Global AIDS Response Progress Reporting 2012

Country Progress Report

Saint Lucia

Reporting period: January 2010 – December 2011

Submission date: 31 March, 2012

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Acknowledgements

The consultants wish to acknowledge the contribution and support of the following individuals in the preparation of this report:

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I. STATUS AT A GLANCE

Background

Saint Lucia's 238 square miles are comprised of mountains, hills and valleys. It forms part of the Eastern Caribbean and is situated approximately 40 km south of Martinique and 32km north of St. Vincent.

Its capital city is Castries, located in district of the same name. The official language of St. Lucia is English; however the majority of locals also speak French –Creole.

HIV infection and AIDS have been tracked in Saint Lucia since 1985, when the first case of AIDS was diagnosed.

HIV testing and counseling services are provided free of cost to citizens of Saint Lucia at the STI clinics and Laboratories in the public sector, and for a fee in the private sector. Anonymous and confidential testing is guaranteed in the public sector only; all tests in the public sector are code-based and only positive results are reported to the MOH.

HIV prevalence in St. Lucia is estimated at below 1%. However, there is a lack of definitive prevalence data with quoted figures ranging from 0.22% to 0.93%[1]. Based on the number of people living with HIV the National AIDS Program (NAP) has estimated an HIV prevalence rate of 0.28%[2].

Regardless of the estimated rate, it is likely to be an underestimate as the surveillance system is based on reports from public and private laboratories on clients tested, thereby missing groups known to be at highest risk of exposure to the virus in other countries, who are reluctant to use available services and remain underground (for example, MSM and sex workers). In addition, it is believed that a number of people travel outside the country to seek HIV testing and treatment, due to perceived weaknesses with confidentiality and anonymity in their home countries, so these cases are not included in the official count.

Risk factors in St. Lucia include a range of behaviors, including anal sex between men, sex work, and drug use. Similarly, a number of cultural factors identified by stakeholders could also be helping to drive the epidemic. These include multiple sexual partners, men on the 'down low', young women involved in transactional sex for survival or for 'gains', stigma and discrimination (which keeps people from testing and getting the prevention education and care they need), continued belief in myths and misconceptions about the virus, the taboo nature of sex (which inhibits discussion that could help prevent transmission), and a changing socio-economic

[1] NAPS estimates an HIV prevalence rate of 0.28%, while the estimates from AIDSProj and Spectrum indicate a prevalence of 0.93%

[2] St. Lucia, UNGASS Country Progress Report, 2009

context. In addition, legal barriers to working openly with men who have sex with men (MSM), sex workers and drug users make it difficult to reach these populations in need of support. Lastly, poverty seems to be playing a role in increasing vulnerability to HIV infection.

The principal mode of transmission has continued to be through sexual intercourse, with an increasing trend of:

- sex in exchange for gifts and support
- sex in exchange for drugs (most frequently crack cocaine)
- sex in exchange for cash (this is facilitated through foreign women working in brothels, "gentlemen's clubs", strip clubs or local street workers.

Commercial Sex Workers (CSWs), men who have sex with men (MSM), Cocaine/Crack Abusers, Prisoners and Pregnant Women comprise specially targeted sub-populations. Accurate estimates of these sub-populations however, are not available in Saint Lucia due to the lack of behavioral data for HIV and AIDS surveillance.

The heavy stigma attached to and the illegal nature of sex work, male on male sexual contact[3] and crack use has also resulted in a very significant aspect of the epidemic being left explored. Behavioral and prevalence data are therefore unavailable for CSWs and MSM.

Stakeholder Involvement in the Reporting Process

The data used to populate the indicators and to generate this report was obtained through an in-depth desk review and interviews with participants.

Group interviews were considered ideal, however due to the extremely hectic work schedules of most participants, individual interviews had to be conducted in order to facilitate participants. Some opted to have the questionnaires delivered electronically while others preferred telephone interviews.

Regardless of the type of interview conducted, all participants made themselves available for further questioning and clarification of concerns.

Stakeholders consisted of members of Civil Societies, Line Ministries and Government Officials.

A list of the participants is attached as Annex 1.

[3] While male on male sexual contact is not illegal, anal intercourse (buggery) continues to be listed in the Criminal Code of 2002 as an offense.

Overview Table

Indicator # and Name		Achievements (2011)	Notes
1.1	Percentage 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.	No Data Available	Indicator Relevant
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	No Data Available	Indicator Relevant
1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	No Data Available	Indicator Relevant
1.4	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of condom during their last intercourse	No Data Available	Indicator Relevant
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	No Data Available	Indicator Relevant
1.6	Percentage of young people aged 15-24 who are living with HIV	No Data Available	Indicator Relevant
1.7	Percentage of sex workers reached with HIV prevention programmes	No Data Available	Indicator Relevant
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	No Data Available	Indicator Relevant
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	No Data Available	Indicator Relevant
1.10	Percentage of sex workers who are living with HIV	No Data Available	Indicator Relevant
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	No Data Available	Indicator Relevant
1.12	Percentage of men reporting the use of a condom the last time they had sex with a male partner	No Data Available	Indicator Relevant
1.13	Percentage of men who have sex with men that received an HIV test in the past 12 months and know their results	No Data Available	Indicator Relevant
1.14	Percentage of men who have sex with men who are living with HIV	No Data Available	Indicator Relevant
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	No Data Available	Indicator Relevant
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	No Data Available	Indicator Relevant
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	No Data Available	Indicator Relevant
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	No Data Available	Indicator Relevant
2.5	Percentage of people who inject drugs who are living with HIV	No Data Available	Indicator Relevant

3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	80%	
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	80%	
3.3	Mother-to-child transmission of HIV (modelled)	0%	
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy*	89%	
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	76.9%	
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	100%	
6.1	Domestic and international AIDS spending by categories and financing sources		Completed
7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace, programmes, stigma and discrimination and monitoring and evaluation)		Completed
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	No Data Available	Indicator Relevant
7.3	Current school attendance among orphans and non-orphans aged 10–14*	No Data Available	Indicator Relevant
7.4	Proportion of the poorest households who received external economic support in the last 3 months	No Data Available	Indicator Relevant

II. OVERVIEW OF THE AIDS EPIDEMIC

HIV infection and AIDS have been tracked in Saint Lucia since 1985, when the first case of AIDS was diagnosed. As of December 31, 2011 a cumulative total of 879 cases of HIV infection have been reported among Saint Lucians comprising 530 (or 60%) with AIDS and the remaining 349 without AIDS. A total of 338 (or 38%) are known to be deceased – through update notifications by doctors, active surveillance, and reviews of death registers at the Central and District Registrars of Civil Status.

The number of PLHIV has increased significantly due to the introduction of ART (from 2006) – which has slowed the progression to AIDS disease (and death) – and the addition of new infections (or incidence) diagnosed each year to the existing number of PLHIV (prevalence).

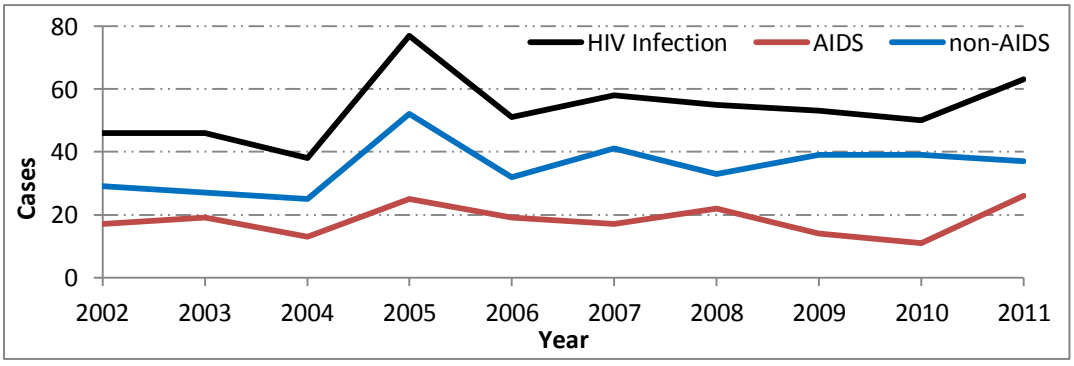
The mode of exposure to HIV is not known for 47% of reported cases. Heterosexual contact accounts for 42%, MSM contact for 5% and MTCT for 6%. Perinatal transmission of HIV was zero for 2010 and 2011.

Adults (15-49 years) represent 75%of reported cases; the youth (15-24 years) account for 12%. Children (<15 years) represent 7%.

The epidemic is geographically concentrated in the north, particularly in the district of Castries (where the capital city is located) and the neighboring districts of Gros Islet, Babonneau, Anse La Raye and Dennery.

Figure 1 illustrates that over the past 10 years (2002-2011) after a peak in 2005 the annual number of new cases declined from 2007 to 2010, ending with a sharp rise in 2011. The number of AIDS cases also peaked in 2005 declined from 2008 to 2010 and also ended with sharp rise in 2011. The number of new non-AIDS peaked in 2005 but remained stable from 2009 to 2011.

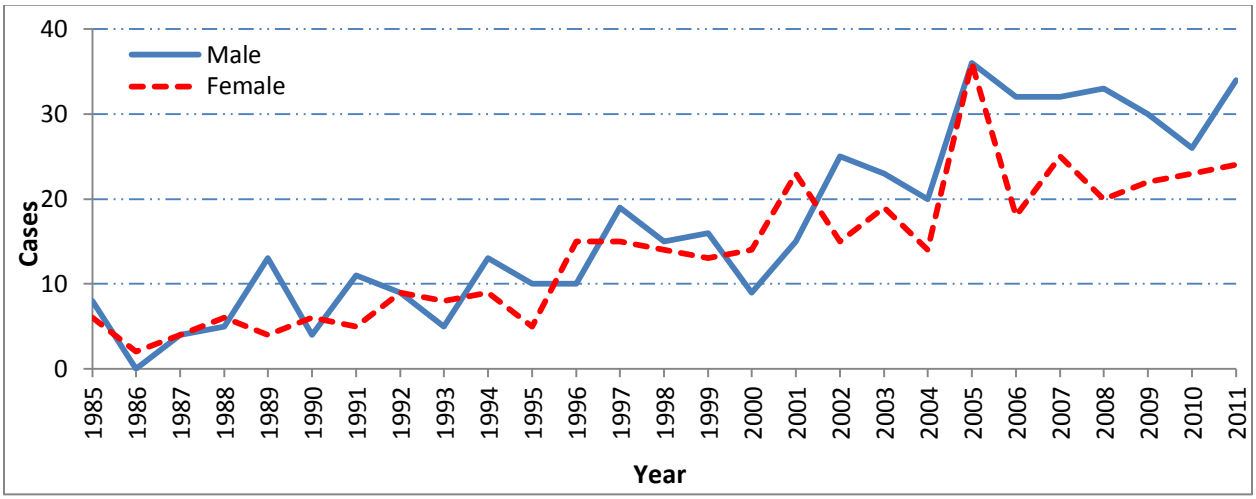
Figure 1: Number of newly diagnosed cases of HIV infection by disease status at diagnosis, 2002-2011



Source: NAP Database, 2011

Males have accounted for the majority of newly diagnosed HIV infections (52%) since the beginning of the epidemic; over the past 10 years males accounted the majority of cases for each year and 54 percent of new HIV infections. During 1992-2001 males represented 46 percent and 47% occurred among females. Gender is not known for about 5 percent of new cases. This is demonstrated in Figure 2 below.

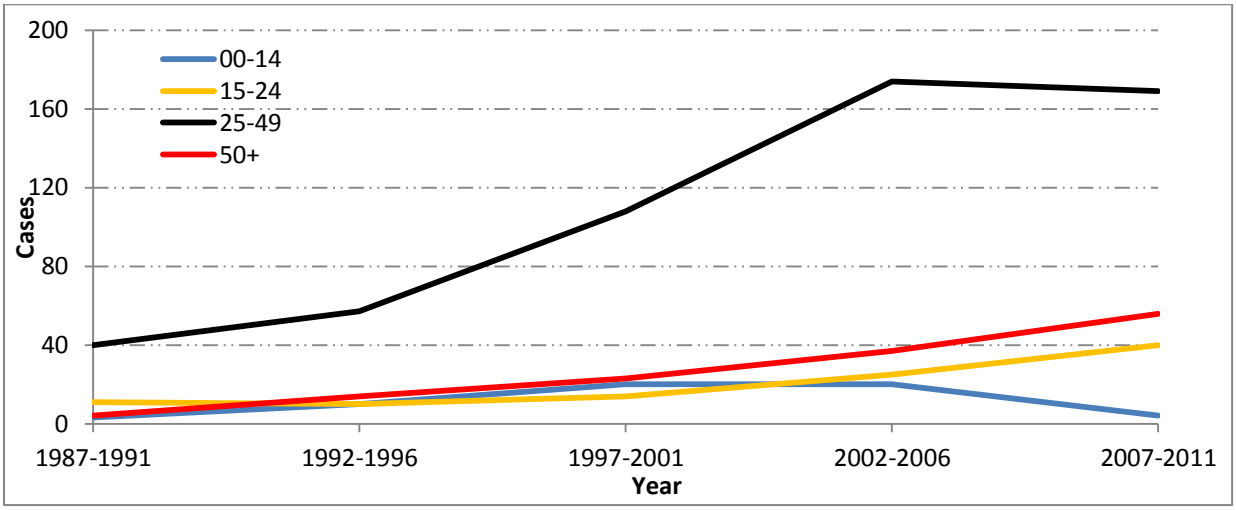
Figure 2: New HIV infections by gender and year of diagnosis, 1985-2011



Source: NAP Database, 2011

The majority of cases are among persons 25-49 years which accounted for 77 percent of new cases from 2002-2006 and 75 percent for 2007-2011. The actual number of new cases in that age group over the past 5 years was lower than that of the previous period for the first time since the start of the epidemic. About one percent of new cases are among children (0-14 years); the number and percentage of cases in children also declined to lowest levels ever reported, over the past 5 years. The youth (15-24 years) represent 14 percent of new cases in 2007-2011; the highest number and percentage is since 1992-1996. The number and percentage of newly diagnosed cases among persons 50 years and older increased substantially for 2007-2011 to their highest ever recorded; 20 percent of new cases belong to that age group. Figure 3 displays the new HIV infections by age group and year at diagnosis.

Figure 3: New HIV infections by age group and year at diagnosis, 1987-2011



Source: NAP Database, 2011

Trends by age and gender show some variation. Females account for the majority of new cases among the youth (15-24 years). During 2001-2011 about 58 percent of new cases were females (the lowest percentage since the start of the epidemic), compared to 64 percent for 2002-2006. Males continue to account for the majority of new cases among persons aged 50 or older since 1992-1996. Over the past 5 years about 60 percent of new cases among persons aged 50 years or older were males, compared to 57 percent for 2002-2006.

As of December 31st, 2011, there were 65 new cases of HIV in St. Lucia. The majority of individuals were located within the age group 25-49 years, followed by the age group of individuals 50 years and over. Overall, males accounted for the majority of new cases as illustrated in Table 1 below.

Table 1: Distribution of new HIV cases by sex and age group (2011)

AGE GROUP	MALE	FEMALE	UNKNOWN
15-24	2	4	1
25-49	24	17	3
50+	7	5	0
Unknown	2	0	0
TOTAL	**35**	**26**	**4**

Source: NAP Database, 2011

There were a total of 16 deaths in 2011; males accounted for approximately 80% of these deaths (13/16). The age group with the highest number of deaths was 25-49 years (8 deaths), followed by the age group 50 years and above. See Table 2.

Table 2: HIV/AIDS deaths (2011)

AGE GROUP	MALE	FEMALE
<15	0	0
15-24	1	1
25-49	6	2
50+	6	0
UNKNOWN	0	0
TOTAL	**13**	**3**

Source: NAP Database, 2011

The success of ART (which started in 2006) has significantly reduced the number of AIDS cases and deaths. Although ART does not cure, it delays the progression to AIDS and death among PLHIV. The number of PLHIV continues to increase over time. There are 541 PLHIV on the National HIV and AIDS database as at December 31, 2011.

About 62 percent of PLHIV belong to the 25-49 years age group; 15 percent are youth (15-24 years), 6.8 percent are children (less than 15 years of age) and 14 percent are 50 years or older. Age is unknown for about 3 percent of PLHIV.

Table 3: Distribution of PLHIV by age and gender, Saint Lucia, as at December 2011

Age Group (Years)	Total		Male		Female	
	No.	%	No.	%	No.	%
<15	37	6.8%	10	4.1%	16	6.3%
15-24	79	15%	27	11%	46	18%
25-49	333	62%	162	67%	154	61%
50+	76	14%	36	15%	32	13%
Unknown	16	3.0%	8	3.3%	4	1.6%
All Ages	**541***	**100%**	**243**	**100%**	**252**	**100%**

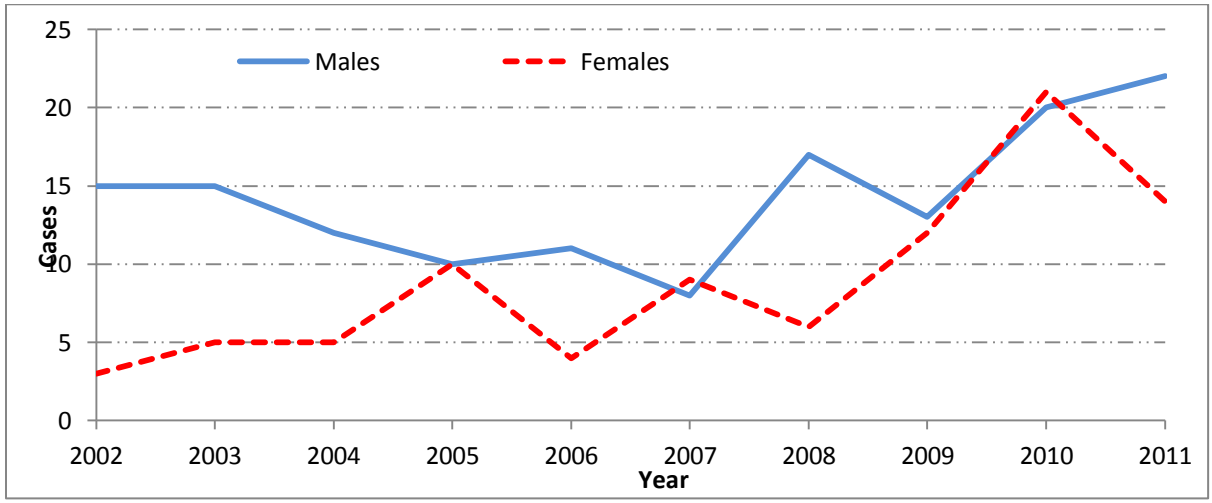
*Total includes PLHIV of unknown gender

The age distribution of PLHIV varies by gender. While the youth (15-24 years) account for 15 percent of PLHIV, they make up only 11 percent of males compared to 18 percent of female cases. In addition, about 67 percent of males living with HIV are 25-49 years of age compared to 61 percent for females. Females account for 47 percent of all PLHIV on record, and males for 45 percent.

Over the past 10 years the mode of transmission of HIV was not known for 54 percent of newly diagnosed cases; males accounted for 62 percent of cases. After a steady decline to its lowest annual number in 2007, the number of males increased to its highest (since the start of the epidemic) in 2011. Among females the annual number peaked to its highest in 2010 and then fell to its 2nd highest in 2011.

Males account for the majority of cases for every year except 2005 (when equal to that of females), 2007 and 2010 (when females had a slight majority). See Figure 4.

Figure 4: Number of HIV infections of unknown Mode of Transmission by Gender and Year of Diagnosis, 2002 to 2011



Source: NAP Database, 2011

During 2002-2011 the number of new cases who reported MSM transmission accounted for about 6 percent of total new cases (30 cases). The annual number ranged between 1 and 6 cases. About 60 percent of cases (18 cases) were reported during the last 5 years.

Deliberate underreporting of MSM exposure by newly diagnosed cases is suspected because of high levels of stigma and discrimination of MSM; buggery is illegal in Saint Lucia. For this reason, there is no available data on HIV rates among men who have sex with men in St. Lucia.

A total of 10 newly diagnosed cases of HIV infection among infants of HIV-positive pregnant mothers were reported during 2002-2011. There were no cases of HIV infection transmitted from pregnant mothers to their unborn infants reported for 2002, 2008, 2010 and 2011.

All pregnant women in Saint Lucia are offered and receive at least one HIV test before delivery. A total of 1201 antenatal clients were testes, with 682 returning for results.

III. National Response to the AIDS Epidemic

The purpose of the St. Lucia National HIV/AIDS Strategic Plan (NSP) 2010-2015 is to guide the management and implementation of the national response to the AIDS epidemic, highlighting priorities for the allocation of financial and technical resources. The plan builds upon the NSP 2005-2009. It has been developed based on an assessment of the available evidence about the epidemic, the factors that influence the transmission of HIV in the country, and lessons of past implementation experience

The strategy proposes a two-phase approach due to the fact that epidemiological and behavioral data are limited and do not provide a sufficiently-strong foundation on which to design effective targeted prevention interventions. Thus the first phase focuses on strengthening the evidence base as a precursor to further prevention planning. It also includes continuing critical interventions (in particular, program coordination and management; treatment, care and support; and targeted prevention work). Once there is a better understanding of the epidemic, stakeholders will review the new evidence and elaborate a well-targeted prevention plan for the remaining three years of the strategic plan period.

The strategy also prioritizes continuing critical interventions in particular, program coordination and management; treatment, care and support; and targeted prevention work. Once there is a better understanding of the epidemic, stakeholders will review the new evidence and elaborate a well-targeted prevention plan for the remaining three years of the strategic plan period.

This two-year strategy is structured around six outcome results that are to be achieved during the first phase of the five-year NSP. They include the following:

1) Evidence base strengthened to provide a solid foundation for future prevention planning
2) Targeted prevention work with MSM, sex workers and drug users based upon existing evidence scaled up
3) Support to OVC and needy people living with HIV and prevention work with youth and in the workplace maintained
4) Treatment, care and support services maintained and strengthened
5) Capacity to manage the national response strengthened
6) Institutional arrangements in place to continue program implementation and monitoring

Government commitment to sustaining the gains achieved over the past five years will be essential for the achievement of these outcomes for 2010-2011 and beyond.

Prevention and Behavior Change

- **Targeted prevention** work with MSM, sex workers and their clients, prisoners and drug users based upon existing evidence scaled up:

  A minimum package of services will be designed and implemented by civil society partners with experience in working with the targeted communities, in collaboration with the National AIDS Programme. The objective is to increase coverage and improve the quality of services to these

groups, thereby reducing the risk of transmission within the groups and between members of the groups and the general population. The minimum package of services will include:

- Behavior change prevention education to ensure that communities believed to be at highest risk have correct knowledge about HIV and STIs and have the motivation and ability to act on their knowledge
- VCT in prioritized locations where those most likely to have been exposed to the virus are likely to be found
- Condoms/lubricant for communities engaged in risky sex
- STI services for individuals at high risk of infection

In order to fully implement provision of the minimum package of services, a supportive environment to encourage behavior change will be enhanced through:

- Increased awareness among decision-makers of the risks confronting these groups and the factors that impede efforts to reduce these risks
- Improved collaborative relations with the police and local authorities/communities to support prevention interventions with the groups at greatest risk
- Respectful, client-friendly, confidential STI clinical services

- **Prevention work with youth, the prisons and the workplace maintained**

The strategy will focus on young people, both in school and out of school, in light of the apparent low level of understanding of the epidemic, how to protect themselves, and the high level of sexual activity:

- For in-school youth: While the assessment of the current HFLE program is going on, the Ministry of Education will continue its ongoing work program, with the expectation that it will be refined on the basis of results from the HFLE assessment.
- For out-of-school youth: Outreach by CSOs to youth on the block will be scaled-up.

The strategy will maintain prevention work for staff and inmates at the prisons. Interventions will include:

- TB screening for inmates only
- HIV 101 training for staff and inmates
- Distribution of IEC/BCC materials
- HIV testing (VCT/PITC)

The strategy will also support scaling-up of workplace HIV/AIDS programming through collaboration between the private sector, CSOs and the government; the Ministry of Labour will coordinate the implementation of the National HIV/AIDS workplace program. The purpose of

these efforts is to enhance basic knowledge of HIV prevention and reduce HIV and AIDS-related stigma and discrimination in the workplace. Interventions will include:

- Workplace education programs
- Workplace testing campaigns
- Expanded coverage of HIV workplace policies to prevent stigma and discrimination with respect to employment

VCT, PMTCT and blood safety programs and services maintained

The VCT program will cover the general population, MARPS and other sub-populations. Interventions will include:

- Scaling-up of rapid testing;
- Outreach VCT to workplaces and MARPS;
- Review of National VCT strategy and program, based on results of clinical management study;
- Continued training of health care providers and other stakeholders

All pregnant women and all children of HIV-positive pregnant women will be tested for HIV. The strategy will also seek to increase coverage of male partners of pregnant women through strong community education and testing. Interventions will include:

- Testing of pregnant women at antenatal clinics and delivery rooms;
- Provision of feeding formula to HIV+ mothers;
- Provision of ARVs for HIV-positive mothers and their infants;
- IEC/BCC at antenatal clinics and delivery rooms;
- Provision of feeding formula to HIV+ mothers;
- IEC/BCC and testing of male partners;

The strategy also supports HIV testing and screening for other STDs/STI among all blood donors. National Blood Bank Service staff will be trained on program maintenance and updates, first aid, donor marketing, customer service.

Treatment, Care and Support

Based upon assessment of the clinical care program over the past several years, the following interventions are included in the strategy in order to further strengthen the provision of services to those living with HIV and AIDS. Implementation will be led by the Ministry of Health:
Priority Interventions

- Make available human resources to maintain quality of care delivered by Government (including nutritional support, surveillance officer, data entry, pediatrician, phlebotomist)
- Implement and monitor the contact tracing program
- Strengthen adherence programs
- Increase enrollment of people living with HIV into the treatment and care program.

- Enhance integration of components supported through the World Bank-financed project into the Ministry of Health
- Increase the number of private and community clinicians treating patients with HIV through provision of incentives for the private sector, such as training of physicians in HIV-STI management
- Increase co-operation and planning with support groups of people living with HIV
- Integrate HIV and AIDS in the public health system. This will require training for health care providers on provision of HIV services and respectful and confidential treatment of HIV patients
- Strengthen leadership and training for health care providers
- Increase collaboration between the TB and HIV programs
- Scale up rapid testing
- Maintain and strengthen PMTCT program by encouraging testing of male partners including strong community education and testing to ensure greater coverage.

Services for MARPS (part of package of services)

- Treatment for all those who test positive for HIV
- Ongoing psychosocial counseling for all those who test positive for HIV
- Legal services

Support to OVC and needy PLHIV maintained

- Foster care
- Trained school counselors
- Transportation assistance
- Book bursary program
- Food Bank services
- Psycho-social counseling
- Food Bank (it is estimated that over 90% of those taking advantage of this service are unemployed). Ongoing efforts by the Ministry of Health to mobilize support from the private sector can play an important role to sustain this service in collaboration with Government.

- The Ministry of Health will continue to strengthen linkages with government programs that provide welfare payments, skills training, employment and housing

IV. Best Practices

These include:

- Elimination of mother-to-child transmission of HIV, which is largely due to the PMTCT programme which makes it compulsory to test all pregnant women for HIV once admitted to the maternity ward or in labour.
- Elimination of HIV transmission through blood transfusions. All blood donors receive HIV tests.

V. Major achievements and challenges

Challenges

- The broad-based culture of not using evidence to inform programming poses a challenge to obtaining support from policy makers and implementers that is critical for appropriate program development and monitoring. Health care providers do not consistently observe the reporting requirements thus leading to insufficient data necessary to provide an understanding of the epidemic and consequently to inform programming, for example private physicians do not routinely report the number of people testing positive for HIV. These cases are picked up from lab-provided reports, since all positive tests are sent to the public sector lab for confirmation but as a consequence all the relevant basic client data including mode of transmission are missing. The national response to HIV and AIDS needs to receive greater commitment by Government, which has tended to view it as a health issue rather than as a development issue

    - Stigma and discrimination continue to inhibit the program's ability to work effectively with MARPs due to the limiting legislative environment, and are likely responsible for the fact that roughly 28% of those who test positive are not registered with the national program and that 43% present late with stage 3 or stage 4 AIDS diagnoses[3]

    - After having provided a comfortable and enabling environment for patients it has become increasingly clear that their social support needs are outpacing their clinical treatment. Without the social support structures, issues of treatment adherence and reducing high risk behavior is difficult

Achievements

The Major Achievements in the past five years include:

- Stabilized incidence of HIV and reduction in STI rates

- Reduction in the mortality rate of patients with HIV from 46.2 per 100,000 in 1999 to 14.8 per 100,000 in 2009

- Prevention of mother-to-child transmission (PMTCT): Due to scale up of testing of pregnant women, there has not been a single case of peri-natal transmission of HIV in St. Lucia since 2006 among all those enrolled in care.

- Anti-retroviral therapy has been made widely available, and taken up by two-thirds of those medically-eligible clinic patients registered in the clinic, leading to a reduction in both mortality and morbidity. In 2009, of the 15 registered patients whose CD4 count indicated eligibility for ART, 13 are now on treatment.

[3] D'Auvergne, ibid (p.22,23)

- Voluntary Counseling and Testing (VCT) and Provider-Initiated Testing and Counseling (PITC): since 2006 outreach efforts have led to an increase in the number of tests from 4,852 in 2005 to 20,430 in 2009, with growing acceptance of the importance of testing.

- Strengthened health care response more broadly[4]:

    - Integration of the treatment and care program covered by the World Bank-financed project into MoH
    - More health care providers delivering care and increasing decentralization of service provision
    - Creation of clinical teams to provide guidance on clinical and programmatic management of patients with HIV and STIs
    - Strengthening the PLHIV support group and stronger collaboration with vulnerable groups (sex workers, drug abusers, men having sex with men)
    - Community involvement through education of men and youth on STI/HIV
    - Improved access to STI treatment for vulnerable youth
    - training of health care providers in clinical management of STI/HIV and expansion of service
    - Continued service expansion at the Bordelais Correctional Facility
    - Strengthening integration of the clinical team, increasing collaboration between in-patient and out-patient care services and the HIV and TB programs
    - Strengthening management information systems
    - Implementation of the pharmacy information system at Victoria Hospital
    - Clinical mentoring program

- Strengthened management and coordination of the national program, with greater participation of civil society and the mainstreaming of prevention programs into a number of important line ministries
- Capacity of the Ezra Long Laboratory in Victoria Hospital and St. Jude Hospital Laboratory was increased to enable confirmatory testing to be done locally and more quickly and to undertake CD4 testing
- Draft National Policy on HIV and AIDS, including a model for use in workplaces across the island

VI. Support from development partners

- NACC (National AIDS Coordinating Council)
    - Established by Cabinet in 2005 to oversee the national program. It is chaired by the Minister of Health, co-chaired by the MoH Permanent Secretary, with the Chief Medical Officer serving as Secretary
    - Comprised of 15 representatives from Government and civil society
    - Serves as the Country Coordinating Mechanism for 3 ones principles
    - Meets when and as needed to endorse proposals put before it
    - A NACC sub-committee, chaired by a representative of the private sector, reviews and approves annual work plans from line ministries and proposals from CSOs

[4] St. Lucia HIV/AIDS Control and Prevention Project Quarterly Report January – March 2010, Cleophas d'Auvergne, MD, MPA, Clinical Care Co-ordinator (29/4/10)

- The NACC has not been seen to have authority to make significant changes in the national response

- NAP (National AIDS Program)
  - Based in MoH, responsible for the health sector response to HIV and AIDS
  - Coordinates and monitors all MoH departments involved in HIV and AIDS (e.g., lab, Bureau of Health Education, Community Nursing Service, General Hospital maternity and medical wards, and the Blood Bank)
  - Staff include: Director, Health Educator, Secretary, STI Physician and Nurse
  - It is looked to for leadership to provide technical support to other partners on specific issues (e.g., VCT)

- Ministry of Health Accounts Department
  - Provides financial management and procurement support to projects funded through PAHO, UNAIDS, bilateral and UN agencies

- Project Coordination Unit (PCU)
  - Provides financial management and procurement support to NAPS for the WB-financed and GFATM projects, including training of NAPS staff and implementing agencies
  - Located in the Ministry of Finance and Economic Affairs
  - Part of the technical committee that assesses ministry work plans and proposals from CSOs
- Civil society organizations (CSOs)

The main partners include: AIDS Action Foundation, Tender Loving Care, Planned Parenthood, St. Lucia Red Cross, United and Strong, CDARI, CAFRA, ASPIRE, and St. Lucia Medical and Dental Association. Several trainings were conducted to build the capacity of CSOs: Sub projects applicants' orientation seminar, proposal writing, leadership and management, trainer of trainers' workshop, Behavior Change Communication (BCC) workshops and HIV group education workshops. Broadly, the work of CSOs over the past five years has covered:

  - General population sensitization and awareness raising
  - Support to people living with HIV and AIDS
  - Community outreach to and mobilization of MSM, sex workers, drug users and prisoners
  - Support to young people, including in-school and out of school youth
  - Workplace policy development and awareness raising in cooperation with the private sector
  - Provision of ARVs
  - Counseling and testing
- Line ministries
  - MOE: teacher training, implementation of compulsory Health and Family Life Education (HFLE) in primary and secondary schools, integration of the book bursary program for orphans and vulnerable children (OVC), and school transport for OVC at most schools, organization of VCT with Scotia Bank on Valentine's Day, and development of an education sector policy that has recently been sent to Cabinet for approval
  - Department of Human Services: social welfare support to OVC and needy PLHIV including counseling, operating a Food Bank, publication and distribution of a
  - booklet featuring stories of St. Lucians living with HIV and basic facts (which helps address stigma and discrimination and has been useful to people newly-diagnosed)

- Ministry of Home Affairs: conducted psycho-social and counseling training for prison staff, peer education for officers and inmates, the Bordelais Correctional Facility provides treatment, care and support to HIV positive inmates and referral links for their children to be supported under the OVC programme.
- Ministry of Communications and Works: provides prevention education for taxi and bus drivers, and for their own staff
- Intra-Ministerial Committee (comprised of representatives from the ministries of Education, Finance, Public Service, Community Development, Tourism, Youth and Sports, the Department of Human Services and the NAPS).

VII. Monitoring and Evaluation

The end of the World Bank-financed project and the closure of the NAPS meant that the responsibility for management and coordination of the national response – comprising responses from heath and non-health sectors - was transferred to the NAP of the Ministry of Health.
The NAP presently does not have a monitoring and evaluation unit and the M & E function is shared between the Director of the NAP and the Surveillance Officer. Some of the challenges faced in HIV-related monitoring and evaluation include:
1. Lack appropriate structure, human and financial resources for M&E
2. Creating and sustaining a culture for M&E
3. Lack of M&E advocacy and communication
4. Insufficient use of M&E data and information to guide and support decision making
5. Current organizational structure not appropriate given the system requirements and stakeholder needs
6. No technical working group in place to guide M&E technical functions and advise on all issues related to the scheduling design and conduct surveys, surveillance and research

Annexes

Annex 1: Individuals Interviewed

Name	Position	Representing
Mr. Nahum Jn Baptiste	Director	National AIDS Program
Dr. Michelle François	Surveillance Officer	National AIDS Program
Ms Veronica Cenac	Attorney at Law	AIDS Action Foundation
Mrs. Natasha Lloyd-Felix	Acting Director	Bureau of Health
Ms Erma Jules	Senior Program Officer	CHAA
Dr. Cleophas d'Auvergne	CCC	National AIDS Program
Ms Marguerite Jn. Charles	VCT/PMTCT	National AIDS Program
Dr. Sonia Alexander	Public Health Consultant	
Ms Lisa Albert	Representative	CHAA
Dr. Franklin Bray	Clinical Psychoanalyst	
Ms Flavia Cherry	Director	CAFRA
Mr. Michaelango Andrew	Accountant	OECS HAPU
Dr. Minerva King	STI Physician	National AIDS Program
Dr. Merlene Fredericks	Chief Medical Officer	Ministry of Health

Annex: 2 Acronyms

AAF	AIDS Action Foundation
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral (drugs)
BSS	Behavioural Surveillance Survey
CAFRA	Caribbean Association for Feminist Research and Action
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community and Common Market
CHRC	Caribbean Harm Reduction Coalition
CBO	Community Based Organization
CDARI	Caribbean Drug Abuse Research Institute
CCM	Country Coordination Mechanism
CIDA	Canadian International Development Agency
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DAART	Directly Administered Anti-Retroviral Therapy
DFID	Department for International Development
DOTS	Directly Observed Therapy
EU	European Union
FBO	Faith Based organisation
FSW	Female Sex Worker
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HAART	Highly Active Anti-Retroviral Therapy

HCW	Health Care Worker
HDI	Human Development Index
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IEC	Information, Education and Communication
LAC	Latin America and the Caribbean
MAP	Multicountry HIV/AIDS Prevention and Control Programme
MARP	Most-at-risk populations
M & E	Monitoring and Evaluation
MOH	Ministry of Health, Human Services, Family Affairs and Gender Relations
MSM	Men who have Sex with Men
MSW	Male Sex Worker
MTCT	Mother-To-Child-Transmission
NACC	National HIV/AIDS Coordinating Council
NACCHA	National Coordinating Committee on HIV/AIDS
NAP	National AIDS Programme
NAPS	National AIDS Programme Secretariat
NGO	Non Governmental Organisation
NHSP	National Health Strategic Plan
NYC	National Youth Council
NWU	National Workers' Union
OECS	Organisation of Eastern Caribbean States
OI	Opportunistic Infection
OVCs	Orphans and other Vulnerable Children

PAHO	Pan American Health Organisation
PCU	Project Coordination Unit
PLACE	Priorities for Local AIDS Control Efforts
PLWHA	Persons Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child-Transmission
PPP	Public-Private Partnership
RST	Regional Support Team
RCM	Regional Coordination Mechanism
SLMDA	St Lucia Medical and Health Association
SLPPA	Saint Lucia Planned Parenthood Association
STI	Sexually Transmitted Infection
SW	Sew Worker
TB	Tuberculosis
TLC	Tender Loving Care
TOR	Terms of Reference
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USD	US Dollars
UWI	University of the West Indies
VCT	Voluntary Counseling and Testing
WB	The World Bank
WHO	World Health Organization

Annex 3: Documents Consulted

CAREC, The Saint Lucia national HIV and AIDS Strategic Plan 2011-2015

D'Auvergne, C. (2010) *St. Lucia HIV/AIDS Control and Prevention Project Quarterly Report January – March 2010*

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Jules, E. et al. (2010) *UNGASS Country Progress Report, 2010: St. Lucia*

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United Nations Entity for Gender Equality and the Empowerment of Women (2011) [Online] Available from: http://www.unifemcar.org/GBVlawportal/SaintLucia.aspx (Accessed: March 15, 2012)