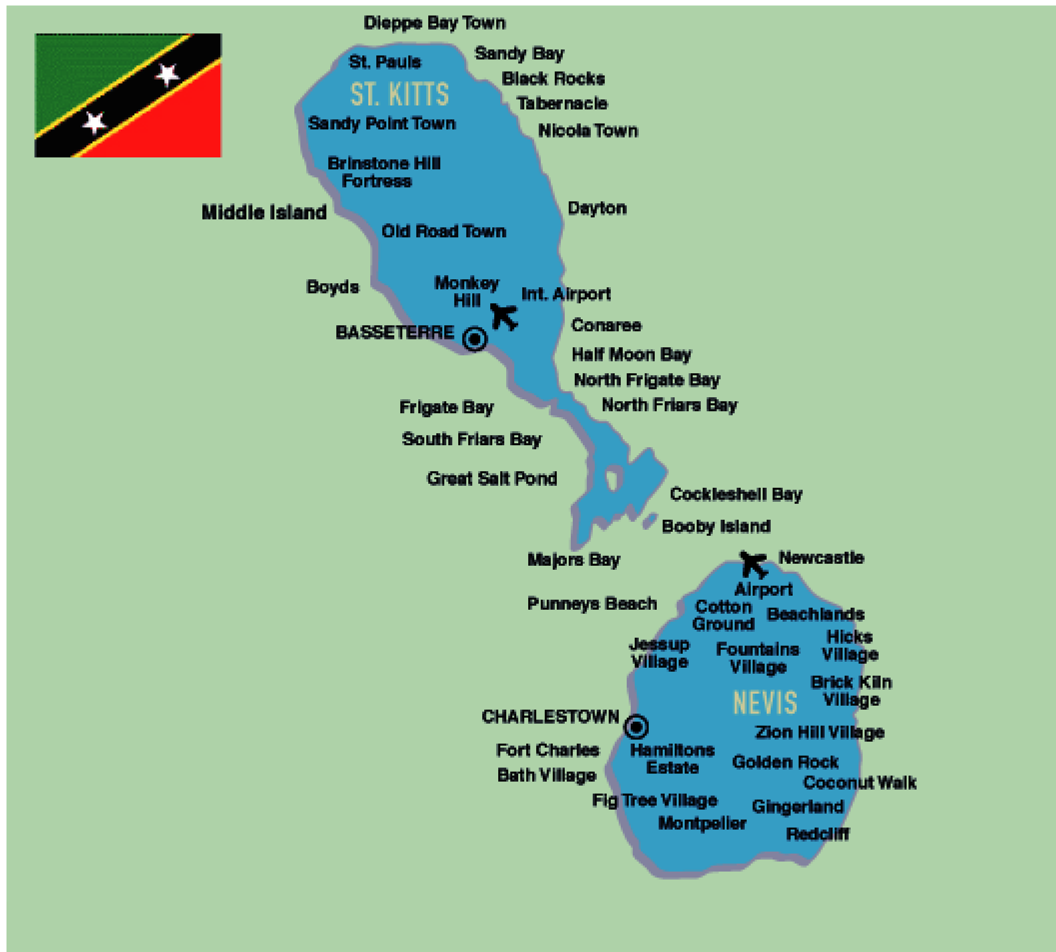
GLOBAL AIDS RESPONSE PROGRESS

2012 Reporting



ST. CHRISTOPHER (ST. KITTS) & NEVIS Narrative Report

MINISTRY OF HEALTH,

NATIONAL AIDS PROGRAMME

National AIDS Programme, St. Kitts & Nevis

Country Progress Report

To the Secretary General of the United Nations

On the United Nations General Assembly Special Session

Reporting period: January 2010–December 2011

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Ministry of Health

St. Kitts & Nevis

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic(s)
ART	Antiretroviral Therapy
ARV	Antiretroviral
CHAA	Caribbean HIV/AIDS Alliance
CRIS	Country Response Information System
CSW	Commercial Sex Workers
CT	Counselling and Testing for HIV
GAMET	Global HIV/AIDS Monitoring and Evaluation Team
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
IDP	International Development Partners
KABP	Knowledge, Attitudes, Behaviour, and Practices
M&E	Monitoring & Evaluation
MERG	Monitoring and Evaluation Reference Group
MoH	Ministry of Health
MSM.	Men who have Sex with Men
MICS	Multiple Indicator Cluster Survey
NHP	National HIV Programme
NAC	National AIDS Committee
NGO	Non-Government Organization
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organization
PLHIV	Persons Living with HIV

PMTCT	Prevention of Mother to Child Transmission
SISTA	Sista Informing Sister on Topic about AIDS
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNDP	United Nations Development Programme
VCT	Voluntary Counseling and Testing

I. Status at a Glance

The Global AIDS Reporting Process

The St. Kitts and Nevis Global AIDS reporting process was conducted over a three month period where stakeholders were engaged at different levels. The data input and completion was sourced from a number of areas and inputted in the CRIS by the Monitoring and Evaluation Officer. Data was validated by the Chief Medical Officer, Epidemiologist, Clinical Care Coordinators, National AIDS Program Coordinator, Civil Society (CHAA) and the legal expertise of Miselle O'Brien-Norton. Support was also received from the Caribbean Health Research and Council and the PAHO Country Specialist.

The National Commitments and Policy Instrument was informed though four consultation meeting with both government and Civil Society representatives. Consensus was gained through positive discussions where stakeholder agreed on appropriate responses. Desk reviews of the following documents were also conducted:

- National Strategic Plan (2010-2014)
- Monitoring and Evaluation Plan (2010-2014)
- Operational Plan (2010-2011)
- National HIV Reports 2010 and 2011
- Knowledge, Attitudes, Practice and Behaviors Survey (2010)
- Biological Surveillance Sentinel survey for Men who have sex with men(MSM) 2011
- Anti-Discrimination Laws of the Federation of St. Christopher and Nevis.

The narrative writing process also included input from various officers contributing in different areas of the report. The final report was reviewed and validated by the Permanent Secretary and the Chief Medical Officer. In addition, the report was submitted to the CHRC for final review prior to submission.

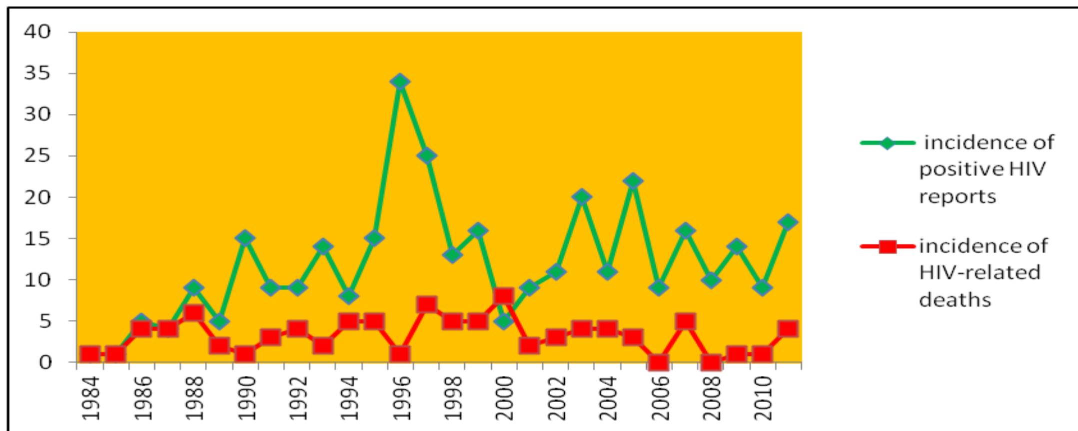
Status of the epidemic

In St. Kitts and Nevis as elsewhere in the Caribbean, HIV/AIDS has emerged as a major public health and socio-economic problem affecting all walks of society, including vulnerable and most- at-risk groups.
At the end of 2011, the population of the twin island federation was estimated at 53,000 and GDP was estimated at 918 million USD (purchasing power parity), with an economy mainly based on tourism and financial services.

The first case of HIV/AIDS was reported within the federation in the year 1984. Over the period 1984-2011, a cumulative total of 335 HIV/AIDS cases were reported to the Ministry of Health, yielding a cumulative prevalence rate of 0.5 % for the reported cases.

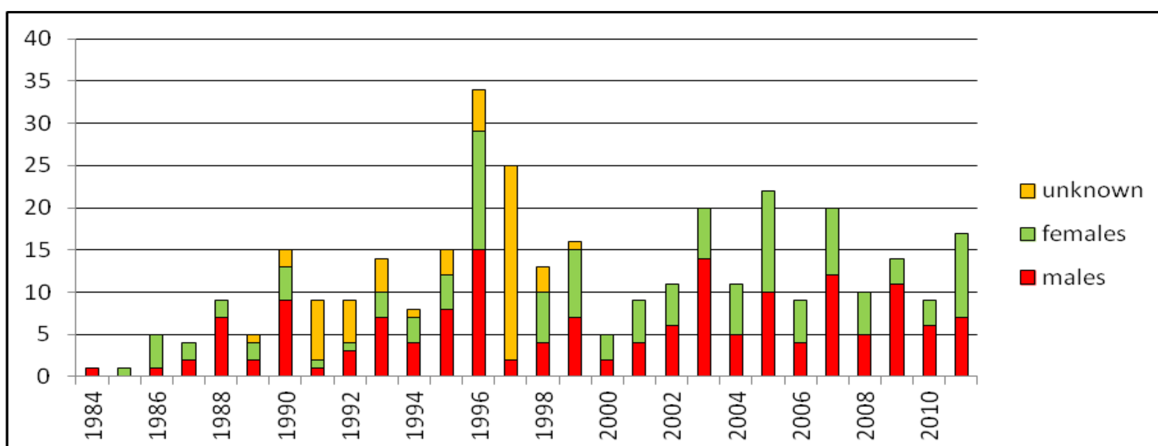
In the absence of sero-prevalence studies, there is no evidence of a generalized or concentrated epidemic. Existing data suggests that the epidemic depicts a generalized pattern which is consistent with the rest of the Caribbean with an adult HIV prevalence rate of 0.9-1.1 %. There is also widespread perception that more serious sub-epidemics may be affecting vulnerable and most-at-risk populations that are unwilling to be identified and labeled in certain categories due to fear of stigma, discrimination and breach of confidentiality.

Figure 1: Incidence of HIV Positive Reports and HIV-Related Deaths in St. Kitts & Nevis, 1984-2011



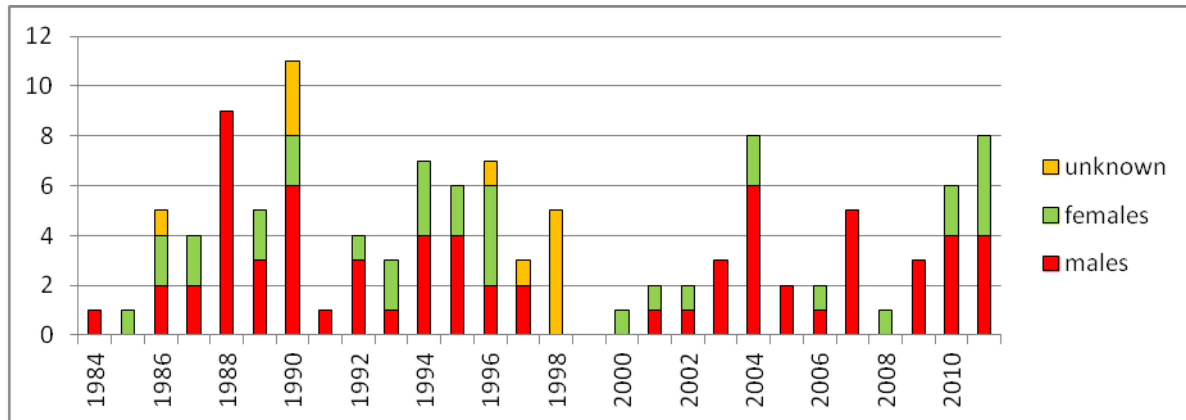
During the years there has been significant variability in the incidence rates of HIV. Compared to 1996 when the epidemic peaked with 34 newly diagnosed, fewer new cases have been recorded. There were 9 and 17 new cases in 2010 and 2011 respectively. (Fig.1) The annual prevalence of AIDS-related deaths has remained at 5 or less for the last decade. However concerns of underreporting still exists due to issues of stigmatization to family members as well as failure of the M&E system to link coded names to death certificates.

Figure 2: Incidence of HIV Positive males and females from St. Kitts and Nevis, 1984-2011



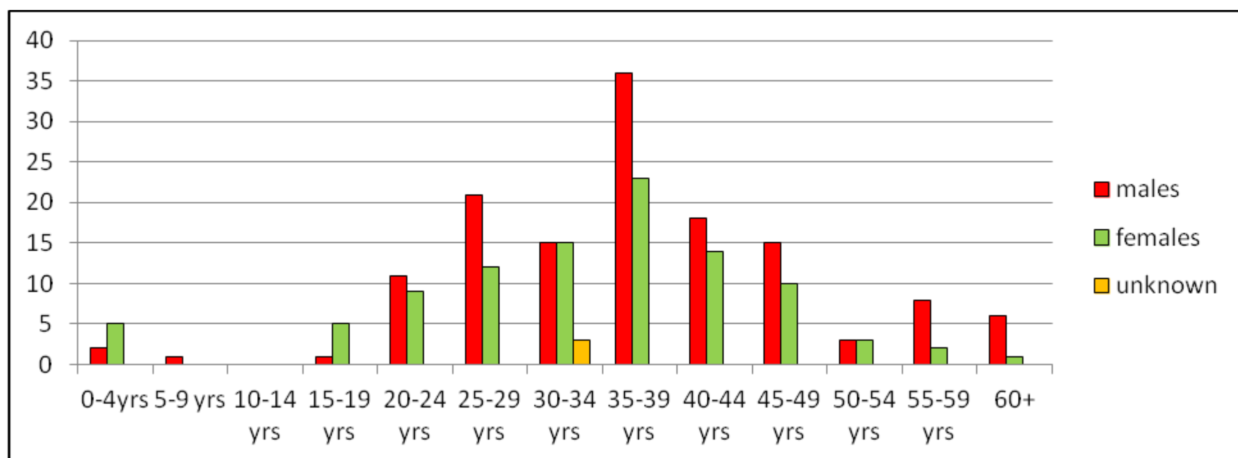
Over the period 1984-2011, HIV and AIDS have been found to be more prevalent in males than females with a cumulative ratio of 1.3: 1 for HIV positive diagnosis and 2: 1 for AIDS diagnosis (Figures 2 & 3).

Figure 3: Incidence of AIDS in males and females from St. Kitts and Nevis, 1984-2011



The age and gender distribution among HIV reported cases has shown that the prevalence rate for men is higher in most age categories. The 0-4 yrs, 15-19 yrs, 30 -34 yrs, and 50 -54yrs age groups are exceptions In addition, the predominant age group affected, the 35 -39 age cohort, represents almost 25 % of all reported cases (Fig. 4). .

Figure 4: Prevalence of HIV/AIDS in St. Kitts and Nevis Disaggregated by Age Group and Sex, 1984-2011



Transmission during injecting drug use is thought to be minimal and may not significantly contribute to the HIV epidemic.

Indicator Data

Table 1: Global AIDS Indicator data

Targets		Indicator	Indicator Value	Comments
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015				
General population	1.1	% of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	51.48% N=202 2010)	It was noted that 51.48% of persons aged 15-24 both correctly identified ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. The data was disaggregated according to gender and age. The NAS has focused its efforts on improving knowledge and moderating behaviour that fuel the HIV epidemic through the use of the media, in school and out of school youth life skills improvement programmes and talks and seminars. Programmes implemented are addressed at the preventative level.
	1.2	% of young men and women aged 15-24 who have had sexual intercourse before the age of 15	13.86% N=202(2010)	The survey conducted indicated that a total of 13.86% of which 21.15% were males and 6.12% were females, had sexual intercourse before the age of 15. There is no later surveillance to assess behaviour change. However, teenage pregnancy may be used as a proxy for sexual intercourse.
	1.3	% of adults aged 15-49 who have had sexual intercourse with more than one partner in the	15.19% N=454(2010)	The data was disaggregated by age and gender and it was noted that 25.39% of males and a lesser 7.92 % of females indicated that they have had sexual intercourse with more than one partner in

Targets		Indicator	Indicator Value	Comments
		past 12 months		the last 12 months. The NAP has identified the youth (15-24) as an existing MARP.
	1.4	% of adults aged 15-49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse	53.6% N=69(2010)	The data shows that 47.6% of women of which 55.56% were aged 15-24 used a condom during their last sexual intercourse while 56.3 % of males of which 57.69 aged 15.24 indicated the same. The National AIDS Programmes in St Kitts and Nevis have been instrumental in implementing numerous preventative programmes and policies
	1.5	% of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Data relevant but not available	There was no data available when this indicator was measured.
	1.6	% of young people aged 15-24 who are living with HIV	0 (2011)	The indicator value was 0%. The data was derived from the Antenatal Clinic data its interpretation can be attributed to the possibility that based on previous data, that the epidemic may have a higher prevalence in males than females.
Sex workers		The data for indicators 1.7,1.8,1.9 and 1.10 are relevant but not available	Data relevant but not available	
Men who have sex with men		The data for indicators 1.11, 1.12, 1.13, 1.14 are relevant but not available	Data relevant but not available	

Targets		Indicator	Indicator Value	Comments
Testing and Counselling	1.15	% of health facilities that provide HIV testing and counselling services	80% N=20 (2011)	Figure represents public sector facilities. While many private facilities reported they were providing counseling and testing, no reports were submitted by them during the reporting period.
	1.16	Number of women and men aged 15 and older who received HIV testing and counselling in the past 12 months and know their results	1784 (2011)	
Sexually Transmitted Infections	1.17	% of women accessing ANC services who were tested for syphilis at first ANC visit	Data relevant but not available	
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015				
	2.1	The data for indicators 2.1, 2.2, 2.3, 2.4, 2.5 are not applicable	Data not applicable	
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths				
	3.1	% of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	100% N=3 (2011)	The denominator used for all the reporting years is the actual number of HIV positive women in the last 12 months and it has been estimated that 100% of the population in question are able to access antenatal care in St Kitts. The numbers involved in the denominator is insufficient to make a trend analysis.
	3.2	% of infants born to HIV-positive women receiving a virological	Data relevant but not	

Targets		Indicator	Indicator Value	Comments
		test for HIV within 2 months of birth	available	
	3.3	Mother-to-child transmission of HIV (modeled)	Data relevant but not available	
	3.4	Pregnant women who know their HIV status	465 N=548 (2011)	There were 548 pregnant women of which 527 were tested and a subsequent 465 received their results.
	3.5	% of pregnant women attending ANC whose male partner was tested for HIV in the last 12 months	Data relevant but not available	
	3.6	% of HIV-infected women assessed for ART	100% N=3 (2011)	This assessment was done through CD4 testing and data shows that 100 % of HIV infected women were assessed for ART.
	3.7	Infants born to HIV-infected women receiving ARV prophylaxis for prevention of mother-to-child transmission.	100% N=3 (2011)	Data shows that 100% of infants born to HIV infected women receiving ARV prophylaxis for PMCT.
	3.8	Infants born to HIV-infected women who are provided with	0 N=0 (2011)	Of the HIV infected women who were provided with ARV, the indicator stands at 0.

Targets		Indicator	Indicator Value	Comments
		ARV		
	3.9	% of infants born to HIV-infected women started on CTZ prophylaxis within 2 months of birth	100% N=3 (2011)	Data showed that 100% of infants born to HIV-infected women were started in CTZ prophylaxis within 2 months of their birth.
	3.10	Distribution of feeding practices for infants born to HIV-infected women at DPT3 visit	N=3 All were replacement breast feeding (2011)	All women were practicing replacement breast-feeding at the time of DPT3 visit.
	3.11	Number of pregnant women attending ANC at least once during the reporting period	548 (2011)	It was reported that 548 women at the time of reporting had attended at least one ANC session.
	3.12	% of health facilities that provide virological testing serves for diagnosis of HIV in infants on site or from dried blood spots	0 N=0 (2011)	**At this time there are no health facilities that provide virological testing services for diagnosis of HIV in infants on site or from dried blood spots.**
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015				
	4.1	% of eligible adults and children currently receiving	98%	Anti retroviral therapy is available to all who need. As of

Targets		Indicator	Indicator Value	Comments
		antiretroviral therapy	N=51 (2011)	2010 there was a 98% access of ART drugs.
	4.2	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	100% N=7 (2011)	100% PLHIV are adherent to ART therapy.
	4.3	Number of health facilities that offer ARV	N=2 (2011)	
	4.4	% of health facilities dispensing ARV that have experienced a stock-out of at least one required ARV in the last 12 months	0 N=2 (2011)	
	4.6	% of adults and children enrolled in HIV care and eligible for CTX	96.2% N=52 (2011)	
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015				
	5.1	% of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	0 N=0 (2011)	During the period 2009-2010, 4 and 2 cases respectively were recorded in the TB register. All persons were tested negative for HIV; hence there were no cases with co-infections of TB and HIV.
	5.2	Number of health care facilities possessing ART services for PLHIV with demonstrable	N=2 (2011)	

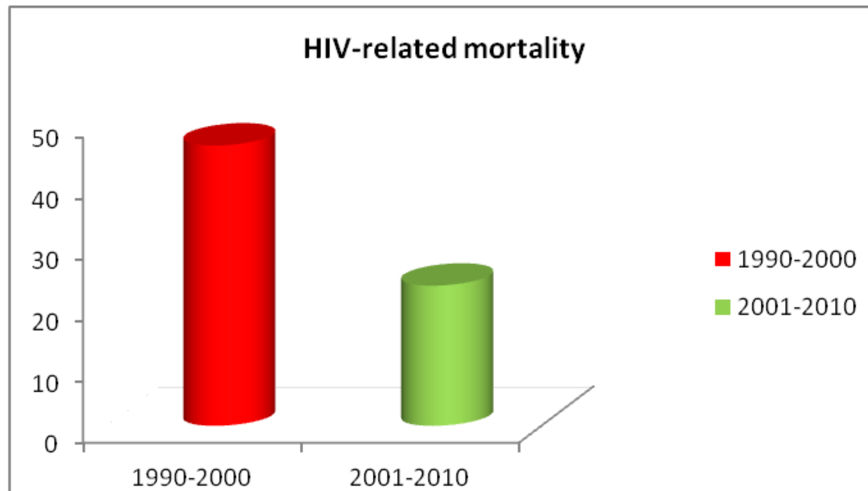
Targets		Indicator	Indicator Value	Comments
		infection control practices that include TB control		
	5.3	% of adults and children newly enrolled in HIV care starting IPT	Data not relevant	
	5.4	% of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	Data relevant but not available	
Target 6: Reach a significant level of annual global expenditure (US$22.24 billion) in low-and middle-income countries				
	6.1	Domestic and international AIDS spending by categories and financing sources	See appendix	
Target 7: Critical Enablers and Synergies with Development Sectors				
	7.1	National Commitment and Policy Instruments		
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Data relevant but not available	

Targets		Indicator	Indicator Value	Comments
	7.3	Current school attendance among orphans and non-orphans aged 10-14	0 (2011)	
	7.4	Proportion of the poorest households who received external economic support in the last 3 months	Data relevant but not available	

II. Overview of the AIDS Epidemic

The first HIV/AIDS case in the Federation of St. Kitts and Nevis was reported to the Ministry of Health in 1984. Between 1984 and 2011, there were 335 documented cases of HIV infection of which 115 progressed to AIDS.

Figure 5: HIV-related mortality by decade, 1990-2010



During the same time period 89 persons died from AIDS-related illnesses. The annual prevalence of AIDS-related deaths has remained at 5 or less for the last ten years (2002-2011), with 1 and 4 deaths recorded in 2010 and 2011 respectively. When compared to the previous decade, there is a decrease by one-half in the HIV-related deaths (*Fig 5*). In spite of the concerns regarding underreporting, this decline can be reasonably attributed to improved treatment access, increase in campaigns encouraging persons to get tested as well as the availability of free anti-retroviral therapy within the Federation.

Due to the variability in the reported number of cases between years, no clear trend can be described from the annual reported number of HIV cases. In 2010 and 2011 respectively, there were 9 and 17 reported HIV cases, representing incidence rates of 17.3 and 32 per 100,000 populations.

In the last two years (2010 and 2011), 13 males and 13 females were tested positive for HIV. Although, overall there is a preponderance of males who are infected with the disease (*Fig. 4*), evidence has emerged that the epidemic is infecting and affecting both sexes without any clear distinction, and likewise indicating that an increase number of women are also bearing the burden of the disease.

The age and gender distribution among the most sexually active groups (15- 49) also show that with the exception of the 15-19 age group, males are most affected by HIV among all sexually active age groups including 60 years and older (*Fig.4).*

Although some progress has been reported in promoting knowledge of HIV sero status through the VCT programme, greater emphasis in preventive and VCT strategies should be focused on vulnerable and most-at-risk groups.

As of 2011, 58 persons living with advanced HIV disease are under medical supervision of which 50 receive ART. St. Kitts and Nevis has made significant progress in ensuring that persons living with HIV/AIDS are able to receive free of charge anti-retrovirals and supplements necessary to live healthy and productive lives.

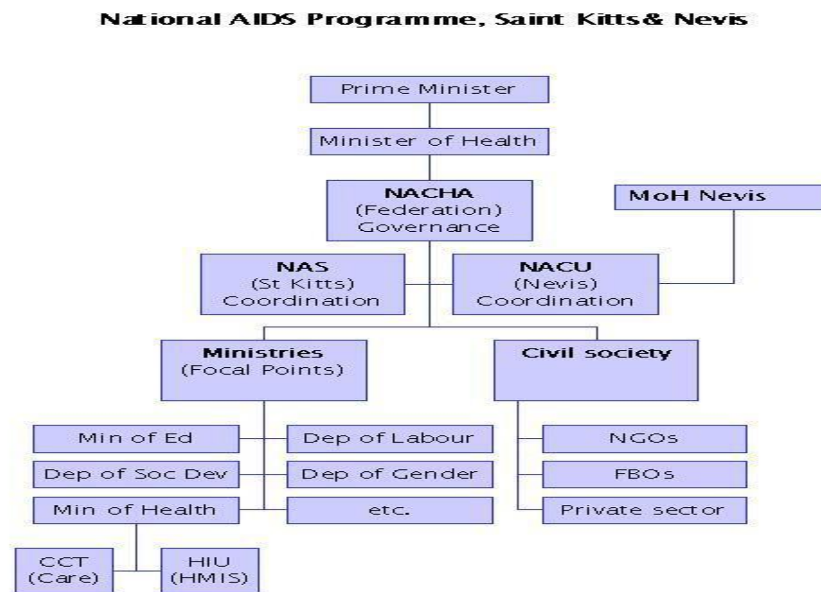
III. National Response to the AIDS Epidemic

Policy and programmatic response

As of 2005, the national response to HIV has been under the responsibility of the National Advisory Council on HIV/AIDS (NACHA). This body comprising of Civil Society, PLHIV and government representative has its mandate from the office of the Prime Minister. NACHA's roles and responsibilities include the coordination of the national response through its implementing partners, the development of national strategic and operational plans and monitoring of the national response. There are three mandatory and one ex- officio seats on the NACHA for the sister island of Nevis to ensure adequate representation. The

organogram below shows the structure of the National AIDS response for St. Kitts and Nevis.

Figure 6: Organogram of the NAP in St. Kitts & Nevis



The government of St. Kitts and Nevis continues to make HIV a priority and demonstrates this in its efforts towards the reduction of HIV incidence, zero tolerance of stigma and discrimination and zero AIDS related deaths. These efforts are guided by the current 2010 -2014 National Strategic Plan. There has been a decline in financial support from donor agencies and the government has been instrumental in maintaining and sustaining the response through local government funding. Funds are directed mainly to program management and coordination, treatment and care of PLHIV and prevention activities such as outreach Counselling and Testing (CT), Information, Education and Communication (IEC) materials. As a consequence, there has been a significant increase in the number of persons knowing their HIV status through the community outreach activities and partnerships with the Caribbean HIV/AIDS Alliance (CHAA).

Despite the strengthening of these program areas there is still a lack of capacity and functioning of Civil Society and other line ministries. With the recent economic depression, there has been the scaling back of prevention activities. This was combated through the

integration of HIV into existing program including those of the Gender Department and Ministry of Health. Additionally, the decrease in funding affected the ability to provided IEC materials and the extensive utilization of the media, specifically privately own media houses. While it is felt that there is some “buy in” from the private sector, harsh economic times have forced everyone to reevaluate and reprioritize.

Notwithstanding the shortfall of funds, the government has committed itself to the review and initiation process of the amendment of anti-discriminatory laws. Through the Prime Minister’s Office, the Attorney General is engaged in the review of policy and model legislation to repeal laws within the Federation that marginalize and contribute to stigma and discrimination of certain groups including MSM, SW and PLHIVs. Support is being provided through the UNAIDS in promoting an equality agenda that is geared towards engaging civil society in discussions on prejudice and tolerance of persons, fostering a tolerant society.

Gender Issues

As part of the national policies of St. Kitts and Nevis, the government has identified the rights of the women as an important component in the advancement of gender equality. Gender equality is a central element in advancing sustainable development, social justice, peace and security. St. Kitts and Nevis has always played a lead role in women's empowerment. For us, the occupying of high offices and decision making roles by women have been the norm, a tradition we embrace and continue to cultivate. However, although women do not occupy as many senior positions as men in our society, women and men received equal salaries for comparable jobs. St. Kitts and Nevis thus remains committed to gender-equal opportunities at home and abroad.

In an effort to detect and reduce gender based violence, the Ministry of Gender Affairs offers an array of services including counseling, mediation, legal and social assistance for victims of abuse and conducts training on domestic and gender base violence for officials in the police and fire departments, nurses, school guidance counselors, ombudsman, other government employees, the private sector, faith-base and civil society organizations.

The Federation has enacted legislation such as the Domestic violence Act of 2000 and as measures to address Gender base violence.

Additionally, the federation is a State Party to the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women "Convention of Belem do Para", Inter-American Convention on the Granting of Civil Rights to Women and the Inter-American Convention on the Granting of Political Rights to Women.

St. Kitts and Nevis is also signatory to the United Nations Declaration for the Elimination of Violence Against Women (CEDAW 1993, and has also ratify the Optional Protocol in 2006) The Beijing Platform for Action (1995), the Millennium Declaration (2000), and the U. N. Security Council Regulation 1325 (2000) on Women Peace and Security (2000).

MSM

Along with other countries throughout the Caribbean, St Kitts and Nevis has a substantial information gap with regard to MSM activity. To date, policy makers and programme managers have been limited in their ability to develop and implement evidence-based prevention and control interventions geared towards MSM. There is a particular challenge in doing research in the very small populations of the Eastern Caribbean countries as the population size makes it even more difficult to access and work with populations which operate under a cloud of social and legal disapproval and rejection.

A cross-sectional anonymous survey of HIV related knowledge, attitudes, behaviours, practices as well as HIV sero-prevalence was conducted among men who have sex with men was conducted in St Kitts and Nevis in June 2011 with the support of UNAIDS. The sample included 150 men who were at least 16 years of age and who had ever had penetrative sex with men. The majority (67%) of respondents were under the age of 25 years. Being the first of this kind of research to be conducted in St. Kitts and Nevis the data is the best available to estimate the extent of knowledge, attitudes and practices among MSM in St. Kitts and Nevis but should not be used as a generalization. The results of the survey are sufficient as a tool in monitoring the HIV response.

Ninety eight percent knew about the availability of HIV testing in St. Kitts and Nevis however a quarter (25.9%) believed that a person could not obtain a confidential HIV test in St. Kitts and Nevis. More than two thirds (68.7%) of respondents had ever received a test in the last six months with 95% knowing their result. The majority (88.9%) was tested in country. There is a widespread perception there is breach of confidentiality regarding HIV test report.

	Same sex (regular partner)	*Same sex (non-regular partner)*	*Female*
Percentage of men reporting the use of a condom the last time they had anal sex	67.4	59.3	62.4

The data indicated above demonstrates that condom use was not consistently employed (67.4% in same sex, regular partners; 59.3% in same sex, non-regular partners; and 62.4% in female partners), although it was higher in same sex, regular partners. More than half of the respondents reported having first sexual experience between ages 10 - 15 years while thirty percent (30.7%) were between 16 – 20 years. Additionally, with 74% of MSM respondents indicating that they were not in a monogamous relationship, there should be a renewed emphasis on condom use regardless to a) the HIV status of partner, b) if in a perceived monogamous relationship, regardless of the length of that relationship.

In spite of the different education programmes that have been conducted over the last five years, the level of promiscuity of the MSMs remains high. The frequency of multiple partnerships and condom use with all types of partners increases the risk of infection. This gap between the knowledge and the practices indicate that new educational strategies should be implemented and reach a greater percentage of the MSN population.

Treatment, Care and support

PLHI treatment, care and support in St. Kitts and Nevis are managed through both the private and public sectors. A clinical management team comprising of various expertise

oversees the comprehensive management of PLHIV. The team is managed by Clinical Care Coordinators on both islands. Antiretroviral therapy is made available free of cost to all PLHIV and is accessible at two points of service. However, patients have the freedom to seek medical care at any physician of their choice.

Patients are tracked through a standardized paper-based system. While having some merits, this mechanism has proven to be challenging in collection of data from some physicians. Despite trainings and orientations to the system, there still exist inadequate data input which makes it difficult to ensure clinicians are adhering to standardize care and management to PLHIVs. An HIV Policy and Procedure manual has been in existence since 2006 and serves as the operational guide for managing HIV. There are still reported instances of clinicians not being familiar with protocol despite widespread circulation.

VCT Efforts

VCT efforts have increased in 2010 and 2011 where there was an increase in the level of activities by community health centres. HIV outreach efforts have resulted in increased visibility and access to health centres and the number of persons knowing their HIV status. In 2011, 2175 persons were counseled and tested compared 1478 in 2010 (*Fig. 7*). However, there is still minimum uptake of males where in 2010 just under 400 (364) men were tested and 534 in the following year (*Fig. 8*).

Figure 7: Overall counseling and testing Uptake for 2010 & 2011

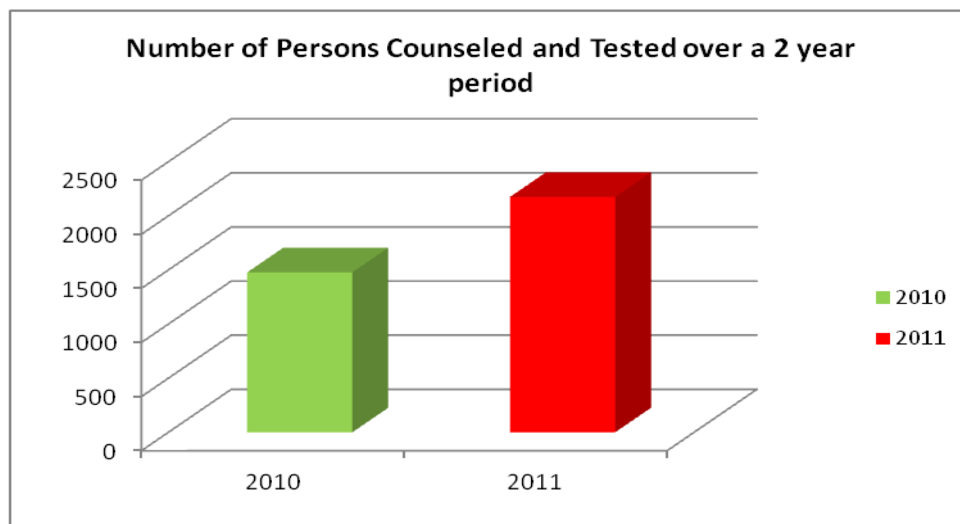
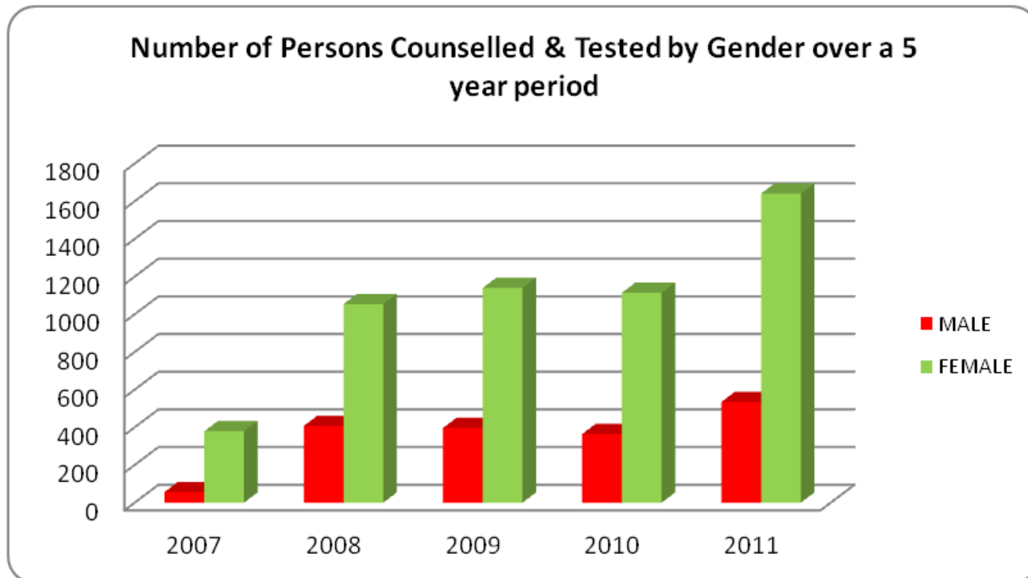
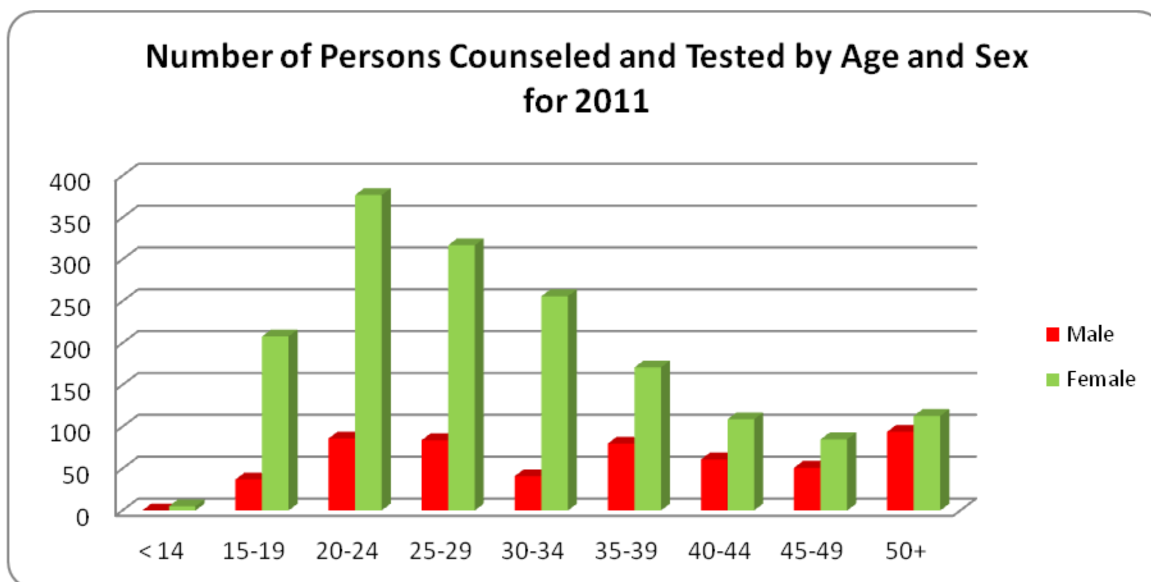


Figure 8: Counseling and Testing uptake by Gender



Efforts are being made to address this shortfall through the intensified men's heath programs within community health centres and also the targeting of non-traditional outlets such as barbershops, construction sites and ferry terminals where men congregate on a regular basis. The most dominant age range accessing testing and counseling services was the 20-29 age groups (*Fig 9*).

Figure 9: Counseling & Testing uptake by Age and Sex



IV. Best Practices

The National AIDS Program continues to make significant strides in the "*Know your Status*" Outreach initiative. This program which was first launched in 2005 has seen a marked increase in the number of persons receiving HIV tests and knowing their status. As a result, the number of positives individuals in care has increased where PLHIVs are currently living longer, productive lives.

The strategy involves mobile HIV testing where educators, nursing and lab personnel organize testing and screening within communities on specific days. The activity is preceded with ample promotion and awareness to ensure targets are met. In addition to the community testing days, national testing days including regional HIV testing day on June 27th are also organized. Additionally, work place testing is well received in many organizations.

Feedback from the public indicates that outreach testing is favored over attending the clinics or private physicians for HIV testing. Rationales given are that in an atmosphere such as the outreach, there is community anonymity that takes away the fear of doing the test. It is also convenient and free as opposed to the cost at physicians' office. They also highlighted the same day results as a significant advantage.

V. Major Challenges and Remedial Actions

CHALLENGES	REMMENDATIONS
Programme Coordination and Management	
1. In adequate human resources to effectively coordinate national response.	Consideration given to the recruitment and retention of additional staffing for the National AIDS Program.
2. Absence of strong CSO involvement and presence in national response.	➢ Needs assessment of CSO ➢ Development of CSO plan.
3. Inadequate Line Ministries "*buy in*" and involvement and absence of	Mandatory inclusion of Line item in Ministries budget.

mandatory HIV Line budgets for Ministries.	
4. Inadequate skilled and appropriated human resource	Competency evaluation and training plan for staff.
5. Limited financial resources to fully operationalize HIV Strategic Plan.	Mobilization of external funding to complement government current HIV/AIDS expenditure.
Policy and Legislation	
1. Absence of legislation on Stigma and discrimination re: disease status and sexual orientation.	Revision of current legislation to repeal discrimination laws and practices.
2. Absence of Healthy workplace and HIV policy.	Completion, sensitization and dissemination of HIV and other Chronic Disease workplace policies.
3. Limited monitoring mechanisms for HIV discrimination.	Strengthen and expand capacity of Human Rights Desk for HIV and other types of discrimination.
4. Lack of enabling environment for enacted of anti-human rights legislation.	Engage Civil Society in consultation on Human rights and equality education and promotion.
Prevention	
1. Inadequate and absence of key sero-prevalence data on vulnerable populations.	Improve on local capacity to design, implement and analyze data for strategic use.
2. Absence of HFLE curriculum in school.	Development and implementation of country contextual HFLE curriculum.
3. Lack of structured program for out-of- school youths.	Development and implementation of out-of-school strategy.
4. Discomfort of teachers to teach sexual and reproductive health.	Sensitization training and sexuality trainings for teachers and counselors to improve comfort level and scale up of prevention in school settings.
5. Absence of Champions for change in HIV prevention and advocacy.	Meaningful engagement of key opinion leaders in the delivery of HIV Prevention strategies.
Treatment, Care & Support	
1. Lack of standardized care and treatment for PLHIV despite presence of policy and procedure manual.	Re-sensitizing of clinicians and increased promotion and circulation of HIV Policy and Procedure manual
2. Limited and sporadic nutritional support for PLHIVs in need.	Inclusion in government annual funds for a minimum of PLHIV who are in need of

	nutritional support.
3. Lack of available public sector psycho-social support for PLHIV.	Recruitment of two psycho-social professionals designated to the provision of these services to PLHIV.
4. Non-functioning of Clinical Care Team.	Restructuring, promotion and additional financial support to team.
5. Perception of lack of confidentiality by vulnerable groups of health care providers.	➢ S& D assessment among Health care providers ➢ Trainer of Trainer S&D training for Health care providers and persons from key populations
Monitoring and Evaluation	
1. Inadequate M&E structure and Unit.	Restructuring of Unit.
2. Lack of capacity of human resources in Unit.	Increase human resource and build capacity through trainings.
3. Poor M& E culture.	Continue promotion and awareness of M&E.

VI. Support from the country's development partners

Currently there is the challenge of detailing AIDS spending in the absence of the National AIDS Spending Assessment tool. Efforts are being made to address this through the provision of funding matrix that can be used as part of routine financial monitoring.

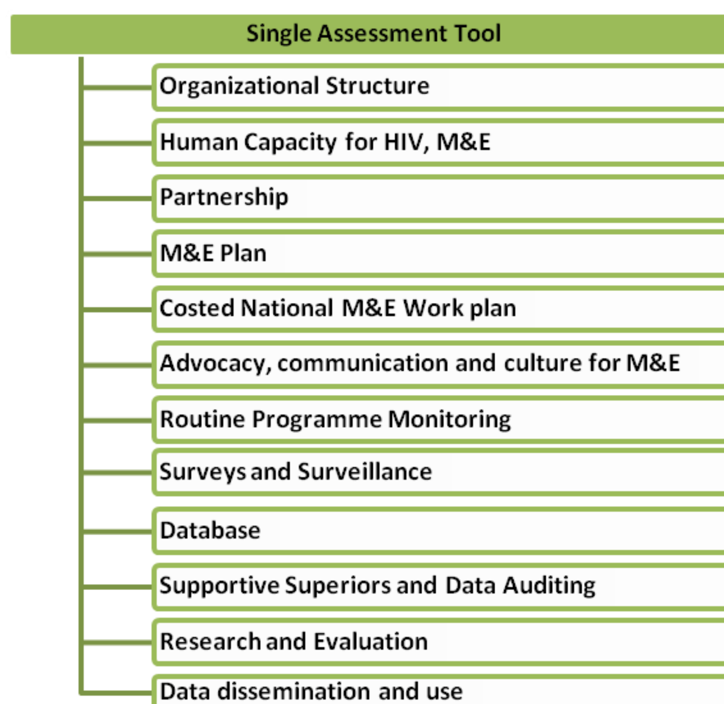
Funding Agency	Amount EC $	Amount USD $
UNAIDS	$59,772.00	$22,000.00
PAHO	$4, 125.00	$1518.00
Local Partners	$9,300	$3423.00
Total	**$73,197.00**	**$26,941.00**

VII. Monitoring and Evaluation

The Caribbean Health Research Council was commissioned by the OECS HIV/AIDS Project Unit to conduct an assessment of the Monitoring and Evaluation system in St. Kitts and Nevis. This assessment was conducted over a five day period in July, 2010.

The methodology was derived from a philosophy of sustainability, and integral to this was the cooperation and involvement of local and regional stakeholders from the multi-sectorial response to HIV and AIDS. The Caribbean Health Research Council utilized the Single Assessment tool which is based on a twelve component organizing template of a functional national HIV Monitoring and Evaluation system (Fig 10).

Figure 10: Single Assessment Tool



Component 1: Organizational Structure

The Ministry of Health in both St. Kitts and Nevis has specific persons assigned to perform the M&E functions for the HIV Programme. In St. Kitts, the M&E focal point is a person with the job title of "Data Entry Clerk" who has been trained in M&E and fulfills the M&E functions for the HIV Programme and provides M&E support to other areas of health as required. The M&E functions performed by this staff member are inconsistent with the official job title and description. The Ministry of Health in Nevis has an official M&E post in the bureaucratic structure that is filled by someone who has received training in M&E. The

M&E Officer in Nevis has responsibility for M&E for the HIV Programme and all other areas of health. HIV partner organizations do not have dedicated M&E focal points of M&E Officers. The exception is the Alliance which has an M&E officer to fulfill the M&E requirements associated with that project.
Other organizations have focal points who contribute to the M&E system through facilitating the collection and reporting of data to the HIV focal point at the National AIDS Programme.

Their importance and role of M&E is recognized by staff in senior positions in the Ministry. The Government of St. Kitts and Nevis has not yet conducted a formal M&E needs assessment. The current M&E staff complement is based on fiscal and organizational realities of the country. At present, there is sufficient staff to fulfill the HIV/AIDS M&E functions in St. Kitts and Nevis.

Component 2: Human Capacity for HIV M&E

Official M&E posts have not been created in St Kitts. There are therefore no career paths for M&E. Currently the Data Entry Clerk at the Health Information Unit functions as the M&E Officer and has been assigned responsibility for data collection and reporting to both internal and external stakeholders. She has demonstrated that she has the minimum required skills required for the job.

There has been no formal assessment of human capacity for M&E and consequently no capacity development plan. The M&E capacity of selected staff members has been developed utilizing support from M&E technical support agencies in the region. The technical requirements of M&E posts, functions and structure are well understood at the policy level. There is also strong support for the development of human capacity for M&E. Consequently, the M&E Officer has benefitted from several M&E training opportunities, preceptor ships and mentorship programmes.

It is important to note that the post of M&E Officer has been established in Nevis and is funded by the Ministry of Health. This approach serves as an example to Ministries across

the region as it demonstrates high-level commitment to M&E. The Ministry of Health in Nevis is also seeking to establish a unit to focus specifically on M&E. This unit will be a combination of the Health Information Unit and the Statistics Unit. The new Unit will serve the M&E needs of the ministry and will not be limited to HIV.

Component 3: Partnerships

There are no national M&E or Health Sector Technical Working Groups in St. Kitts and Nevis. The draft M&E plan provides guidance on the roles and the responsibilities of the HIV/AIDS M&E TWG in addition to its structure and composition.

The National AIDS Programme has compiled a list of stakeholders which is available upon request. The key stakeholders involved in the HIV/AIDS response include line ministries and civil society organizations. However, the level of participation by these agencies in the HIV M&E system varies. The work of national partner agencies relates primarily to the implementation of activities as M&E is not a key function of the agencies included in the assessment. This is evidenced by the lack of agency specific plans. Exceptions include the Caribbean HIV/AIDS Alliance and the Ministry of Education which utilize an M&E framework and an M&E plan, respectively.

Component 4: M&E Plan

St. Kitts and Nevis has had a draft M&E plan since 2008, some stakeholder input was involved in the development of this plan. Although the draft M&E plan was shared by the NAP with the different stakeholders, there is not full endorsement for this document in each key organization involved in HIV M&E.

The time period of the existing draft M&E plan is aligned with the time period of the National Strategic Plan. All indicators on which St. Kitts and Nevis need to report, are incorporated in the plan and are linked to the objectives of the NSP

Component 5: Costed National M&E Work Plan

There is no national M&E work plan for St Kitts & Nevis. However, a draft M&E Plan exists and can be used to guide the development of an M&E work plan and accompanying budget once it is completed. Currently, M&E activities are directed largely by the reporting requirements of the Global Fund project for which there is an annual work plan and budget. As such, reporting on indicators do not focus on specific tasks related to the development of M&E in St Kitts & Nevis.

Component 6: Advocacy, Communication and Culture for M&E

Stakeholders at all levels are familiar with M&E and its importance. However, the M&E culture in St. Kitts and Nevis is still in the early stages of development, and there is growing recognition within the Ministry of Health that M&E is not only of relevance to HIV/AIDS but other areas of public health.

The knowledge, attitudes and perceptions of stakeholders could be attributed to the importance that is placed on M&E by external agencies and resulting efforts at the national level to (i) provide M&E data, (ii) include M&E in HIV/AIDS programmes as necessary and (iii) to undertake the training and sensitization of stakeholders on M&E within the context of HIV/AIDS. The M&E communication materials include quarterly and annual reports with M&E data. Pamphlets are also used to disseminate statistics and programme data to general audiences. To date, no M&E champions have been identified in St. Kitts and Nevis. Although persons working within the NAP have promoted M&E within the Federation, the broad acceptance of the value of M&E is still lacking.

Stakeholders, such as the MoH, have demonstrated a commitment to M&E through the provision of M&E data and programmatic information as requested. For example, data use and dissemination is included in the NSP, the operational and draft M&E plans, and the NSP and operational plans incorporates M&E. However, no mechanism exists for the communication of information on the M&E plan and the performance of the M&E system on a routine basis

Component 7 - Routine Program Monitoring

In St. Kitts and Nevis, limited written guidelines exist for procedures regarding the recording, collection, and collation of data at national and health facility levels, however, these guidelines are donor-specific (GFATM and UNGASS). Double-counting is minimized through the use of a national client coding system. While this coding system is used consistently within the public sector, there is inconsistent use of the code among private sector providers. No existing system of enforcement is available to facilitate routine use of the code among private sector physicians or private sector providers of laboratory services.

Standardized forms for data recording and collection are used among some providers of services in St. Kitts and Nevis. VCT data is reported separately by the National AIDS Secretariats of St. Kits and Nevis. Steps are underway to harmonize data collected for HIV Care and Treatment Patient Monitoring through the use of a standardized HIV Care/ART card in both of the clinical care settings. Other line ministries and CBOs reporting is activity-specific. Systems for the collection of routine program monitoring data, according to each of the main program areas: HIV Care and Treatment, Community Health (VCT, PMTCT and STI Treatment/Prevention), lab, pharmacy, and prevention/BCC, are unlinked. A hospital information system also exists at the public hospital facility in St. Kitts, but is limited to the collection of vital statistics and demographic data for all patient registrations. Both Clinical Care Coordinators in St. Kitts and Nevis are transitioning to the use of standardized paper forms for HIV Care and Treatment patient monitoring and tracking.

Component 8 - Surveys and Surveillance

At the MOH, a limited inventory of HIV related surveys exists within the Federation of St. Kitts and Nevis. A repository of these surveys does not yet exist within the National AIDS Programs of St. Kitts or Nevis. While survey-based indicators are included in the draft M&E plan, related surveys are still to be completed for the current reporting on these indicators.

Component 9: Databases

Electronic data entry in St. Kitts and Nevis is primarily found at the national HIV unit. Microsoft excel is used to record data pertaining to testing, etc. Different excel sheets are used according to data type. These data collection sheets have unique identifiers which make it possible to link information from different sources. The design of data collection sheets followed the reporting requirements of the Global Fund and other donor organizations.

Limited electronic data entry occurs at the sub-national level or with national partners, the Alliance is possibly the only organization known to do data entry which emanates from aggregated reports. There is no electronic transfer of data from sub-national and facility databases to the national level. However, pharmacies in St. Kitts and Nevis have a database to enter patient information; this information is provided to the HIV unit in paper based format. Not all data captured by the HIV M&E system is stored electronically. Quality control issues such as double entry are addressed and reduced through the use of unique identifiers used on excel sheets. The relatively small population size should also reduce the occurrence of double entry. Additionally, clinical data from health facilities are complemented by pharmacy data.

There are dedicated persons performing data entry and updating Excel spread sheets. An identified challenge is the limited human resources available and capable of maintaining this process. Only one person is familiar with data entry and this same person is responsible for preparing reports. Both islands have capable IT support and maintenance.

Component 10: Supportive Supervision and Data Auditing

To date, no written manuals or protocols exist for supportive supervision and auditing of routine HIV service data. However, verification of the quality, accuracy, and completeness of routine monitoring data is conducted by the M&E Officer of Nevis and the data entry clerk of St. Kitts performing M&E functions.

Supportive supervision is conducted as part of the routine data collection process particularly for preparation of the quarterly report to the OECS. Such supervisory visits are limited to facilities, like health centers, that submit information for the generation of reports. Data auditing is conducted primarily at the National HIV AIDS Secretariat, this process is synchronized with the time frames set for the submission of reports to the OECS. Reports on these visits are not recorded and audits are not provided. Also absent are improvement plans to help build capacity of the individuals collecting the data and by extension, improving on the quality of the data collected.

Component 11: Research and Evaluation

There is currently no inventory of research and evaluation conducted in St. Kitts and Nevis. Selected staffs within the MOH are aware of critical research and evaluations conducted in the Federation. Copies of research and evaluation reports can be readily accessed upon request from the MOH and affiliated departments. In Nevis, research and evaluation reports are kept in a centralized location and can be readily accessed.

A strategy for commissioning research and evaluation within the Federation does not exist. While the Chief Medical Officer has the authority to review and approve research projects, there is no coordination/oversight body nor is there an ethics review committee. The Caribbean Health Research Council has provided support to St. Kitts with its Essential National Health Research activities in the past.

Research in the Federation is largely externally driven and supported and thus tends to adhere to international standards and guidelines. Structured processes and schedules for programme and project reviews are not currently performed, but these activities are conducted by regional and international organizations offering assistance to the Federation. The review processes component does not integrally involve local staff in a manner that facilitates capacity building. In Nevis, annual programme reviews are conducted as part of the annual budget process during which the status of each programme is reviewed internally. In addition, the MOH has periodic interval programme review meetings throughout the year for each programme.

Component 12: Data Dissemination and Use

The area of data dissemination and use needs further development in St Kitts and Nevis. No analysis of stakeholders‟ information needs or their ability to use data has been assessed. From discussions with stakeholders, it appears that of data collection, dissemination and use are not driven by national stakeholder needs but rather, by external reporting requirements.

Data collection is done routinely and collated at the offices of the NAS to satisfy reporting requirements particularly to the OECS Global Fund Project. However, a systematic method of providing feedback to those organizations and facilities which supply the information for the generation of reports does not currently exist. Notwithstanding the fact that stakeholders have access to the information that is being produced, it is only made available to them when requested and not through a structured data dissemination plan. Facility level data are collected on a routine basis as part of the general surveillance system. Other types of HIV specific data (e.g. the number of persons in treatment, numbers receiving voluntary counseling and testing etc.) are collected specifically for external reporting. Data is disseminated widely within the MOH and National AIDS Secretariat and to stakeholders upon request. Although data and information are readily available, they are not made easily accessible to stakeholders. Reports, summaries and tables are disseminated to stakeholders mostly when requested. There is no inventory of what data is sent to which agencies.

Data dissemination and use has been mentioned in the incomplete M&E plan, however, a plan or strategy for data dissemination and use does not exist, nor is there a structured schedule for data and information dissemination. In both St Kitts and Nevis annual reports on the functioning of the NAS are disseminated within the MOH and are used to guide programming. In conjunction, Nevis has adopted a wider avenue for information sharing by utilizing electronic media, public forums, quarterly pamphlets and copies placed at key institutions.