, care and support for PLWHA
- To increase the profile and impact of the various HIV/AIDS action committees, including the UNAIDS Theme Group
- To do more at a social level to deal with the impact of HIV/AIDS
- To improve the surveillance and data collection system

6.0 Broad Strategic Areas for Action

The workshop identified a number of areas for action. These Broad Strategic Areas (BSA) represent the areas or issues, which most concerned the group and required immediate attention if the national strategies are to be effective and impacting. In addition these broad strategic areas will form the basis

for the development and articulation of specific objectives, which would inform the development of the national annual work plans which will guide the allocation of resources and define outcomes.

It is expected that this listing of BSA is not exhaustive and can be added to throughout the planning cycle and process. However, it is suggested that for new BSA to be added to the list that the core group, together with the National AIDS Programme Coordinator and the National AIDS Committee should convene a meeting to discuss the suggested BSA and the antecedent problems that has brought it for consideration. The five BSA identified were:

- Health Promotion for Behaviour Change
- Diagnosis, Treatment, Care and Support
- Surveillance and Epidemiology
- Advocacy and Partnerships
- Institutional Strengthening and Resource Mobilization

6.1 Health Promotion for Behaviour Change and Prevention

This broad strategic area seeks to bring together the critical issues identified that impact on the social, cultural and behavioural dimensions of HIV/AIDS. Issues such as public attitude to change, public attitude to HIV/AIDS, behaviour change, community development, including the school education system, treating with the issue of migration, engaging ministers of religion (i.e., FBO) in the dialogue on HIV/AIDS, and using them not only as messengers of God but in the mitigation of stigma and discrimination, care and support. Building community networks for public education for targeting special at-risk groups, such as, youths, women, children, men, migrant husbands, homosexuals, commercial sex workers, MSM and other at risk populations.

6.2 Diagnosis, Treatment, Care and Support

The broad strategic area of treatment, care and support refers to the continuum of a managed clinical, psychological, social and rehabilitative intervention, provided by professional care givers, that caters to the need of the HIV infected and the PLWHA. Priority should be given to discussion on policy as it relates to the standardization of clinical protocols for the management of the HIV/AIDS patient, including the selection, expansion and availability of ARV medication as well as studies on drug resistance and the introduction of HAART therapy. The issue of resistance testing and alternative therapy was also discussed as a key issue for Aruba. The issue of quality should be one that crosses testing, treatment, care and support.

6.3 Surveillance and Epidemiology

Improvements to the surveillance system and data collection mechanisms and methodologies should be paramount with quality testing system being available to the population, as well as the development

of laboratory capacity to conduct viral loads, CD4 and CD8 tests to support ARV treatment programs which are currently available to all citizens of Aruba.

6.4 Advocacy, Legislative Support and Partnership

An integral part of the HIV/AIDS campaign is creating sustainable programmes as well as heightening awareness, not just to the wider population in the form of health education, but also to key stakeholders and partners. Such awareness building transcends knowledge and involves lobbying, advocacy, building linkages and sustaining support. The broad strategic area of advocacy and partnership would address these issues, focusing on key players in the private sector (Business Community), the political directorate, strategic linkages between the public and private sector, labour unions, NGOs and community groups, the media and finding a credible voice for promoting and championing HIV/AIDS, through effective leadership. A key function in this strategy should be resource mobilization for program sustainability and development of linkages with international partners.

6.5 *Institutional Strengthening and Resources Mobilization*

A necessary complement to the development of a national strategic policy on HIV/AIDS is the development of managerial, technical and operational capacity on the ground that can operationalize and implement the national expanded response to HIV/AIDS for the country. This issue of institutional strengthening is the cornerstone to the successful implementation of the NSP. The second critical issue is that of financing the plan and the sustainability of such financing over the life of the plan to ensure the continuity of the project. Resource mobilization has to be seen as critical to the longer-term sustainability of the expanded response. Special attention therefore has to be paid to securing additional sources of funding and finance for specific activities in the NSP.

6.6 Expected Results of NSP

The expected results of these Broad Strategic Areas would be:

1. *Health Promotion for Behaviour Change (Prevention)*
    - That the National AIDS Programmes in Aruba would be strengthened so as to develop and evaluate health promotional, prevention, behavioural and communication intervention targeting priority vulnerable populations (e.g., youth, PLWHA, MSW, male and female commercial sex workers) strengthened.

2. *Diagnosis, Treatment, Care and Support*
    - Capacity of Aruba to deliver efficient and effective HIV/AIDS/STI service in clinical and diagnostic management, including care and psychological support increased (e.g. MTCT, VCT, VRG, PLWHA and youth and “male friendly” sexual reproductive health services).

3. *Surveillance and Epidemiology*
    - Health information surveillance systems and research capabilities strengthened to generate reliable data on HIV/AIDS/STI transmission and status to allow for focused decision-making, planning, implementation and evaluation.

4. *Advocacy, Legislative Support and Partnership*
    - Capacity of decision makers strengthened to utilize scientific data, national strategic priorities and the expanded response approach for effective policy formulation and legislative support to the ethics and rights of the PLWHA.

5. *Institutional Strengthening, Partnering and Resource Mobilization*
    - Capacity of NAP strengthened to use the expanded response approach for policy planning, programme implementation and outcome evaluation of HIV/AIDS programmes that will build alliances through involvement with NGOs, civil society and sub-regional institutions and structures (CAREC, CARICOM, CARIFORUM, COSHOD and PANCAP) and mobilize resources.

7.0 Country Coordinating Mechanism (CCM) for NAP

Ideally, the structure of the Country Coordinating Mechanism for the HIV/AIDS program should allow for the following:

1. High level policy decision making and direction
2. Multisectoral partner co-ordination and collaboration
3. Technical operational implementing capacity to execute projects, plans and programs as defined in the NSP

To effectively achieve this level of organization efficiency would require a dual hierarchy structure, with one body being responsible for policy, direction, decision making and leadership and a separate body with responsibility for operations and implementation and serve as the secretariat for the policy advisory body.

Although there was no formal evaluation at the National Consultation about the organization structures currently managing the HIV/AIDS response in Aruba with respect to its organization capability and capacity in terms of their efficiency and effectiveness, some recommendations will be suggested. The following therefore seeks to establish a benchmark for assessing the structures for managing an effective national expanded response to HIV/AIDS in Aruba.

7.1 National AIDS Program – Terms of Reference

The purpose of the National AIDS Programme is to facilitate and sustain an effective expanded response to AIDS through the stimulation and coordination of activities implemented by an alliance of different government ministries and divisions, the business sector, non-government organizations, CBO, FBO, PLWHA, labour unions and the media. Its specific objectives should include:

- To serve as the executing and implementing agency for the execution of policies, programmes and directives of the National AIDS Committee (NAC) and/or the Ministry of Public Health
- To develop suitable programmes to meet the needs of the country in terms of education, information dissemination, training, counselling in the area of HIV/AIDS
- To coordinate the multiple efforts from other public and private agencies in stemming the spread of HIV/AIDS in Aruba
- To serve as the focal point for information and advice on HIV/AIDS
- To ensure continuous networking and dialogue between the partners to achieve the necessary synergies
- To encourage contributions from new partners in the expanded response to HIV/AIDS and to mobilize and channel resources
- To ensure that surveillance and research are conducted by the competent agencies to generate information required for the planning and evaluation of HIV/STI prevention and support
- To act as the national clearing house/repository for all HIV related information and to analyze and disseminate this information to all partners and publics
- To present to the political directorate via the National AIDS Committee (NAC) updates on the national HIV/AIDS situation

7.2 National AIDS Committee - Terms of Reference

The National AIDS Committee, or whatever title it is given, is the body responsible for policy making, influencing and lobbying and provides the structure and infrastructure for national AIDS programming within the regulations of a broader ministry. The National HIV/AIDS programme for the prevention, care and support for HIV/AIDS requires the contribution, cooperation, support and intervention from different groups, both in the public and private sectors and including regional and international representation. The National AIDS Committee (NAC) is the coordinating mechanism for this high level, multi-sectoral support.

The Committee's composition should/would reflect the fact that HIV/AIDS is not a health issue but a developmental issue, which transcends health or any one area and affects and impacts on all aspects of society. Toward this end, it is critical that the private/business sector be included at the highest level of the dialogue and is allowed to play an integral role in the strategic direction of the planning process.

The NAC is an advisory, coordinating body, responsible for considering the macro policy issues and strategies on the use of resources and determining the way forward. What the NAC is not, is an operational, implementing, administrative body with the responsibility for executing programmes. Its expressed purpose should be:

- To articulate the commitment from the highest level of the government on HIV/AIDS prevention and control
- To profile the issues of and related to HIV/AIDS to as wide a cross section of the population and society as possible, that would attract attention to the issue of HIV/AIDS
- To solicit broad support for the National AIDS Programme (NAP)
- To serve as the lobbyist and the advocacy body for HIV/AIDS in the highest circles– national, regional and international
- To advise on HIV/AIDS policy and review existing related policies to ensure consistency with the strategic direction and vision for HIV/AIDS, consistent with the developmental objectives of the country
- To facilitate communication and coordination between government sectors and other organizations involved in national AIDS mitigation efforts
- To facilitate resource mobilization for the National AIDS Programme (NAP)

8.0 Recommendations and the Way Forward

Aruba has done a significant work, which has been advanced by the strategic planning exercise, culminating in the development of this strategic planning framework and plan. There is need to continue to meet, to flesh out the strategic framework and expand the broad strategic areas for action into a work plan with well defined achievable objectives, with assigned time frames and monitoring indicators. There must be a custodian of the process who will take full responsibility for ensuring the process is implemented and energies are harnessed and synergised. Other recommendations include:

1. Development of national policy guidelines for "AIDS in the Workplace" policy, which can be adopted by both the public and private sectors which will assist in the mitigation of stigma and discrimination of PLWHA;

2. Development of an integrated national sector plans with other relevant government and non-government sectors, such as ministries with responsibility for education, youth, immigration social services and tourism. These work plans should be developed in conjunction with the private sector, NGOs and other public sector ministries, to reflect the expanded response concept, while at the same time placing greater emphasis on private sector partnering. This strategy in the long run should auger well for sustainability of the programme;

3. Follow up on earlier initiatives from former years, for example, KABP studies and commission new sentinel studies on vulnerable populations and at risk groups, such as, CSW, MSM or migrant populations. The need to measure the progress of the programme, its impact on knowledge, attitude and behaviours is critical to the evaluation process and to directing the effective use of resources through prudent programme management;

4. With the convening of a new National AIDS Committee and the launching of the new NSP for an Expanded Response to HIV/AIDS for Aruba 2003 –2006, it is crucial that the new committee function effectively as a team. A workshop on "Good Governance" addressing the role, structure and function of the committee, relationship to other organizations, and their own human relation dynamic. This meeting should be convened early in their new appointment; and

5. Sensitivity training with respect to quality of care and treatment and support for PLWHAs. This should be an integral part of the annual programme for caregivers, doctors, nurses and primary care providers.

The Way Forward

The experience coming out of the September 2002 National Consultation and the Sensitization and Advocacy Session with the Prime Minister, Minister of Health and Minister of Finance and Economic and Parliamentarians, called for a renewed thrust and a recommitment to reducing the impact and incidence of HIV/AIDS in Aruba.

The way forward should represent a shared and collective responsibility to the fight against AIDS in Aruba and should be shouted with one voice throughout the island.

The way forward therefore calls for the inclusion and incorporation of the church clergy (FBO) and the community elders (CBO) to join in the battle of the information sharing process.

The way forward is to draw on the strengths of the existing program and build on it. The way forward should focus on sustainability of the National AIDS Program and more importantly, the national AIDS mitigation effort. This is necessary if the Government wishes to create an impact on the reduction and incidence of the number of HIV/AIDS reported cases. This sustainability refers not just to funding and resource mobilization, but also to sustainable energy and commitment at the highest level. Donors are particularly interested in projects that have a clear plan of how the project will be able to continue in the future while decreasing reliance in donor funds. Specific strategies should be developed and implemented for ensuring long-term sustainability.

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ANNEXES

Annex I

LOGICAL FRAMEWORK
National Strategic Plan for an Expanded response to HIV/AIDS

ARUBA

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Goal: To reduce the spread of HIV/AIDS/STIs and to minimize the impact of the epidemic on individuals and communities in Aruba	1. Reduction in the number of new HIV cases.	HIV/AIDS Status and trend reports.	1. The gains achieved under this project are sustained by government as well as supported by other developmental programmes and agents.
Purpose: The capacity of NAP of Aruba strengthened to manage and provide sustainable programmes for the prevention and control of HIV/AIDS/STIs and care of persons living with HIV/AIDS	1.1 At least 60% reduction of HIV transmission in children born to infected mothers who have received ARV in Aruba by 2007 1.2 At least 50% increase in the human and financial resources allocated by government on HIV prevention and care programmes in Aruba by the end of the second year of the project	Updates on implementation of MTCT programmes in Aruba Surveillance forms and analyses submitted to the government and monitoring committee annually National Budget allocations, NAP budgets	1. National Strategic Plans will be implemented in a timely and efficient manner so that Project Activities will compliment other strategic activities 2. Government and other partners and stakeholders in Aruba as well as in the Region remain committed to the prevention and control of HIV/AIDS/STIs 3. Government's willingness to be included and participate in the HIV/AIDS activities in the wider Caribbean region

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Expected Results: 1. Strengthened capacity of National AIDS Programmes in Aruba to develop, implement and evaluate prevention, behavioural and communication interventions targeting vulnerable populations (e.g., youth, PLWHA, MSM, male and female commercial sex workers, immigrant populations) strengthened.	1.1 Aruba will have implemented specific behavioural change programmes for at least two vulnerable groups 1.2 Aruba to develop a comprehensive social marketing programmes for responsible condom distribution and utilization	Evaluation Reports of interventions conducted	1. Willingness of vulnerable groups to work/collaborate with the NAP 2. Minimal social and religious resistance to the promotion of the use of condoms as part of the promotion of a “safer-sex” campaign

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Expected Results:			
2. Increased capacity of Aruba to deliver efficient and effective HIV/AIDS/STI service in clinical and diagnostic management, including care and psychosocial support (e.g. MTCT, VCT, PLWHA and youth and male friendly sexual reproductive health services)	2.1 90% of reported PLWHA receiving appropriate clinical management, including supportive counselling, home visits and support in accordance with approved standards of case management in at least all of the islands by the end of the project 2.2 90% of patients with conventional STIs at selected health centres are appropriately diagnosed and treated according to established regional guidelines in Aruba. 2.3 Aruba to establish "youth-friendly clinics" in at least one school. 2.4 80% of pregnant women diagnosed with syphilis and 60% of their sexual partners adequately treated in Aruba 2.5 National Blood Bank to adhere to Caribbean Regional Blood Bank Standards by EOP	Quality of care surveys regarding HIV/AIDS/STIs services Baseline surveys; Quality of care surveys regarding HIV/AIDS/STIs services Physical audit, clinic reports Clinic reports, home visits reports, monitoring reports Baseline information surveys In-country lab reports	1. Willingness of general population to access care and support services offered by Government. 2. Private sector inclusion and cooperation in all aspects of clinical and diagnostic management, including private physicians and private labs 3. Comprehensive insurance coverage for the population to ensure access to comprehensive care

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Expected Results:			
3. Health information, surveillance systems and research capabilities strengthened to generate reliable data on HIV/AIDS/STI transmission and status to allow for focused decision-making, policy formulation planning, implementation and evaluation.	3.1 Semi-annual Epidemiologic updates based on data generated by laboratories and epidemiology surveillance units, produced, disseminated and utilized for health decision-making by NAP in Aruba by end of project	Semi-annual Epidemiologic updates	1. Government commitment to fully implement and maintain surveillance systems 2. Required resources (human and financial) will be committed by Government to operationalize new surveillance systems
	3.2 A minimum of one sentinel study on at least one vulnerable group developed and executed in Aruba by EOP	Research protocols, and reports	
	3.3 At least one national research project related to STIs developed and executed in Aruba and one other island by end of project	Research protocols, findings of final report	

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
4. Advocate for the increased use of research data by decision-makers for effective policy formulation and implementation that address all aspects of the HIV/AIDS expanded response	4.1 National policy statement on HIV/AIDS by the end of the project	Annual Reports from the NAC/NAP, End of Project Report	1. Accurate, high integrity data would be available from the surveillance system to inform good decision making
	4.2 Approved legislation to protect the rights, including confidentiality, of PLWHA by EOP	Annual Reports of the NAP/NAC	2. Activities implemented under this programme will assist in reducing the stigma and discrimination against people living with HIV/AIDS and assist in creating a supportive environment 3. Governments willingness to implement the Paris Declaration that focuses on the rights of PLWHA

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
5. Management and coordination capacity of the NAP strengthened to coordinate an expanded response approach to policy planning, programme implementation and evaluation of HIV/AIDS programmes.	5.1 Multisectoral management mechanisms (National AIDS Committees, including NGO and PLWHA) which reflect the expanded response to HIV/AIDS in Aruba	Terms of Reference of National AIDS Programmes and National AIDS Committees List of Appointees and representing sectors	The National Authorizing Agencies (NAO) will continue to facilitate island programmes to take ownership of national and island-level programme implementation for externally funded HIV/AIDS projects NAP Project Teams appointed, instituted and approved by government
	5.2 Operational AIDS Programme Teams with full-time, remunerated National HIV/AIDS Coordinator	Reporting structure in place for NAP, NAC to governments for effective operation	Appointment of National AIDS Programme Coordinators in Aruba
	5.3 Develop and execute multi-sectoral annual work plans	Organizational Structure of National AIDS Programmes National Budgets for National AIDS Programming SARA, NSP and Annual Work Plans, evaluation reports	

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Activities 1. Train NAP staff in Aruba to design, implement and evaluate communication interventions to reach vulnerable groups, including the design of relevant materials 2. Strengthen partnership among local media houses in Aruba and with the regional-level media organisations 3. Increase condom distribution points in all islands 4. Develop special education programmes targeted to in and out-of-school youth to communicate HIV/AIDS prevention messages including the implementation of family life education or life skills programmes with training of educators for effective implementation. 5. Evaluate and document special initiatives for identification of best practices including the "Sex Carousel" in Aruba 6. Procure and produce HIV/AIDS education material for the general population 7. Strengthen capacity of health care professionals in clinical management of HIV at institutional and community levels including training on Universal precautions for Blood and Body Fluid for Nurses, HCP in hospitals and care providers in home settings, as well as police, prison officers and teachers 8. Strengthen coverage and accessibility of care and support systems for PLWHA (including HAART) with corresponding laboratory support services (e.g. PCR, CD4, viral load etc.)			Persons not covered by health care insurance will be covered for HIV/AIDS care by Government

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Activities (continued) 9. Strengthen STI syndromic management in Aruba 10. Promote access to care for vulnerable groups (PLWHA, young women, CSW, youth, MSM and the uninsured) 11. Strengthen and promote home care for PLWHA 12. Strengthen counselling services for PLWHA 13. Technical Support for the provision of part-time Specialist Medical services to PLWHA 14. Develop a counselling programme to include the recruitment of professional counsellors, trainer-the-trainer programmes for volunteer counsellors and pre- and post-test counselling. 15. Develop and implement a voluntary counselling and testing (VCT) programme 16. Explore alternative diagnostic testing methodologies for the diagnosis of HIV, including rapid oral saliva testing in collaboration with regional initiatives 17. Establish Male Reproductive Health Clinics that are "user friendly" to men			

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Activities (Continued) 18. Provide operational support to youth-friendly clinics. 19. Promote the use of regional surveillance standards and guidelines among national professionals. 20. Conduct in-country audits and training to strengthen surveillance and data collection systems. 21. Conduct regular data collection and analysis to monitor HIIV/AIDS/STI and associated risk behaviours trends among targeted groups and effectively disseminate results at local, national and regional levels, including baseline and follow-up KAPB Studies for high-risk populations (young people, in-school youth, CSW and MSM) 22. Conduct capacity building workshops in surveillance and research skills 23. Facilitate collaboration and exchange of experiences in the collection/dissemination of data between Aruba and the NAN and the wider Pan Caribbean region to share information and experiences (including participation in regional for a and conferences)			

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Activities (Continued) 24. Conduct sero-prevalence and sentinel studies with targeted/vulnerable groups e.g. in-school youth, MSM, CSW and immigrant populations 25. Conduct in-country sensitization and training to build partnerships to increase political commitment for the implementation of NSP 26. Conduct Economic Impact Study 27. Promote alliances with regional and international partners to support the development of a legal/ethical framework that addresses all aspects of HIV/AIDS including human rights of PLWHA 28.Support HIV/AIDS activities of NGO, CBO and FBO wishing to participate in the HIV/AIDS response 29. Support establishment and active participation of PLWHA support groups, to include capacity building in key issues (e.g. self-care, proposal preparation, advocacy) 30. Technical assistance in the development and implementation of all legislation addressing HIV/AIDS issues e.g. mandatory testing of pregnant women and CSW			

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Activities (Continued) 31. Develop and implement appropriate "HIV in the Workplace" policies to prevent discrimination against of PLWHAs in the workplace 32. Conduct sensitization workshops on the ethics of Confidentiality as it relates to testing, the rights of clients and PLWHAs, both in the institutional and the work setting 33. Train NAP personnel and other partners (including NGO, CBO and FBO (churches), in the use of management tools. 34. Conducting "Good Governance" workshops for the NAP and senior government and private sector managers 35. Facilitate participation of NAP and MOH senior personnel in regional coordination and technical meetings organized by PAHO/WHO, CARICOM, UNAIDS, UNDP, and other agencies including the regional meetings of HIV/AIDS Programme Coordinators 36. Allocate sufficient human and financial resources for effective coordination of an expanded response to include the recruitment of Project Managers and the establishment and operationalization of National AIDS Programme offices			

ANNEX II

ARUBA

NATIONAL AIDS PROGRAMME

STRATEGIC FRAMEWORK 2003 – 2007

(some suggestions for work plan activities…not exhaustive and has to be costed)

BROAD STRATEGIC AREAS

1. Health Promotion for Behaviour Change (Prevention) thru Public Education and creating a Supportive Environment

2. Treatment, Care and Support, Continuous Quality Improvement, Surveillance and Data Collection

3. Advocacy, Legislative Support and Partnerships

4. Resource Mobilization and Financing

Strategic Planning Framework

ARUBA

Broad Strategic Area

Health Promotion for Behaviour Change (Prevention)

Thru Public Education and Creating a Supportive Environment

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
1.0	**Community Development and Empowerment**	1.1	Sensitization and education of the community through TV and radio Programming	1.1.1 Develop video and radio material 1.1.2 Coordinate with community groups / village councils 1.1.3 Draft implementation schedule 1.1.4 Market and disseminate material	• No. of programmes produced • No. of persons exposed to sensitization training • Baseline studies and follow up KAP study	• A more sensitized, aware and educated public • Increased practice of safe sex
2.0	**Employee Empowerment**	2.1	HIV/AIDS sensitization programmes in the workplace	2.1.1 Engage private and public sectors managers in the sensitization process and conduct workshops	• 100% of employed Arubans exposed to HIV/AIDS in the workplace seminars	

Broad Strategic Area

Health Promotion for Behaviour Change (Prevention)

Thru Public Education and Creating a Supportive Environment

	Strategic Activity		Programme Objectives	Activities	Indicators	*Results/Impact*
2.0	**Employee Empowerment** (cont'd)	2.2	HIV/AIDS sensitization programmes in the workplace	2.1.2 Conduct HIV and Development Workshops for senior Public servants and senior private sector management including CEOs. 2.1.3 Conduct needs analysis of vulnerable groups and engage vulnerable groups in dialogue to determine needs	• No. of persons interviewed • Documentation of needs analysis • Development of appropriate response mechanisms	• Reduction, mitigation or removal of risk • Heightened sensitization and awareness of risk groups • Greater compliance with safe sex practices

Broad Strategic Area

Health Promotion for Behaviour Change (Prevention)

Thru Public Education and Creating a Supportive Environment

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
3.0	**Individual empowerment**	3.1	Changing public attitude to sex, safe sex, HIV/AIDS and PLWHA	3.1.1 Continuation of sensitization activities as in 1 and 2 above 3.1.2 Increase promotion of safe sex messages and the consistent use of condoms 3.1.3 Identification of a respected community voice for the promotion of change	• Tangible improvement in public attitude toward PLWHA • Increased knowledge of safer sex practices • Increased use of condoms • More open discussions on safe sex practices	• More knowledgeable and informed public Greater awareness and sensitivity toward those affected by HIV/AIDS • More support for PLWHA and their families • Improved family life • Improved relationships • Improved sex/condom negotiation between partners • More positive attitude toward sex ands sexuality

Broad Strategic Area

Health Promotion for Behaviour Change

Thru Public Education and Creating a Supportive Environment

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
4.0	**Enhancement of the sexual reproductive health and development of young people**	4.1 4.2 4.3	Targeted youth education and sensitization wrt sex education and sexuality Sensitization of media personalities DJs and entertainers Establish a youth friendly "Sexual and Reproductive Health Clinic for youths" counselling and support	4.1.1 Identify and mobilize community groups by types and target e.g. Rasta, ghettos, rural, urban, religious, etc 4.1.2 Sensitization workshops for media 4.1.3 Reinforced by media awards and DJ HIV sensitive awards 4.1.4 Identify suitable location and resources for the establishment of such a clinic service in conjunction with established partners	• No. of youths sensitized • No. of groups reached/engaged • No. of media persons sensitized • No. of DJs sensitized • Establishment of YSRH Clinic • Staffing of YSRH Clinic • No of clinic visits	• Improved sexual reproductive health of youths • More informed youths • Better decision making by youths as a result of new information • Improved self esteem among youths • More informed and healthier sexual choices • Healthy sexuality (personal comfort with sexuality)

Broad Strategic Area

Treatment, Care and Support

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
5.0	**Improved treatment quality**	5.1	To improve the availability and access to appropriate and affordable medication to those infected with HIV.	5.1.1 Establishment of a HIV/AIDS drug Committee to determine a HIV/AIDS Drug Formulary 5.1.2 Negotiating prices and supplies through ECDS or NGOs 5.1.3 Expansion of surveillance practices to improve reporting and monitoring of HIV	• Appropriate medication available to treat PLWHA in a timely and efficacious manner consistent with established protocols • Affordably priced drugs to patients • More data collection	• Reduced morbidity and mortality
		5.2	Development of protocols and standards of treatment and management of HIV/AIDS patients	5.2.1 Utilization of CAREC's protocols to develop a locally relevant set of clinical protocols	• Utilization of the CAREC protocols in the treatment and management of HIV/AIDS patients	• More informed and trained clinicians • More consistent standards of clinical practice

Broad Strategic Area

Treatment, Care and Support

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
6.0	**Improved treatment quality**	6.1	Adequate training of health care personnel in the treatment care and support of those infected with HIV	6.1.1 Development of a training programme for doctors, nurses and other care providers in the management and care of persons infected with HIV/AIDS	• All staff (100%) hospital and community involved in the treatment, care and support of PLWHA trained in the management and care of the illness and its pathology	• Higher quality care, more appropriate care, improved service, less discrimination, reduced morbidity and mortality
	Hospice care for end-stage AIDS patients	6.2 6.3	Physical completion of the AIDS Hospice for end-stage PLWHA Adequate funding for the AIDS Hospice		• Fully functional, equipped and maintained hospice building • Appropriately staffed hospice in terms of match of services to skills	• Appropriate palliative care to PLWHA • Dying with dignity for PLWHA • Relief and support for families of PLWHA

Broad Strategic Area

Treatment, Care and Support

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
7.0	**Care**	7.1	To ensure quality care for those infected, both in the formal health care setting and in the home/ community environment	7.1.1 Development of clinical care programmes for non-clinicians who have the responsibility for caring for PLWHAs 7.1.2 Establishing a volunteer programme of care providers who would be willing to support the home care process for PLWHA 7.1.3 Training of volunteers in hospice care and care of PLWHA 7.1.4 Development of sensitivity training programmes for hospital and home care providers	• No. of non clinicians trained in the HIV/AIDS process • No. of volunteers recruited to sup[port the care process • Feedback on improvements in the quality of acre at hospice and home level	• Improved quality of acre both in and outside the formal health acre setting • Mitigation of social impact on families • More support to families of PLWHA

Broad Strategic Area

Treatment, Care and Support

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
8.0	**Support**	8.1	To develop a holistic approach to the management of HIV/AIDS (body, mind and spirit) address the physical, emotional, spiritual; social and psychological needs of PLWHA	8.1.1 Conduct needs assessment of the needs of PLWHA in Focus Group 8.1.2 Engage Attorney Generals Office in dialogue wrt legal rights of PLWHA 8.1.3 Train more counsellors in pre and post HIV testing skills	• Introduction of a "Service Centre" for PLWHA as a "one stop" shop • Introduction of EAP in all large private sector organizations, including banks, hotels, telecommunications companies etc.	• Improved continuity of care and better overall health outcome • Better mental health for those so afflicted and affected • Reduced morbidity • Increase sense of bien etre among PLWHA
		8.2	To develop a respectful and supportive environment for PLWHA free of discrimination and stigmatization	8.1.4 Promote the introduction of EAP (Employee Assistance Programmes) in both private sector and public sector organizations		
		8.3	To establish a one tone counselling service for PLWHA and their affected			

Broad Strategic Area

Treatment, Care and Support

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
9.0	**Community support for the prevention of MTCT of HIV and mitigation of HIV effects**	9.1	Educate and motivate young mothers to be part of a women's empowerment programme to establish a Domestic Peer Counselling group among young to be mothers	9.1.1 Identify young willing mothers through antenatal clinics and community groups 9.1.2 Conduct education and counselling sessions with young mother, doctors, nurses and counsellors	• No. of young mothers enrolled in programme • Ranges of services offered in support group • No. of peer counsellors trained • Establishment of database of orphaned children • No. of orphaned children supported	• Stronger more involved MCH programme • Reduction in MTCT rates • More physically and socially viable orphaned children • More cohesive community groups
		9.2	Establish a domestic support group of young mothers to support HIV positive mothers	9.1.3 Develop data base of young mothers in need		
		9.3	Advocate for the development of an Orphan Support Programme	9.1.4 Develop data base of orphans or children of HIV parents who are at risk		

Broad Strategic Area

Treatment, Care and Support

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
10.0	**Surveillance and Testing**	10.1	Improved collection, timeliness and accuracy of HIV/ AIDS surveillance data for analysis	10.11 Development of data collections and surveillance systems	• Improved data collection and surveillance systems • Implementation of secrecy/confidentiality policy for public officers • Disciplinary action for offending public officers • Increase in no. of local testing	• More accurate and timely date for analysis and decision making • More efficient reporting and monitoring • Greater confidence in the testing system • More test locally done • Improved data collection
		10.2	Strengthening of the testing system to allow for more public confidence in the system	10.2.2 Introduction of a code of secrecy for all public officers 10.2 .3 Imposing of sanctions for public official breach of confidentiality		

Broad Strategic Area

Advocacy and Partnership

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
11.0	**Developing the National Expanded Response**	11.1	Promoting the message that HIV/AIDS is not Health's business, but every sectors business	11.1.1 Constituting a multi-disciplinary, cross sectional National AIDS Committee to lead the NAP	• Sector leadership other than health and public sector • Comprehensive national AIDS programme • On-going national public dialogue on HIV/AIDS	• More regional and international support and recognition for national AIDS programme and efforts • Higher profiling of HIV/AIDS
		11.2	Developing a comprehensive National AIDS Plan that involves key ministry sectors as well as the private sector, community, church and NGO	11.1.2 Developing a draft National AIDS Policy for circulation and feed back involving all sectors 11.1.3 Convening a special consultation on HIV/AIDS		
		11.3	Ensuring that HIV/AIDS is put on the national agenda and that it keep its position of pre-eminence	11.1.4 Establishing a National AIDS secretariat		

Broad Strategic Area

Advocacy and Partnership

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
12.0	**Legal and Human rights of PLWHA**	12.1	Identifying areas in need of legislative reform or support	12.1.1 Convene focus group with PLWHA o determine relevant legal and human rights issues	• Development of a legislative reform agenda • Development of a Bill of Rights for PLWHA • Development of a National Policy Statement on HIV/AIDS in the Workplace	• Improved awareness and public acceptance of PLWHA • Improved social and psychological comfort for PLWHA • Increased productivity and contribution of PLWHA to society
		12.2	Examining the need for legislation on the criminalization of wilful spread of HIV/AIDS	12.1.2 Convene public consultation on legal and human rights of PLWHA		
		12.3	Improving systems and personal confidentiality wrt HIV testing and reporting	12.1.3 Convene joint consultation between public and private sectors wrt policy on AIDS in the workplace		
				12.1.4 Development of a policy on AIDS in the workplace		
				12.1.5 Development of national policy of the rights of PLWHA		

Broad Strategic Area

Advocacy and Partnership

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
13.0	**Partnering with strategic partners and key stakeholders**	13.1	Initiating a "Healthy Hotel" project among leading hotel chains	13.1.1 Identifying key contacts in participating hotels 13.1.2 Conducting sensitization workshops for participating hotels 13.1.4 Developing materials including HIV and Development workshops in the workplace 13.1.5 Targeting of beach boys and other commercial sex workers who service hotels and tourists 13.1.6 Promoting safe sex in the hotel i.e. condom in the room or next available place 13.1.7 Conducting pilot hotel project	• No. of participating hotels • No. of workshops held • No. of staff trained • No. of literature distributed • No. of condoms distributed • No. of commercial sex workers reached	• Healthier hotels, staff, guests and commercial sex workers • Reduction in the trans mission of HIV • More informed client and staff

Broad Strategic Area 4

Resource Mobilization and Financing

	Strategic Activity		Programme Objectives	Activities	Indicators	Results/Impact
14.0	**Sustainable financial development**	14.1	Identification of alternative sources of funding and financing	14.1.1 Development of work programs, annual work plans and project proposals for submission for funding, based on the needs defined in the strategic framework 14.1.2 identification of alternative sources of funding for special interest or groups for e.g., women youth, children MSM, commercial sex workers HIV orphaned children, cheaper drugs etc.	• No of programmes and projects developed and submitted • Development of annual work plan • No. of sources identified • No of grants identified and received • No of contributions in kind • % of fund received as a % of budget • No. of programmes funded	• Programme continuity and sustainability

Annex III

ARUBA

and the

NETHERLANDS ANTILLES

PRIORITY AREAS

Coming out of National Consultations

March 11 – 15, 2002

Project Goal

- To reduce the spread of HIV/AIDS and minimize the impact of the epidemic on individuals and communities in Aruba and the Netherlands Antilles**.**

Project Purpose

- To strengthen the capacity of National AIDS Programmes of Aruba and the Netherlands Antilles to manage and provide sustainable programming for the prevention and control of HIV/AIDS/STIs and care of people living with HIV/AIDS.

Expected Results

1. Health Promotion for Behaviour Change (Prevention)

- Capacity of National AIDS Programmes in Aruba and the Netherlands Antilles to develop and evaluate health promotional, prevention, behavioural and communication intervention targeting priority vulnerable populations (e.g., youth, PLWHA, MSW, male and female commercial sex workers) strengthened.

2. Diagnosis, Treatment, Care and Support

- Capacity of Aruba and the Netherlands Antilles to deliver efficient and effective HIV/AIDS/STI service in clinical and diagnostic management, including care and psychological support increased (e.g. MTCT, VCT, PLWHA and youth and male friendly sexual reproductive health services)

3. Surveillance

- Health information surveillance systems and research capabilities strengthened to generate reliable data on HIV/AIDS/STI transmission and status to allow for focused decision-making, planning, implementation and evaluation.

4. Advocacy and Legislative Support

- Capacity of decision makers strengthened to utilize scientific data, national strategic priorities and the expanded response approach for effective policy formulation and legislative support to the ethics and rights of the PLWHA.

5. Institutional Strengthening, Partnering and Resource Mobilization

- Capacity of NAP strengthened to use the expanded response approach for policy planning, programme implementation and outcome evaluation of HIV/AIDS programmes that will build alliances through involvement with NGOs, civil society and Sub-regional institutions and structures (CRICOM, CARIFORUM, COSHOD) and mobilize resources.

1. Prevention and Behaviour Change

Strategic Activities	Aruba	Bonaire	Curacao	St. Maarten	Saba	St. Eustatius
1. To conduct baseline and follow-up KAPB Studies for high-risk populations including youths, school children, CSW and MSM.	✷	✷	✷	✷	✷	✷
2. To increase the points of sales/distribution of "free" condom distribution through the promotion of "safe sex" practices.		✷	✷	✷	✷	✷
3. To conduct review and evaluation exercise of existing health promotion, prevention and education programmes to determine effectiveness, impact and efficacy.			✷	✷		
4. To develop special education programmes targeted to school children and youth to communicate the HIV/AIDS prevention message.		✷		✷		
5. To evaluate Aruba's "Sex Carousel" initiative to determine it vale as a "best Practice" for regional sharing.	✷			✷		

Strategic Activities	Aruba	Bonaire	Curacao	St. Maarten	Saba	St. Eustatius
6. To introduce the Family Life Health Education in primary and secondary schools.		✷		✷		
7. The introduction of Male Reproductive Health Clinics "user friendly" to men.		✷				
8. Procurement of assorted health promotion and education materials (including videos) for HV/AIDS education programmes, for adults and children, as well as specific at risk groups.		✷		✷	✷	✷
9. Infrastructural support for the Saba once per week "Youth Health Clinic" conducted on the compound of the school campus.				✷	✷	
10. Train the Trainers Sex Education Programme for Teachers.				✷		✷

1. Diagnosis, Treatment, Care and Support

Strategic Priorities	Aruba	Bonaire	Curacao	St. Maarten	Saba	St. Eustatius
1. Reducing the stigmatization associated with the Home Nursing Service s so as to promote better Home support and acceptance of the Home Service by PLWHAs.	✷			✷		
2. Technical support in providing part–time nutritional counselling support to PLWHAs.				✷	✷	✷
3. Technical Support for the provision of part –time Specialist Medical services to PLWHAs.				✷	✷	✷
4. Technical assistance in the establishment of a Support Group for PLWHAs.				✷	✷	✷
5. . Technical support for the part-time recruitment of a visiting counsellor to provide.				✷	✷	✷
6. Conducting a Train the Trainers programme for HIV/AIDS support group volunteer counsellors.				✷		✷

Strategic Priorities	Aruba	Bonaire	Curacao	St. Maarten	Saba	St. Eustatius
7. Conduct a training workshop in pre and post counselling for relevant health practitioners		✷		✷		✷
8. Develop a FREE testing programme to promote voluntary testing without the involvement of insurance companies, thereby promoting confidentiality. This programme will require 100 ELISA kits for free testing.					✷	✷
9. Explore alternative diagnostic testing methodologies for the diagnosis of HIV, including rapid oral saliva testing.					✷	✷

2. Surveillance

Strategic Priorities	Aruba	Bonaire	Curacao	St. Maarten	Saba	St. Eustatius
1. Strengthening of surveillance and reporting systems and the inclusion of private physicians in the reporting loop.	✷			✷		
2. Conduct study on the relationship between HIV/AIDS and STIs.			✷	✷		
3. Conduct seroprevalence (Blind Study) to determine a more realistic of the incidence and prevalence of HIV. School populations also to be targeted.				✷	✷	✷
4. Sentinel studies on high-risk groups e.g. MSM and CSW.				✷	✷	✷

3. Advocacy, Policy and Legislative Support

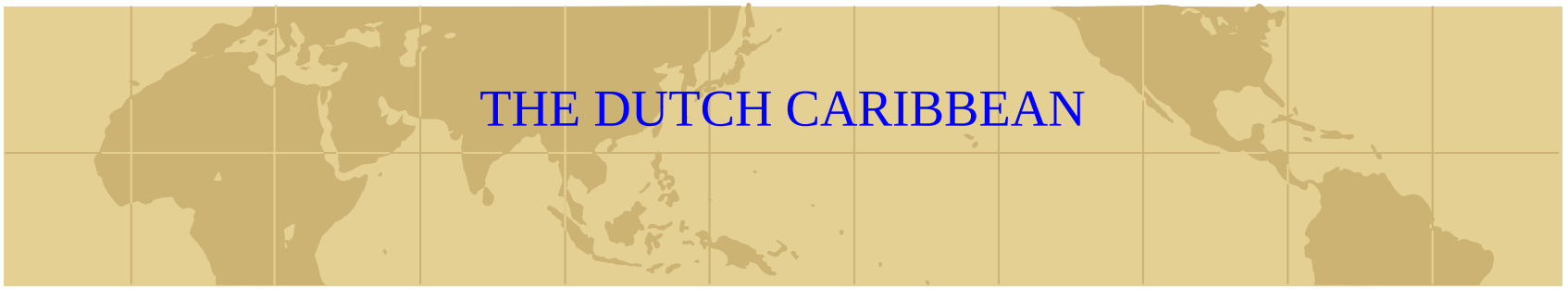
Strategic Priorities	Aruba	Bonaire	Curacao	St. Maarten	Saba	St. Eustatius
1. Behavioural interventions to address and mitigate impact of stigmatization and discrimination	✷			✷		
2. Promote partnering between and among islands for sharing of "Best Practices", information sharing and capacity building / strengthening.	✷	✷		✷	✷	✷
3. Conduct Sensitization and Advocacy Workshops for politicians to promote awareness of and support for HIV/AIDS.	✷	✷	✷	✷		
4. Conducting Sensitization Workshops for members of the media, DJs and the Church as points of influence to promote awareness of and support for HIV/AIDS.	✷	✷	✷	✷	✷	✷
5. Technical assistance in the drafting of legislation on mandatory testing of pregnant women and CSW.		✷				

Strategic Priorities	Aruba	Bonaire	Curacao	St. Maarten	Saba	St. Eustatius
Technical assistance in the development of appropriate "HIV in the Workplace "policies to prevent discrimination against of PLWHAs in the workplace.	✷	✷	✷	✷	✷	✷
6. Technical support for conducting "HIV and Development "workshops for NGO and other key stakeholders and senior government officials.	✷		✷	✷		
7. Conduct sensitization workshops on the ethics of Confidentiality as it relates to testing, the rights of clients and PLWHAs, both in the institutional and the work setting.	✷		✷	✷		

4. Institutional Strengthening, Partnering and Resource Mobilization

Strategic Priorities	Aruba	Bonaire	Curacao	St. Maarten	Saba	St. Eustatius
1. Recruitment of Programme/ Project managers/National AIDS Programme Coordinators to manage the National AIDS Programmes in country.	✷	✷		✷	✷ (Part-Time) .25 FTE	✷
2. Technical support and training for the writing-up and evaluation of work programmes.	✷			✷		
3. Conducting "Good Governance" workshops for NAP and HIV/AIS theme Groups.	✷	✷	✷	✷	✷	✷
4. Establishment and operation-alization of office space for National AIDS Programmes offices.				✷	✷	✷
5. Technical assistance to coordinate a national response to HIV/AIDS involving all the key players, including NGOs.			✷	✷		

Strategic Priorities	Aruba	Bonaire	Curacao	St. Maarten	Saba	St. Eustatius
6. Conduct workshop on Universal practices for Blood and Body Fluid Precautions for Nurse Practitioners in hospital and care providers in home settings, police and prison officers as well as teachers.	✷	✷	✷	✷		✷
7. Conduct Economic Impact Study	✷		✷	✷		
8. Communication and Collaboration workshops to promote inter island collaboration and partnering to help build capacity through sharing of information, services and experience.	✷	✷	✷	✷	✷	✷
9. Conduct inception workshop for all islands, stakeholders and key players to review the management and coordination of the project.	✷	✷	✷	✷	✷	✷


THE DUTCH CARIBBEAN
Aruba
Bonaire
Curacao
St. Maarten
Saba
St. Eustatius

[i] Annual Report and Financial Statements for the year 1999, Centrale Bank van Aruba
[ii] National Development Plan 2000-2004, Department of Economic Affairs, Commerce and Industry (Chapter 1.4 Tourism)
[iii] Labour Dynamics in Aruba 1997, Central Bureau of Statistics