UNGASS COUNTRY PROGRESS REPORT 2010
St Christopher and Nevis

Submitted by:

National Advisory Council on HIV/AIDS
Ministry of Health, Social Services, Community Development, Culture & Gender Affairs

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I. Table of content

List of Acronyms

AIDS	Acquired Immune Deficiency syndrome
ANC	Antenatal Clinic
ARV	Antiretroviral therapy
BCC	Behaviour Change Communication
BSS	Behaviour Surveillance Survey
CAREC	Caribbean Epidemiological Centre
CARICOM	Caribbean Community
CBO	Community-based Organization
CDC	Caribbean Development Committee
CHAA	Caribbean HIV/AIDS Alliance
CHART	Caribbean HIV/AIDS Regional Training network
CHRC	Caribbean Health and Research Council
CHS	Community Health Services
CSW	Commercial Sex Worker
ECCAP	Eastern Caribbean Community Action Project
FACTTS	Facilitating Access to Confidential Care and Testing
FBO	Faith-based Organization
FHI	Family Health International
GAP	Global AIDS Programme
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IEP	Individualized Educational Programmes
LEHR	Law, ethics and human rights
MARP	Most-at-risk population
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoH	Ministry of Health
MSM	Men who have sex with men
NACHA	National Advisory Council on HIV/AIDS
NACU	Nevis HIV/AIDS Coordinating Unit
NAP	National AIDS Programme
NAS	National AIDS Secretariat
NCPI	National Composite Policy Index
NEQAS	National External Quality Assessment Service
OECS	Organization of Eastern Caribbean States
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living With HIV
PLWA	People Living With AIDS
PMTCT	Preventing Mother to Child Transmission
PPMTCT	Prevention of Partner to Mother to Child Transmission services
SKN	St Kitts and Nevis
SRH	Sexual and Reproductive Health

STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
YES	Youth Empowerment through Skills

II. Status at a glance

a) Inclusiveness of the stakeholders in the report writing process

The UNGASS 2010 report is based on the views expressed by the stakeholders in the National HIV/AIDS expanded programme and includes civil society, line ministries and PLHIV.

The report is primarily based on the National Composite Policy Index (NCPI) conducted in March 2010, the 2008-2012 draft National Strategic Plan, the 2008-2009 draft Operational Plan, the 2006 Monitoring and Evaluation Plan for the expanded response, the draft 2009-2013 Monitoring and Evaluation Plan and the 2007 National Assessment on Law, Ethics and Human Rights, all of which utilized an expanded approach to include relevant stakeholders in the formulation of these documents. The NCPI integrated the stakeholders through online questionnaires, face-to-face and telephone interviews. The resolution of disagreements occurred in an environment that embraced the opinions of the stakeholders whilst arriving at a final agreement.

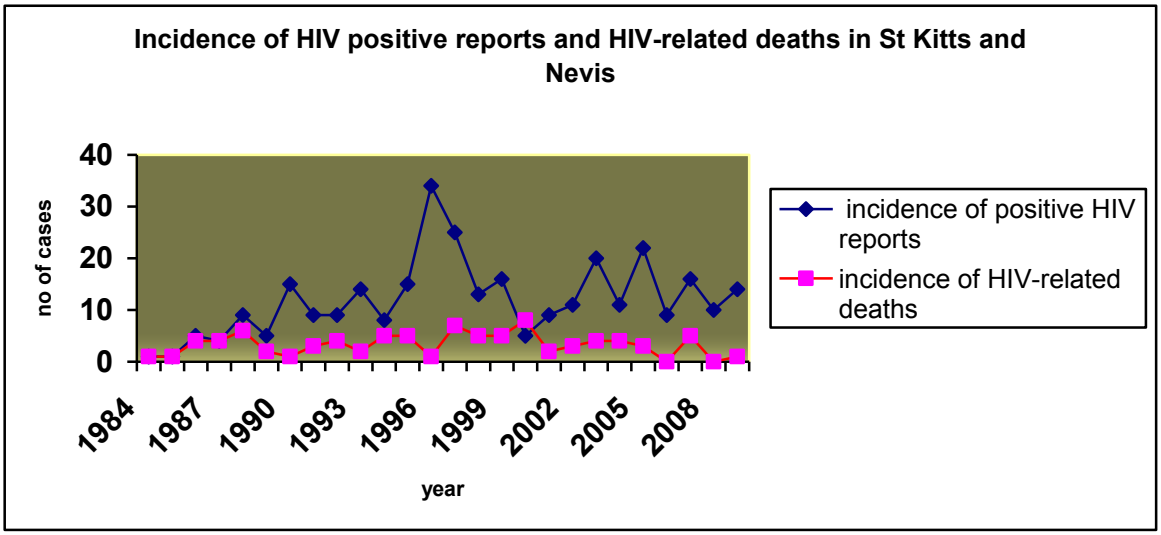
b) Status of the epidemic

St Kitts and Nevis is a member state of the OECS with a population of approximately 50,000 and a GDP of 0.54 billion.[1] Unlike the HIV epidemic in the majority of the other Caribbean islands where the epidemic is characterized as generalized with an estimated prevalence rate of 0.9-1.1;[2] the HIV epidemic in St Kitts, in the absence of sero-prevalence studies, is believed to be concentrated[3].

It has been postulated that the HIV positive cases are being underreported due to a high level of stigma and discrimination and potential breach of confidentiality. The present prevalence rate is calculated at 0.4% with 314 reported cases from 1984. The incidence of HIV-positive reports peaked in 1996 with 34 new diagnosed cases.(*see figure 1*) This appears to mimic the latest epidemiological data which indicates that the global spread of HIV appears to have peaked in 1996.[2] The annual prevalence of HIV-related deaths have remained at 5 or less for the last ten years although there are fears of underreporting as some doctors may not explicitly record AIDS as the cause of death due to fear of stigma and discrimination to the family and the current M&E system does not allow HIV reporting to be linked to deaths.

[1] World bank (2008)
[2] 2009 AIDS epidemic update (UNAIDS, WHO)
[3] An HIV and AIDS situation assessment: Barriers to access to services for vulnerable populations in St Kitts and Nevis

Figure 1



HIV and AIDS have been found to be more prevalent in males than females with an accumulative ratio of 1.3:1 for HIV positive diagnosis and 2:1 for AIDS diagnosis, from the period 1984-2009.(*see figures 2 and 3)*.

The age and gender distribution remain a cause for concern as the HIV prevalence rates for males is higher in all age groups except for 0-4 yrs, 15-19 yrs and 30-34 yrs (*see figure 4)*. The predominant age group affected is 35-39, which represents approximately a quarter of the persons in SKN who are HIV positive. This provides a strong rationale for increased VCT uptake among males and the NAP has embarked on numerous projects and programmes to achieve this. The use of intravenous drugs is thought to be minimal and may not significantly contribute to the HIV epidemic.

Figure 2

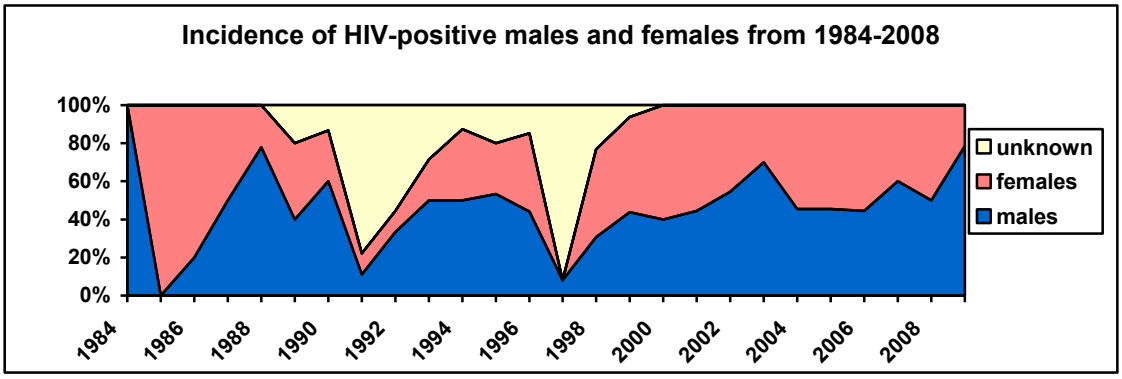


Figure 3

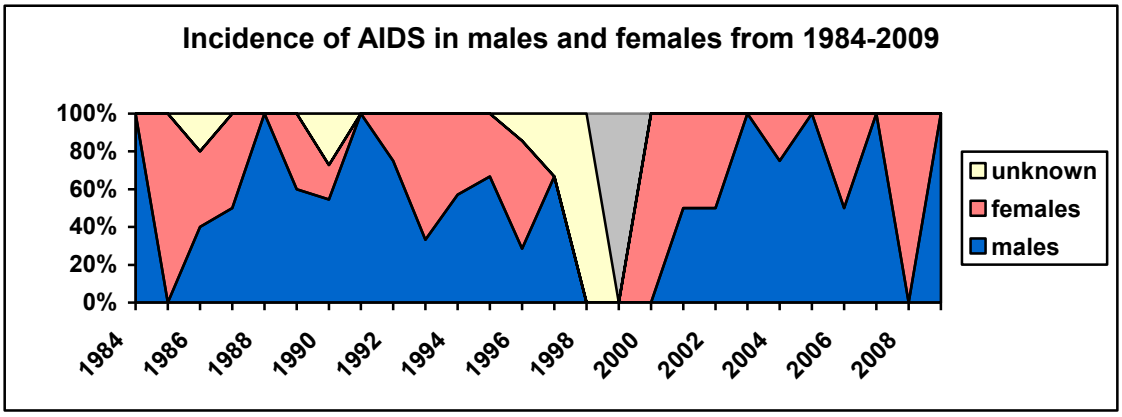
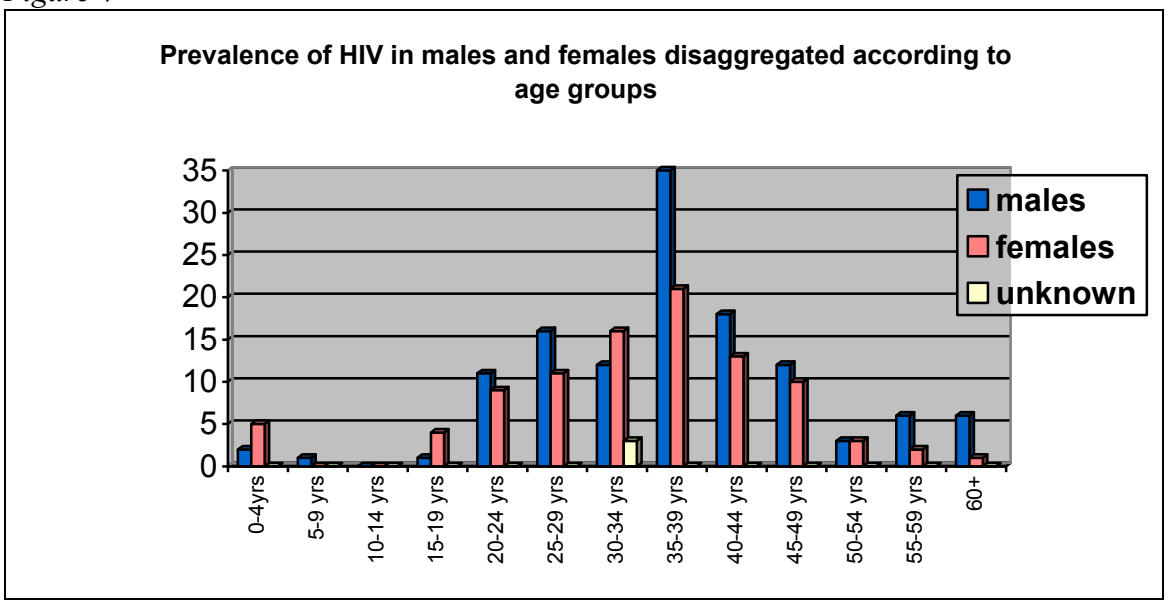


Figure 4

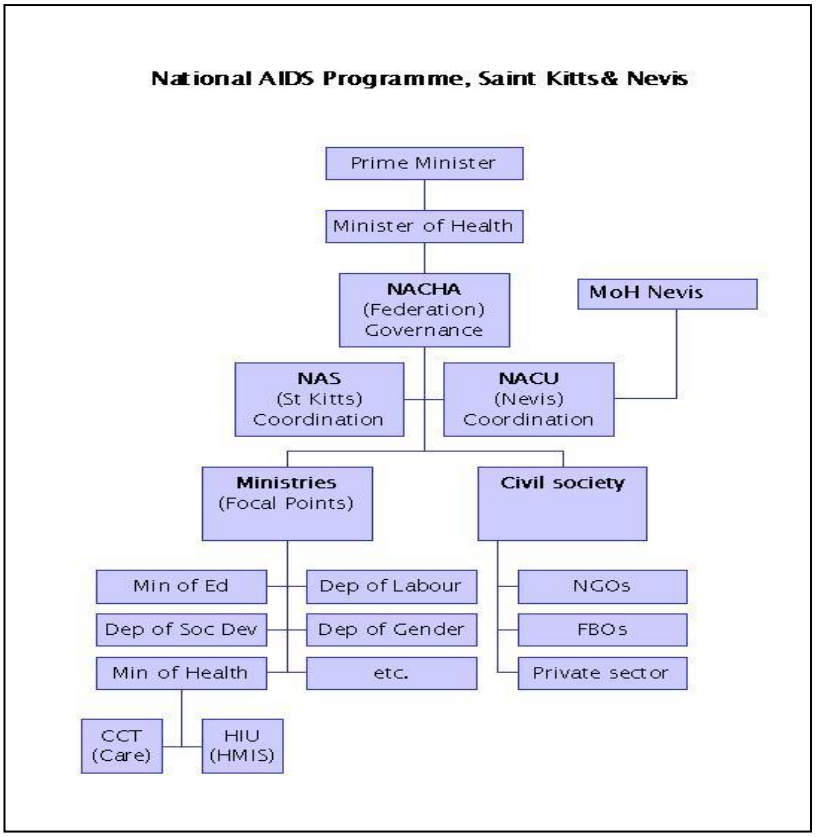


c) Policy and programmatic response

The National Advisory Council on HIV/AIDS (NACHA) is responsible for overall direction, oversight, policy development and resource mobilization. Its members include representatives from government and civil society and its responsibilities include advising the cabinet and the Prime Minister. The National AIDS Secretariat (NAS) is responsible for coordination of all implementing partners, developing operational plans and budgets on the basis of the National Strategic Plan, and for monitoring progress. The Nevis AIDS Coordination Unit (NACU) has similar responsibilities as NACHA, but only for the national programme activities and partners in Nevis. Implementing partners (public sector departments and service providers, civil society organizations, researchers)

are responsible in executing activities under their mandate e.g. service delivery, training, research. The organogram of the National AIDS Programme in SKN is shown below (*see figure 5).*

Figure 5: Organogram of the NAP in St Kitts and Nevis



The Ministry of Health in St Christopher and Nevis remains steadfast in its efforts to stem the HIV/AIDS epidemic. The national expanded response to HIV/AIDS has been guided by the National Strategic Plan (2001-2005). Financial resources to support its implementation have been mobilized through a World Bank Loan and a grant to the OECS from the Global Fund for Tuberculosis, AIDS and Malaria (GFTAM). Funds have been utilized in upgrading facilities, patient and health information systems, improve drug procurement and distribution and access to laboratory services. Significant capacity building for counseling and testing has occurred and strategic alliances have been built with the media, key line ministries and non governmental organizations however HIV related activities have not been mainstreamed into work plans and budgets.

The national structure for management and coordination of the national expanded response has been established but capacities still need to be strengthened. Prevention education occurs but needs to be evidence based and targeted to the most at risk

populations in order to achieve behavior change. Life skills based HIV and sexual health education in the school system is necessary.

The new Strategic Plan (2009-2013) builds on the successes and lesson learnt. Priorities for intervention over the next five years include strengthening surveillance to define the extent of the epidemic; more targeted prevention efforts; strengthening the organizational and technical capacity of civil society to expand programme reach and facilitate execution of activities; address discrimination in the health sector through the formulation and enforcement of policies and guidelines; development of a continuum of care services and ensuring sustainability of the national response through resource mobilization and efficiency in programming. Emerging strategies include the generation and use of strategic information and advocacy for policy development and legislation.

The government facilitated the process of an evaluation of its present policies with an assessment on the Legal Ethics and Human Rights (LEHR) facilitated by CARICOM/PANCAP and executed by the NAS in the Ministry of Health in 2007. This resulted in a proposal for amendments of some laws, which have yet to be addressed. The human rights desk established to record instances of stigma and discrimination and experiences of PLHIV remain underutilized.

Involvement of PLHIV in programme planning is still hindered by stigma and discrimination, thus their participation in the multi sectoral approach, being driven by the NAS, remains restrained. Capacity building programmes directed at the service providers and media-based efforts directed towards the general population with emphasis on the youth are utilized in an attempt to minimize stigma and discrimination. The Caribbean HIV/AIDS Alliance (CHAA) contributes significantly in targeting MARPs (PLHIV, CSW, MSM) with the use of community peer outreach workers (animators) through behaviour change interventions. There is an emergent need, which is presently being addressed, for greater collaboration between the CHAA and the National AIDS Secretariat (NAS) for improved VCT services for the MARP.

Participation by civil society in the programmatic response remains limited, but there has been significant improvement in the involvement of faith-based organizations (FBOs) in 2008 and 2009. Efforts are continually being made by the Department of Gender to empower females and thus reducing the vulnerability of girls and women.

With recent limitations in the availability of international funding, the Ministry of Health has recognized that there is a need to integrate HIV within the SRH programme as a cost effective and more efficient measure. A rapid assessment for SRH and HIV linkages was conducted in 2009 by the NAS, through UNFPA, to provide a preliminary understanding of and identify trends in existing linkages.

d) Table 1: UNGASS indicator data in an overview table

NATIONAL PROGRAMMES

3) % OF DONATED BLOOD UNITS SCREENED FOR HIV IN A QUALITY-ASSURED MANNER

100% (NATIONAL BLOOD BANK RECORDS, 2009)

4) % OF ADULTS AND CHILDREN WITH ADVANCED HIV INFECTION RECEIVING ANTI-RETROVIRAL THERAPY

DATA RELEVANT BUT NOT AVAILABLE

5) % OF HIV-POSITIVE PREGNANT WOMEN WHO RECEIVED ANTI-RETROVIRALS TO REDUCE THE RISK OF MOTHER-TO-CHILD TRANSMISSION

50% IN 2009 (NATIONAL PROGRAMME RECORDS, 2008 & 2009)

6) % OF ESTIMATED HIV-POSITIVE INCIDENT TB CASES THAT RECEIVED TREATMENT FOR TB AND HIV

DATA NOT RELEVANT

7) % OF WOMEN AND MEN AGED 15-49 WHO RECEIVED AN HIV TEST IN THE LAST 12 MONTHS AND WHO KNOW THEIR RESULTS

25-49 YRS: MALES 17%, FEMALES 15% (BSS, 2005)

8) % OF MOST-AT-RISK POPULATIONS WHO RECEIVED AN HIV TEST IN THE LAST 12 MONTHS AND WHO KNOW THEIR RESULTS

DATA RELEVANT BUT NOT AVAILABLE

9) % OF MOST-AT-RISK POPULATIONS REACHED WITH HIV PREVENTION PROGRAMMES

DATA RELEVANT BUT NOT AVAILABLE

10) % OF ORPHANED AND VULNERABLE CHILDREN AGED 0-17 WHOSE HOUSEHOLDS RECEIVED FREE BASIC EXTERNAL SUPPORT IN CARING FOR A CHILD

DATA NOT RELEVANT

11) % OF SCHOOLS THAT PROVIDED LIFE-SKILLS BASED HIV EDUCATION WITHIN THE LAST ACADEMIC YEAR

45% (MINISTRY OF EDUCATION, SCHOOL SURVEY 2009)

KNOWLEDGE, SEXUAL BEHAVIOUR AND ORPHANS' SCHOOL ATTENDANCE

12) CURRENT SCHOOL ATTENDANCE AMONG ORPHANS AND AMONG NON-ORPHANS AGED 10-14

DATA NOT RELEVANT

13) % OF YOUNG WOMEN AND MEN AGED 15-24 WHO BOTH CORRECTLY IDENTIFIED WAYS OF PREVENTING THE SEXUAL TRANSMISSION OF HIV AND WHO REJECT MAJOR MISCONCEPTIONS ABOUT HIV TRANSMISSION

52% (BSS IN SIX COUNTRIES OF THE OECS, 2005-2006)

14) % OF MARPS WHO BOTH CORRECTLY IDENTIFY WAYS OF PREVENTING SEXUAL TRANSMISSION OF HIV AND WHO REJECT MISCONCEPTIONS ABOUT HIV TRANSMISSIONS

DATA RELEVANT BUT NOT AVAILABLE

15) % OF YOUNG WOMEN AND MEN AGED 15-24 WHO HAVE HAD SEXUAL INTERCOURSE BEFORE THE AGE OF 15

MALE=36%, FEMALE=10% (BSS IN SIX COUNTRIES OF THE OECS, 2005)

16) % OF WOMEN AND MEN AGED 15-49 WHO HAVE HAD SEXUAL INTERCOURSE WITH MORE THAN ONE PARTNER IN THE PAST 12 MONTHS REPORTING THE USE OF A CONDOM DURING THEIR LAST SEXUAL ENCOUNTER

15-24=46%, 25-49=23% (BSS IN SIX COUNTRIES OF THE OECS, 2005)

17) % OF WOMEN AND MEN AGED 15-49 WHO HAD MORE THAN ONE SEXUAL PARTNER IN THE PAST 12 MONTHS REPORTING THE USE OF A CONDOM DURING THEIR LAST SEXUAL INTERCOURSE

67% (15-24=68%, 25-49=66%) (UNGASS REPORT 2008)

18) % OF FEMALE AND MALE SEX WORKERS REPORTING THE USE OF A CNDOM WITH THEIR MOST RECENT CLIENT

DATA RELEVANT BUT NOT AVAILABLE

19) % OF MEN REPORTING THE USE OF A CONDOM THE LAST TIME THEY HAD ANAL SEX WITH A MALE PARTNER

DATA RELEVANT BUT NOT AVAILABLE

20) % OF INJECTING DRUG USERS REPORTING THE USE OF A CONDOM THE LAST TIME THEY HAD SEXUAL INTERCOURSE

DATA NOT RELEVANT (NOT A MAJOR POPULATION)

21) % OF INJECTING DRUG USERS REPORTING THE USE OF STERILE INJECTING EQUIPMENT THE LAST TIME THEY INJECTED

DATA NOT RELEVANT (NOT A MAJOR POPULATION)

IMPACT

22) % OF YOUNG PEOPLE AGED 15-24 WHO ARE HIV INFECTED

0.55% (PMTCT PROGRAMME,2009)

23) % OF MARPS WHO ARE HIV INFECTED

DATA RELEVANT BUT NOT AVAILABLE

24) % OF ADULTS AND CHILDREN WITH HIV KNOWN TO BE ON TREATMENT, STILL ALIVE 12 MONTHS AFTER INITIATION OF ART

2008=75%, 2009=100%

25) % OF INFANTS BORN TO HIV-INFECTED MOTHERS WHO ARE INFECTED

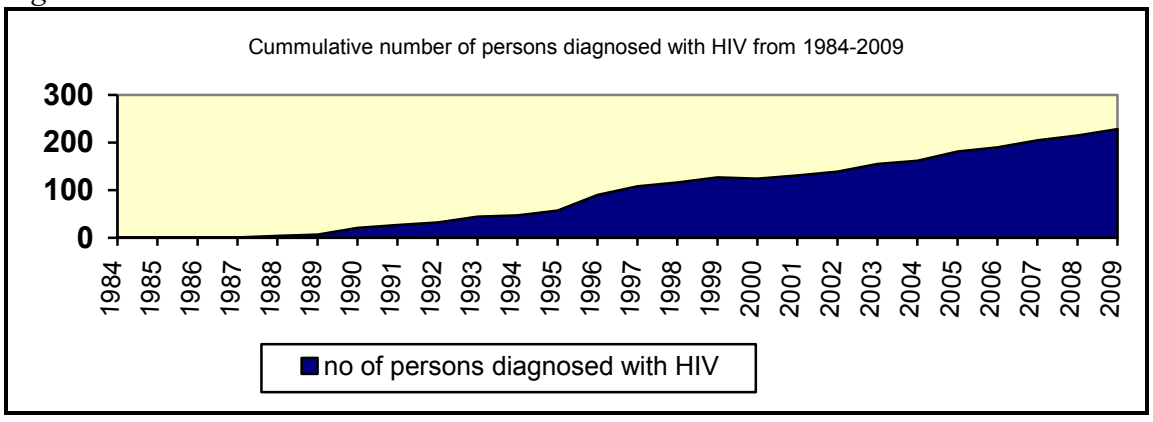
2008=0%, 2009=0%

III. Overview of the AIDS epidemic

In the absence of sero-prevalence studies, difficulties have been encountered in defining the HIV/AIDS epidemic in St Kitts and Nevis. However, unlike the majority of the other Caribbean Islands where the epidemic is classified as generalized, the HIV epidemic in St Kitts and Nevis is believed to be concentrated.[4] This is further substantiated by the sentinel ANC programme sites (with high PMTCT uptakes) which suggests that the prevalence rates for the PMTCT programme is <1%; and the assumption that the prevalence of HIV in the MSM and CSW (identified as the MARPs in the SKN community) is similar to the wider Caribbean Community, where HIV prevalence rates in the MARPs is greater than 5%. The inaccessibility of data from the most-at-risk population may be due to the high level of stigma and discrimination experienced by MARPs in the smaller Caribbean islands. Attempts are being made by the NAS, through collaboration with the Caribbean HIV/AIDS Alliance (CHAA) to offer VCT services directly to MARPs.

The HIV prevalence rate of the actual recorded HIV cases in St Kitts and Nevis in 2008 was 0.43% (215 cases) and in 2009, 0.46% (228 cases). The prevalence peaked in 1995-1997, and although the gradient of the epidemiological curve is still rising it is observed to be less steep (s*ee figure 6).* Significant underreporting of the prevalence rate is suspected as some persons access screening measures abroad and there is a low VCT uptake in SKN. Estimation of the HIV cases in the territory has also proven difficult due to the inaccessibility of MARPs in the territory and surrounding islands with similar epidemiological profiles to conduct appropriate calculations utilizing SPECTRUM.[5]. This may be due to significant stigma and perceived discrimination. Data from the PMTCT programme suggests that the prevalence rate may be around 0.47% (2/422) although interpretation of this data is limited as this data is gender and age specific and SKN has demonstrated higher prevalence rates of HIV in males.

Figure 6



[4] An HIV and AIDS situation assessment: Barriers to access to services for vulnerable populations in St Kitts and Nevis

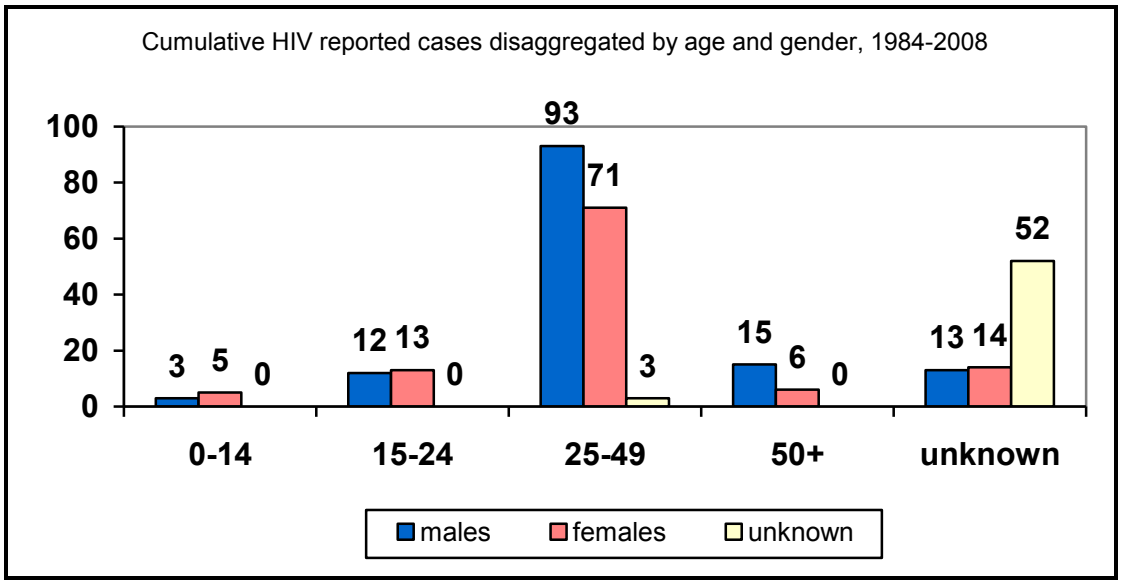
[5] Estimation models recommended by UNAIDS for the calculation of UNGASS indicators.

a) Disaggregation of data by gender and age groups

The number of reported cases of HIV for 2009 suggests that more males were tested positive compared to females (10:3), although the number of males tested in 2009 is significantly less than females (1:3). Based on a trend analysis, the diagnosis of AIDS have been found to be more prevalent in males than females with an accumulative ratio of 2:1 (1984-2009) although more females are being tested 1:3 (males:females,2004-2009). HIV-positive reports from 1984-2009 is slightly higher in males compared to females with a ratio of 1.3 males:1 female. Possible suggestions for the increased numbers of males diagnosed with HIV and AIDS, supported by new evidence which suggests that women require 50% less of the HIV virus to go on to develop AIDS[6], include: (a) the HIV virus may either have been present in men predominantly and has now crossed over to women (b) men are being tested at a later stage in the disease spectrum (c) the prevalence rate of the virus in men is much higher. This is of concern in a society where existing social norms provide acceptance for men with multiple partners.[7]

The prevalence of HIV positive reports in males has been notably higher in age groups 25-49 and 50+ and the majority of HIV-positive reports are found in the age group 25-49 (*see figure 7)*. This data is startling as only 40% of males and 16% of females in this age group used condoms at every sexual intercourse with non-regular, non-commercial partner and 36% of males and 10% of females had more than one non-regular, non-commercial sex partner in the last 12 months.[8] Emphasis in preventative and VCT strategies should continue to focus on this age group.

Figure 7

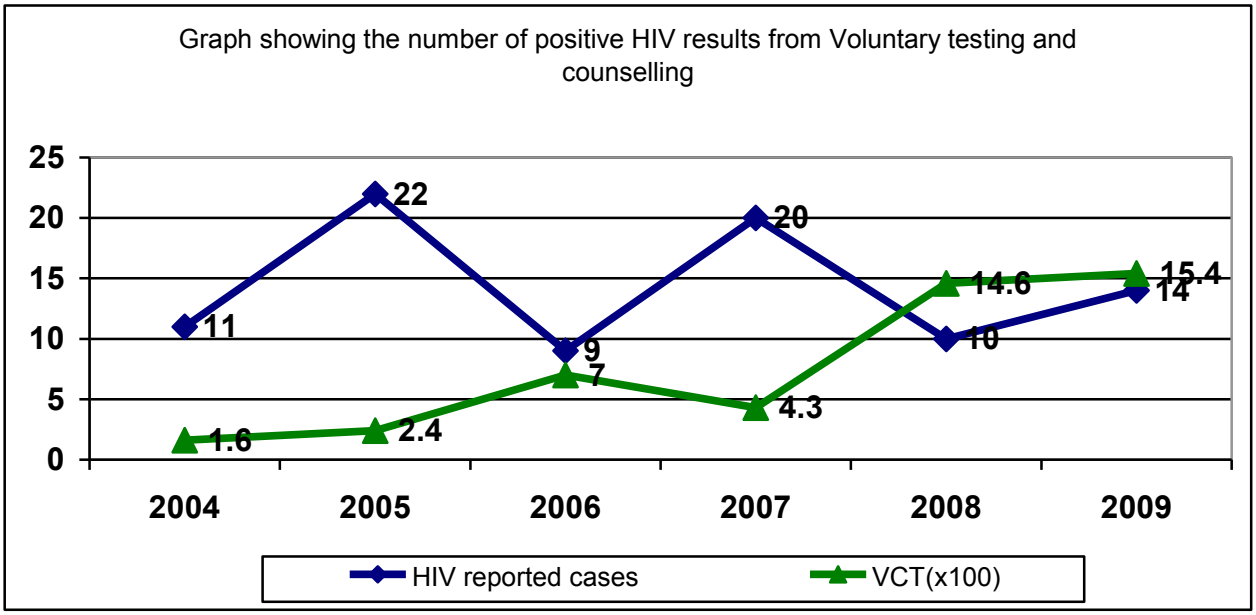


[6] John Hopkins School of Hygiene and Public health in Baltimore said a study of 650 drug users showed that women needed 50% less of the virus to go on to develop AIDS.
[7] Interview responses from NCPI
[8] OECS BSS amongst the general population aged 25-49 years, 2005

b) VCT Efforts

VCT efforts have increased significantly in 2008 and 2009, but in the last few years there appears to be no apparent distinct correlation with HIV reported cases and VCT.(*see figure 8)* VCT is mainly conducted through the health centres, private practitioners and outreach programmes. However, interpretation of the data is limited as it is not disaggregated according to timing of tests and risk assessments and there is a possibility that persons who are least at risk are being tested on multiple occasions.

Figure 8

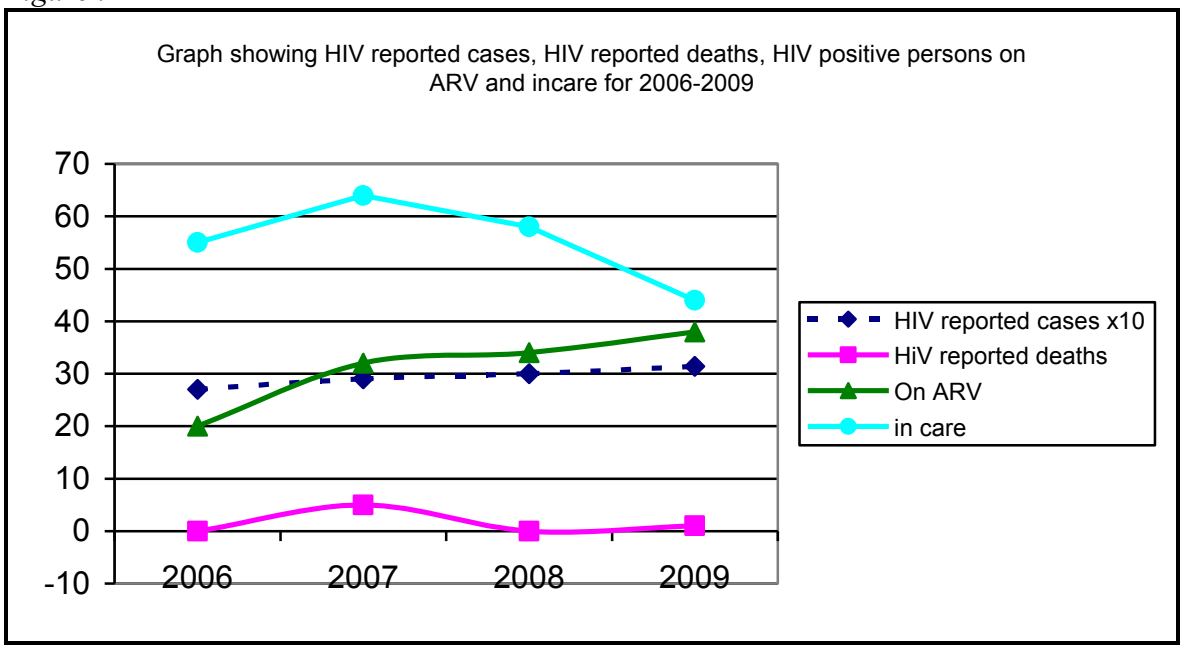


c) PLHIV

The number of HIV persons in care is decreasing and the number of persons on anti-retroviral therapy is increasing (*see figure 9.)* The number of AIDS reported deaths for 2008 and 2009 was minimal (2008-0 and 2009-1)(*see figure 9)*. The small number of deaths could be a result of underreporting, inadequate surveillance system, early stage in the national epidemiological profile or increased use of ARV.

The supportive group for PLHIV is FACTTS (Facilitating Access to Confidential Care and Testing Services) and it was established in November 1999. In 2008 and 2009, FACTTS have been involved in peer counseling, human rights advocacy and coordination of the Nutrition Assistance Programme, through the National AIDS Programme. Although the draft policies are geared towards increasing the participation of PLHIV and social support of PLHIV at the community level, the group remains underutilized due to fear of breach of confidentiality, stigma and discrimination.

Figure 9



d) Situational Analysis for MARP

An HIV and AIDS situational assessment that addressed barriers to accessing services for the vulnerable populations was conducted in August 2007.[9] This assessment was conducted prior to the revision of the current draft strategic plan and its goal was to understand the vulnerability of certain groups to HIV and AIDS infection, the community barriers to accessing HIV-specific services and recommendations for addressing those barriers. The information garnered was helpful in assisting with the requisite information for the UNGASS impact indicators as the researchers was able to provide a qualitative response to UNGASS indicator 19 (% of men reporting the use of a condom the last time they had anal sex with a male partner).

e) The Caribbean HIV/AIDS Alliance, St Kitts and Nevis

Despite the challenges faced by the NAS in accessing the MARPs, the CHAA has been instrumental in bridging this gap. They have defined their most-at-risk populations as MSM, SW and PLHIV. Through peer and group session animator outreach log sheets, quarterly commodity report forms, country reports and quarterly implementing partners reports, they too have provided qualitative responses for the UNGASS indicators 9 and

[9] USAID office of the representative to Barbados, Measure Evaluation. An HIV and AIDS situational assessment: Barriers to access to services for vulnerable populations in Saint Kitts and Nevis. August 2007.

14 (% of most-at-risk populations reached with HIV prevention programmes and % of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission).

f) Monitoring and Evaluation of the response

In 2006, the M&E team, with support from CHRC, CDC/GAP, PANCAP and a local consultant, developed a Monitoring and Evaluation Plan for St Kitts and Nevis, Expanded Response to HIV/AIDS to assist the National AIDS Programme (NAP) and stakeholders in understanding how the current National Strategic Plan, partners and current reporting structures feed into the collection, reporting and utilization of information in-country.[10]

The intention of the document was to capture the existing structures and processes and to identify resources needed for instituting an envisioned system. This information was collected through desk reviews of various documents and interviews with key informants involved in the national response, and used to guide the planned „Integrated Monitoring and Evaluation Programme'. A draft M&E plan (2009-2013) is presently being finalized based on these findings, which will then inform the M&E programme. The draft M&E plan serves as a basis for the development of a comprehensive M&E system which is aligned to the National Strategic Plan 2009-2013.

The purpose of the draft M&E Plan is to assist NACHA, The NAS, the MOH and its multisectoral stakeholders in continuously monitoring the implementation of its HIV/AIDS National Strategic Plan 2009-2013. The development of a M&E system in St Kitts and Nevis will ensure good programme management, programme efficiency and effectiveness because of its ability to[11]:

- Detect problems and make the necessary programme/project changes.
- Provide data on programme progress and effectiveness.
- Provide data to plan for the use of the resources.
- Involve stakeholders and partners in the M&E process.
- Provide information to decision makers to influence policies.

Challenges faced in the present system include[6]

- harmonizing of indicators
- dissemination of data to ground level
- limited capacity in research methodology, database development and management, and behavioural surveillance.

The 12 components of the draft M&E plan (2009-2013) constitute an organizing framework for an HIV M&E system, and can therefore address the challenges of HIV M&E systems in the following ways[11]:

[10] Monitoring and Evaluation Plan for St Kitts and Nevis, Expanded Response to HIV/AIDS, PANCAP, CHRC, 2006

[11] Draft Monitoring and Evaluation Plan 2009-2013.

- As an organising framework for the staff, resources, support, and funding required for the HIV M&E system.
- As the basis for conducting assessments on the national HIV M&E system in which the status of each component can be assessed.
- As a way to develop joint M&E reports or updates on the status of an M&E system, in which each of the components can be reported on.
- As a way to establish a clear division of labour at country level and a framework within which all partners can work together.
- As a means to develop indicators to measure levels of M&E system operationalization, and the extent to which each component is operational within it.
- As the basis for job descriptions and the capacity building of staff in the national HIV M&E unit, this should ensure that the staff members between them have the capacity and competence to focus on all 12 components of the national HIV M&E system.
- As the basis for a checklist of the kind of information needs to be addressed by the national HIV information

IV. National response to the AIDS epidemic

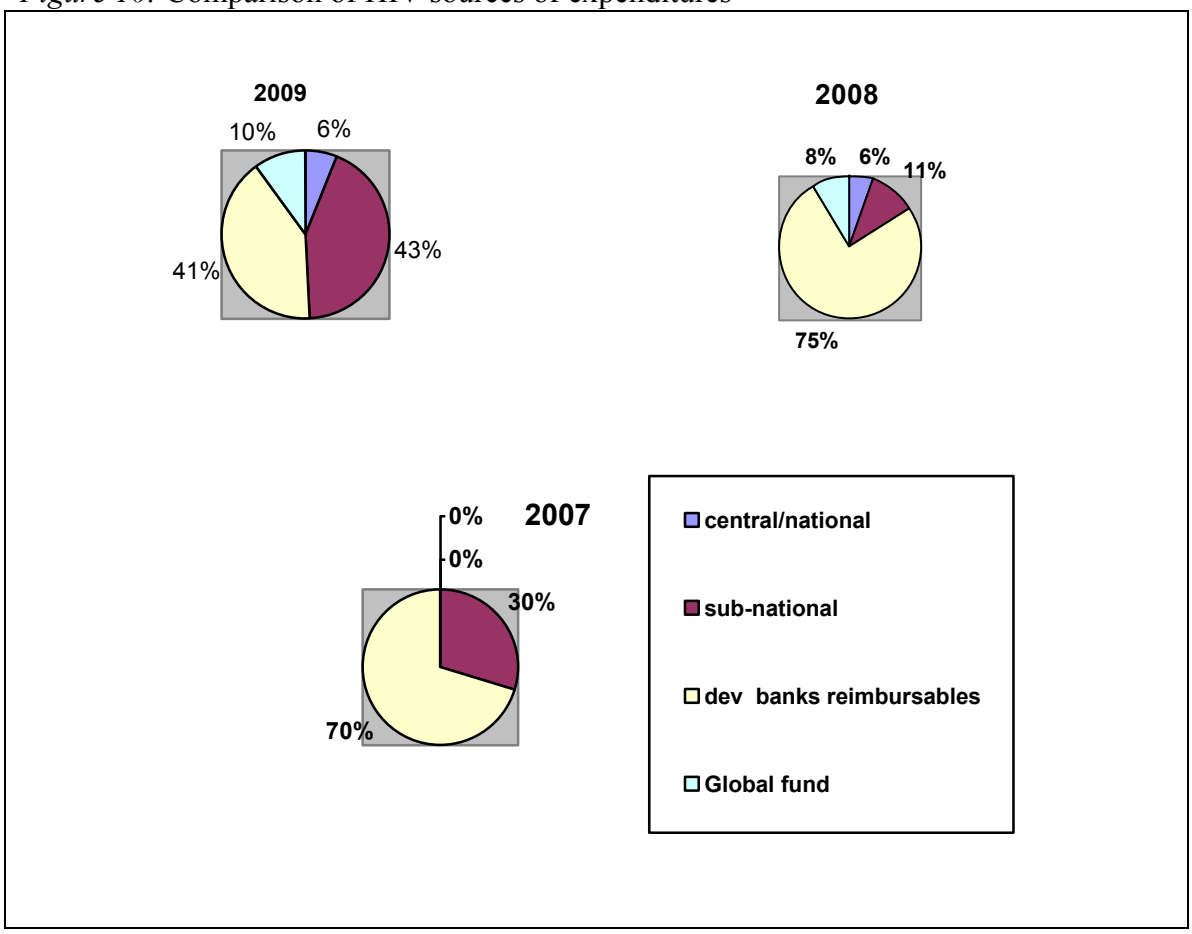
The national response to the HIV epidemic in St Kitts and Nevis is evaluated from the NAP expenditures; policy development and implementation as described in the summary and trend analysis of the responses derived from the NCPI; the programme areas (prevention, care, support and treatment); and knowledge and ehavior change in the population and impact alleviation strategies.

a) NAP expenditures *(Table 2)*

Categories	2007	2008	2009
Prevention	XCD	XCD	XCD
	$87,633	$94,258	$284,087
Care and treatment	XCD	XCD	XCD
	$32,400	$495,071	$173,495
Orphans and vulnerable children	N/A	N/A	N/A
Programme management and administration strengthening	XCD	XCD	XCD
	$3,468,689	$3,302,206	$2,716,135
Human resources	XCD	XCD	XCD
	0	$11,000	$11,000
Social protection and social services	XCD	XCD	XCD
	0	0	0
Enabling environment and community development	XCD	XCD	XCD
	$11,775	$95,548	$68,249
Research	XCD	XCD	XCD
	$8,710	0	0
Total	**XCD**	**XCD**	**XCD**
	$3,609,207	**$3,998,083**	**$3,252,966**

The Strategic Plan for the NAP for the next five years indicated that the priorities for intervention include more targeted prevention efforts, strengthening of surveillance to define the extent of the epidemic, development of a continuum of care services and ensuring sustainability of the national response through resource mobilization and efficiency in programme. The data for the NAP expenditures mimics these priorities. Although it is difficult to conduct a trend analysis due to the limited number of years available, it is observed that for 2009 spending on programme management and administrative strengthening for 2009 resulted in approximately 80% of the budget. This is followed by prevention strategies (8%) and research (7%). The national commitment towards instituting financial obligations geared at preventative strategies has been demonstrated with expenditures increasing drastically by 228% in 2009 compared to 2007. Financial commitments to research have increased drastically by over 3000%. Although the majority of expenditures are for programme management and administrative strengthening, this has decreased by 22% in 2009 from 2007.

Figure 10: Comparison of HIV sources of expenditures



Unlike 2007, there have been additional sources for AIDS spending from the Central/National level and the Global Fund (*see figure 10).* There has been negligible documented financial input from the private sector.

b) Summary of the National Composite Policy Index (NCPI)

The NCPI explores the progress in the development and implementation of national level HIV and AIDS policies. The NCPI is representative of the views of the participating stakeholders comprising the government officials from the MoH and other Line Ministries, FBOs, PLHIV and Civil Society Organizations.

National Commitment

The vision of the Government to prevent and control the spread of HIV and AIDS, promote care for those who are infected and affected, and reduce the personal, social and economic impact of the epidemic[12] remains the same. The Federation continues to provide free access to care and treatment for PLHIV.

The country has integrated HIV into its general development plans which may be interpreted as an indication that there is some commitment geared towards HIV prevention on a national level, however there has been no evaluation of the impact of HIV on its socio-economic development for planning purposes. The estimate of the size of each target population has not been updated and there is no indication of funding sources to support programme implementation. There is rhetoric multisectoralism and a revision of the national strategic plan to incorporate this but there is no earmarked budget for Line Ministries. The multisectoral strategy has been endorsed by most external development partners, but not all of the external development partners have aligned and harmonized their HIV-related programmes to the national multisectoral strategy.

Policy, strategy and law development

There are no specific non-discrimination laws or regulations for the vulnerable sub-populations (MSM, Youth, and CSW) and there are existing laws that present obstacles to effective HIV prevention strategies to these identified target subpopulations. The country has reviewed national laws to determine the consistency with the national AIDS Control policies, but to date there is no amendment of these laws to support the legal framework for programme implementation and enforcement of policies regarding breach of confidentiality, stigma and discrimination. The absence of these laws is presumed to drive the MSM and CSW populations underground making them minimally accessible to programme planning and implementation.

[12] UNGASS 2008 Country Progress report for St Kitts and Nevis

It was reported in the LEHR that there is normative evidence of the involvement of young girls ages 14-18 who are involved in transactional sex and anecdotal evidence of mothers forcing their children into sex work as a means of supporting their family. The legal age of consent for sexual intercourse has been recently amended from 16 to 18 years. During the NCPI, it was noted that this was done to be consistent with the age of majority and to protect adolescents from sexual abuse. There was an acknowledgement in the rapid assessment for HIV and SRH linkages that this will impact the legal age for youth accessing SRH services and this may be a deterrent to providing youth-friendly services which was also reiterated by interviewees from the civil society in the NCPI, who thought that this recent amendment may present obstacles for effective HIV prevention, treatment, care and support for young people.

Ratings from NCPI

Table 3

Rating indicators from NCPI	Participants	Rating #	Comments from interviewees
A1) Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?	Government officials	7	Equal weight in efforts remaining the same and increase efforts from 2007
A2) Overall, how would you rate the political support for the HIV programme in 2009?	Government officials	6	No change in efforts from 2007
A3) Overall, how would you rate policy efforts in support of HIV prevention in 2009?	Government officials	6	Increased efforts from 2007
A3) Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?	Government officials	7	Increased efforts from 2007
A5) Overall, how would you rate the M&E efforts of the HIV programme in 2009?	Government officials	6	No change in efforts from 2007
B1) Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?	Government officials and civil society	1	No change in efforts from 2007

Rating indicators from NCPI	Participants	Rating #	Comments from interviewees
B1) Overall, how would you rate the effort to enforce the existing policies, laws and regulations for human rights in 2009?	Government officials and civil society	1	No change in efforts from 2007
B2) Overall, how would you rate the efforts to increase civil society participation in 2009?	Civil society	5	Increased efforts from 2007
B3) Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?	Civil society	7	Increased efforts from 2007
B4) Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?	Civil society	8	Increased efforts from 2007

c) *Programme Implementation*

The programmes assessed are blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphaned and vulnerable children.

Table 4: UNGASS indicators

NO.	INDICATOR	INDICATOR RELEVANCE	DATA MEASUREMENT TOOL	INDICATOR VALUE	COMMENTS
3.	Blood Safety : % of donated blood units screened for HIV in a quality assured manner.	Data relevant and available	NEQAS-CAREC	2008 **100%** 2009 **100%** 2007 **100%** 2005 **100%**	2008: St Kitts=578/578 Nevis = 256/256 2009: St Kitts = 509/509 Nevis = 245/245
4.	HIV Treatment, Antiretroviral Therapy: % of adults and children with advanced HIV infection receiving antiretroviral therapy	Data relevant but not available	National Programme Records	2008 **86%** 2009 **93%** 2007**100%** 2005 **97%**	The denominator used is the actual (not estimated) number of adults and children with advanced HIV infection. 2008:StKitts=20/21,Nevis=11/15 2009:StKitts=25/25, Nevis=12/15

NO.	INDICATOR	INDICATOR RELEVANCE	DATA MEASUREMENT	INDICATOR	COMMENTS
5.	PMTCT: % of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	Data relevant and available	National Programme Records and Antenatal clinic programme records	2008 **N/A** 2009 **50%** 2007 **100%** 2005 **1 out of 3**	The denominator used is the actual (not estimated) number of HIV pregnant women in the last 12 months. There were no HIV-positive pregnant women in 2008. 2008: St Kitts=0/0, Nevis=0/0 2009: St Kitts=1/2, Nevis=0/0
6.	Co-Management of Tuberculosis and HIV Treatment: % of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Data not relevant	Not applicable	Not applicable	No tuberculosis cases with HIV Co-infections recorded for 2008 and 2009
7.	HIV Testing in the General Population: % of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.	Data relevant and available	BSS in six countries of the OECS, 2005-2006	2005: 25-49 yrs: Male **17%** Female **15%**	There was no available data for ages 15-19 and 20-24.
8.	HIV Testing in Most-at-Risk Populations: % of most-at-risk populations that have received an HIV test in the last 12 months and who know their results.	Data relevant but not available	National Programme Records	2009 **0(n=6)** 2008 **N/A** 2007 **N/A**	Small number was tested by NAS in 2009, in collaboration with the Caribbean HIV & AIDS Alliance, St Kitts; no one was found to be positive.
9.	Most-at-risk populations, prevention programmes: % of most-at-risk populations reached with HIV prevention programmes.	Data relevant but not available	Caribbean HIV&AIDS Alliance, St Kitts: Country Office Data Report	Jan 2009-Dec 2009: Male **1004** Female **504** Unstated **91** Total **1599**	Data stated is the number of individuals reached through community outreach that promotes HIV & AIDS prevention through other ehavior change beyond abstinence and/or being faithful.
10.	Support for children affected by HIV and AIDS: % of orphaned and vulnerable children whose households received free basic external support in caring for the child.	Data not relevant	Not applicable	Not applicable	Orphans are absorbed into the extended family.
11.	Life-Skills based HIV Education in Schools: % of schools that provided life skills-based HIV education within the last academic year.	Data relevant and available	Ministry of Education, School survey	Sept 2008-June 2009 **45%**	St Kitts 11/28 = 39% Nevis 7/12 = 58%

Indicator 3
% of donated blood units screened for HIV in a quality assured manner

All donated blood units are screened for HIV by the National Laboratory at the JN France Hospital according to the laboratory's standard protocols. External quality assurance is conducted in collaboration with CAREC through the National External Quality Assessment Service (NEQAS). This picture is similar in 2005 and 2007(*see table 4)*

Indicator 4
% of adults and children with advanced HIV infection receiving antiretroviral therapy

The denominator used for all reported years is the actual number of adults and children with advanced HIV infection and not the estimated number as defined by the UNGASS indicator. Although there is a slight decrease in the percentage of persons receiving ARV *(see figure 7)*, no trends can be established due to the small sample size.

Antiretroviral therapy is made available and affordable to everyone in St Kitts and Nevis as it is usually provided free of cost. On making a positive diagnosis, clients are referred to a medical practitioner of their choice trained in HIV management. A multidisciplinary Clinical Care Team is established with a Clinical Care Coordinator who oversees the total management of the patient in a very confidential manner. To enhance confidentiality, these services are often offered in a private care setting. Although easily accessible, patients are still uncomfortable with the privacy and security of their health information and as such some persons seek care and treatment abroad. The final report on the national assessment on Law, Ethics and Human Rights acknowledged that the lack of privacy and confidentiality appeared to be the most virulent obstacle in addressing HIV and AIDS care, treatment, prevention along with stigma. The principle culprits of breaches of confidentiality were identified as health care professionals and the general public expressed deep skepticism at the possibility of seeking treatment at the hospital if they were found to be HIV positive. The government has addressed this concern with the introduction of a clinical care team and the NAS has responded by training service providers on the issue of stigma, discrimination and confidentiality. The LEHR has made specific recommendations, which have yet to be instituted, for the amendment of present laws to provide the framework required to hold health care workers accountable for breaches in confidentiality.

Indicator 5
% of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission

The denominator used for all the reporting years is the actual number of HIV positive women in the last 12 months and not the estimated number as defined by the UNGASS

indicator. It has been estimated that < 5% of the population do not access antenatal care in St Kitts[13]; therefore the estimated number of HIV-positive pregnant women may be close to the actual number of HIV-positive women. The numbers involved in the denominator is insufficient to make a trend analysis; in 2008 there was no positive diagnosis in the PMTCT programme and in 2009 there were two positive diagnoses in the PMTCT programme, however only one of those persons, already on ARV pre-partum, received treatment.

Indicator 6
% of estimated HIV-positive incident TB cases that received treatment for TB and HIV

Although there was a total of 4 TB cases diagnosed for 2009, there were no tuberculosis cases with HIV co-infections recorded for 2008 and 2009.

Indicator 7
% of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results

The data available is from the Behavioural Surveillance Survey conducted in 2005, and is available for age groups 25-29 where 17% of males and 15% of females received the HIV test and know the results. However, an assessment can be made from data derived from National Programmes (see *table* 5). The data is not disaggregated according to age groups, geographic location and gender but there has been shown to be a significant increase in the number of persons receiving VCT with over 100% increase in 2008 and 2009 from 2004-2007. However it is difficult to assess the number of persons being tested for the first time and the absence of a risk assessment limits classification of risk groups.

Table 5: Number of women and men in St Kitts and Nevis who received an HIV test in the last 12 months

	2004	*2005*	*2006*	*2007*	*2008*	2009
# of women and men who received an HIV test in the last 12 months	156	238	702	432	1461	1577

Table 6: Number of women and men in St Kitts aged 15-24 and 25-49 who received an HIV test in the last 12 months and who know their results

Age	Received Test		Know Result	
	Male	Female	Male	Female
15 – 24	89	457	71	376
25 – 49	225	591	166	469
Total	**314**	**1048**	**237**	**845**

[13] Estimate garnered from the number of live births , ANC attendees and discussions with technocrats.

Table 6 illustrates the number of women and men aged 15-49 who received an HIV test and know their results. Approximately a quarter of the people receiving the test were males. The NAP has recognized this and is developing innovative ways of targeting males for VCT testing. Approximately 80% know their results after having received the test.

Indicator 8
% of most-at-risk populations that have received an HIV test in the last 12 months and who know their results

It was recommended that the data was collected from a behavioural surveillance or other special surveys; however it is quite challenging to obtain data from a population that is presently underground. The NAP, has acknowledged that an integral part in implementing national prevention strategies is knowledge of the prevalence rates; and for implementation of individual preventative strategies, knowledge of HIV status. The Caribbean HIV/AIDS Alliance (CHAA) has been working closely with the MARPs and has referred 830 MARPs during the period Oct 2008- Dec 2009 *(see table* 7). With the exception of the last quarter (Oct 2009-Dec 2009) there have been significant increases in the number of clients referred for HIV testing. The limitation is that it is not known if these clients access the services and the result. This inhibits programme planning and the data is not available for UNGASS reporting. In 2009, in collaboration with the CHAA, the NAS commenced offering VCT services to MARPs. A small number (n=6) was tested. It is expected that this form of testing will be continuous and improvement will be made in the numbers being tested.

Table 7: Number of MARPs referred for HIV testing

	Oct 2008-Dec 2008	*Jan 2009-Mar 2009*	*Apr 2009-Jun 2009*	*Jul 2009-Sep 2009*	Oct 2009-Dec 2009
# of MARPs referred for HIV testing	116	153	191	247	123

Indicator 9
% of most-at-risk populations reached by prevention programmes

Prevention programmes conducted by the NAS are mainly concentrated on the general population. Positive prevention strategies are limited due to limited accessibility of the most-at-risk population to the NAS and they have had to rely almost solely on the assistance of the Caribbean HIV/AIDS Alliance in targeting MSM, CSW and PLHIV. The number of MARP contacted by the CHAA in 2009 was 1599 and the number of new clients increased significant by 604 (38%) from 2008.[14]

[14] National Programme Records

Indicator 10
% of orphans and vulnerable children whose households received free basic external support in caring for the child

This data is not applicable in our setting as not only do we not have a prevalence rate of orphans of greater that 5%, but the orphans are usually absorbed in the extended families.

Indicator 11
% of schools that provided life skills-based HIV education within the last academic year

The definition of life-skills based HIV-education utilized in the 2009 UNGASS indicators was the provision of least 30 hours of life-skills training to each grade. A representative from the Ministry of Education conducted a survey among nationally-represented samples of public schools. 18 out of 40 (45%) schools were found to be providing life skills to each grade.

Differing definitions were used for reports from the previous years, so it was difficult for trend analyses to be made (*see table 8).*

Table 8: Percentage of schools that provided life skills based education

	2004	2006	2009
% of schools with teachers who have been trained in life skills based education and who taught it during the last academic year	0%		
% of schools that provided life skills (irrespective of hours taught) based HIV education within the last academic year to any grade		100%	83%
% of schools that provided 30 hours of life skills based education to each grade within the last academic year			45%

d) Knowledge and ehavior

Table 9: Expanded UNGASS table

NO.	INDICATOR	INDICATOR RELEVANCE	DATA MEASUREMENT TOOL	INDICATOR VALUE	COMMENTS
12	Current school attendance among orphans and among non-orphans aged 10-14	Data not relevant	Not applicable	1:1	Education is mandatory
13.	Young People, Knowledge about HIV Prevention: % of young women and men aged 15-24 who both correctly identify ways of preventing the sexual	Data relevant and available	BSS in six countries of the OECS, 2005-2006	2009 **N/A** 2007 **N/A** 2005 **52%**	Data was not disaggregated for males and females.

NO.	INDICATOR	INDICATOR RELEVANCE	DATA MEASUREMENT	INDICATOR	COMMENTS
	transmission of HIV and who reject major misconceptions about HIV transmission.				
14.	Most-at-risk Populations: Knowledge about HIV Transmission Prevention: % of most-at-risk population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Data relevant but not available	Caribbean HIV&AIDS Alliance, St Kitts	Not available	Peer outreach workers (animators) probe with general knowledge questions prior to IEC events.
15.	Sex before age 15: % of young women and men who have had sexual intercourse before the age of 15.	Data relevant and available.	BSS in six countries of the OECS, 2005-2006	2005: Male **36%** Female **10%**	
16.	Higher-risk Sex: % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Data relevant and available	BSS in six countries of the OECS, 2005-2006	2005: 15-24 **46%** 25-49 **23%**	Data was not disaggregated for males and females
17.	Condom use during higher risk sex: % of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	Data relevant but not available	UNGASS report 2007	2005 **67%** 15-24 **68%** 25-49 **66%**	Data was not disaggregated for males and females
18.	Sex Workers, Condom use: % of female and male sex workers reporting the use of a condom during their most recent client.	Data relevant but not available	An HIV and AIDS situational assessment: barriers to access to services for vulnerable populations in Saint Kitts and Nevis	Not available	Accessing sex workers proved difficult and it was not possible to gain information on condom use with clients.

NO.	INDICATOR	INDICATOR RELEVANCE	DATA MEASUREMENT	INDICATOR	COMMENTS
19.	Men who have Sex with Men, Condom use: % of men reporting the use of a condom the last time they had anal sex with a partner.	Data relevant but not available	An HIV and AIDS situational assessment: barriers to access to services for vulnerable populations in Saint Kitts and Nevis	Not available	A large number of MSM (n=17) responded that they were using condoms with their partners, but when probed 'Do you use condoms every time' the interviewers notes begin to document comments such as: "Well, I use condoms with him, but when I learn him more [and] he learn me more, then we didn't use them much…"
20.	Injecting drug users, Condom use: % of injecting drug users reporting the use of a condom the last time they had sexual intercourse.	Data not relevant	Not available	Not available	Not available
21.	Injecting drug users, Safe injecting practices: % of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Data not relevant	Not available	Not available	Not available

Indicator 12:
Current school attendance among orphans and non-orphans aged 10-14

The prevalence rate of orphans in the country is less than 5% and there are no known orphans in need. It is mandatory that all children between 10-14 years attend school.

Indicator 13:
% of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

This data was gathered from a Behavioural Surveillance Survey conducted in six countries in the OECS in 2005 with the assistance of USAID, FHI, CAREC and PAHO. It was noted that 52% of persons ages 15-24 both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. The data was not disaggregated according to gender. Since then no additional surveys have been conducted for comparison.

The NAS has focused its efforts on improving knowledge base and mitigating behaviours that drive the epidemic through the use of the media, improvement of life skills in in-school youth and some out-of-school youth, talks and seminars and a key presence at local events. Programmes implemented are addressed at the preventative level.

Indicator 14
% of most-at-risk population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

The data is not available as the most-at-risk population is not easily assessable. The animators (peer outreach workers) from the CHAA probe with general knowledge questions prior to IEC events, however a conduction of a survey will be difficult due to the sensitive nature of work with MARPs, so data is not collected during outreach sessions.

Indicator 15
% of young women and men who have had sexual intercourse before the age of 15:

The BSS conducted in 2005 indicated that 36% of males and 10% of females had sexual intercourse before the age of 15. There is no later surveillance to assess ehavior change. However, teenage pregnancy may be used as a proxy for sexual intercourse (see *table 10)*

Table 10: Number of live births in mothers less than 15 years

	2002	*2003*	*2004*	*2005*	*2006*	2007	*2008*	*2009*
# of live births in mothers <15 yrs	1	0	3	6	4	1	2	5
# of live births in mothers <16 yrs					10	1	6	12

The data reveals that the annual prevalence of teenage births under 15 years remains irregular and the sample size is too small to conduct a trend analysis.

Indicator 16
% of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months

The data is garnered from the BSS and although not disaggregated for males and females, it was noted that twice as much persons aged 15-24 had multiple partners in the last 12 months than those aged 25-49. The NAP has identified the youth (15-24) as an emerging MARP.

Indicator 17
% of women and men aged 15-49 who had more than one partner in the last 12 months who used a condom during their last sexual intercourse.

This data follows on from the preceding indicator (Indicator 16). The data shows that approximately 2/3 of persons aged 15-49 used a condom during their last sexual intercourse.

The National AIDS Programmes in St Kitts and Nevis have been instrumental in implementing numerous preventative programmes and policies for 2008 and 2009 *(see table 11).* Often this requires „stepping out of the box' and exploring innovative ways in targeting subpopulations. A noteworthy example is the noted absence of youth accessing services from the clinic settings, therefore in an effort to increase HIV/AIDS awareness in the general population and the youth; the NACU participates in the annual Culturama parade with a troupe (see f*igure 11).* The NAS also participates in similar marches in St Kitts (*see figure 12).*

Figure 11: Culturama troupe in 2008

Figure 12: NAS march for World AIDS Day

Table 11: Programmes implemented in 2008-2009

Organization	Reporting year	Activities
NAS	*2008*	*Increase HIV/AIDS awareness in the general and targeted populations through the use of IEC e.g. dissemination of posters and brochures; development of a website; radio and television programmes, health education sessions; distribution of literature, promotional items, literature and tee shirts at health fairs, games and festivals; facilitation of workshops.*
NAS	*2008*	*Creation of a supportive environment that fosters acceptance and reduces stigma through media programmes, outreach sessions and reproduction of a*

Organization	Reporting year	Activities
		brochure by the human rights desk and human rights advocate.
NAS & NACU	*2008-2009*	*Increase in the number of persons who know their HIV status by hosting community and national VCT days.*
NAS	*2009*	*Preventing and testing activities amongst out-of-school youth participating in the YES programme.*
NAS	*2008*	*Increased access to condoms through nontraditional outlets eg FBO, sporting events, carnival and music festival events and civil society organizations.*
NACU	*2008*	*Specific targeting of males e.g. special fathers day VCT, mass media campaigns developed to target men and their roles/responsibilities*
NAS	*2009*	*Specific targeting of MARPS*
NACU	*2008-2009*	*Creation of a supportive environment that fosters acceptance and reduces stigma and discrimination by the execution of a workplace programme. In 2009 the workplace programme ran for four months in 27 business places and 15 line ministries which was sponsored by PANCAP.*
NAS	*2008-2009*	*Specific targeting of workplace for prevention strategies and testing.*
NAS	*2009*	*Utilizing outreach programmes, prevention and testing among armed forces.*
NACU	*2008-2009*	*Increase HIV/AIDS awareness in the general and targeted populations e.g. annual Culturama troupe and parade, puppeteer show for kids, ongoing school health and adolescent programmes at the health centre, increased condom distribution including dental dams and female condoms, school education sessions, billboards, 'Kicking AIDS OUTt' campaign, 'Ride the Bus' campaign, Run for Hope run/walk.*
NAS	*2009*	*Prevention and education in schools*
NACU & NAS	*2009*	*Increase in the number of persons trained in PITC and VCT .sponsored by Global Fund, Jhipeigo, CHART*
NAS	*2009*	*Nutrition Subsistence Programme for PLHIV*
NAS	*2009*	*Introduction of an edutainment programme through the use of IRIE(Instituting Respect to Inspire Empowerment)*
Caribbean HIV and AIDS Alliance, St Kitts and Nevis	*2008-2009*	*Continuance of the Eastern Caribbean Community Action Project(ECCAP)geared at reaching the MARP (CSW,MSM, PLHIV) through ehavior change interventions that lead to increased knowledge base in sexual health, improving safer sex practices, and increasing their access to health services as well as*

Organization	Reporting year	Activities
		building their trust, confidence and self worth.
Community Health Services	*2008-2009*	*Educational Programmes for in-school youth focusing on general health issues including STI*
Department of Youth	*2009*	*Promoting IEC on HIV with the introduction of an HIV/AIDS Game show, publication of comic Ref relating to HIV/AIDS, training opportunities, Primary School HIV Jeopardy Quiz*

The present sexual transmission programmes are targeting both the general population and the youth primarily through media-based efforts and talks. There is a proposed integration of SRH and HIV in the present draft strategic and operational plan and the application of recommendations derived from a rapid assessment for SRH and HIV linkages conducted in 2009. Although an SRH policy exists, greater integration of HIV in the SRH policy will be beneficial and this is expected to be addressed during the activation of the draft operational manual for primary caregivers.

Indicator 18
% of female and male sex workers reporting the use of a condom during their most recent client

Although this data is relevant to the country, it is not available. An HIV and AIDS situational assessment was conducted for vulnerable populations in St Kitts and Nevis. The two types of engagement in sexual negotiations identified in SKN are commercial sex and transactional sex. The qualitative data derived from the assessment was noted in Box 1. It was not possible to gain information on condom use with female and male sex workers.

Box 1: Qualitative data derived from male and female sex workers through the situational assessment

"those involved in commercial sex work include foreign Spanish–speaking girls and women and local English-speaking girls and women. It was difficult to identify these women as the Spanish-speaking women interviewed did not distinguish themselves as CSW, because they are not 'visibly' practicing sex work, they are not street based nor do they necessarily operate out of bars or brothels or work with a pimp; they are not even engaged in the CSW activity full time. Spanish bars may be a venue for sex work, but they are also seen as community centres for the women to socialize…… the local girls were not identified by the community as CSW, neither would they self-identify as CSW.

The interviewers documented that during the course of their discussions that seven of the men interviewed engaged in some form of transactional sex. However, when directly asked the question as a part of the demographic form, only three admitted to engaging in transactional sex. Some exchanges between men were documented as exchanges for purchases, like cell phone top ups (extra money added to pre-paid phones), which is documented several times with other groups in this assessment (for example with women). Two interviewers noted that some exchanges may not have been solely done for the money as

the exchange was for relatively small amounts (XCD $5-10) following a statement/comment such as "Give meh something, nuh…" after the sexual interactions—as if the money exchange would "cancel out" the sex and become the primary interaction. The interviewers discussed this occurrence and thought that this may be connected to wanting to deny the act of having just had sex with a man. This assessment recommends more information is needed to understand transactional sex within the MSM community.

Indicator 19
% of men reporting the use of a condom the last time they had anal sex with a partner

The interviewers for the HIV and AIDS situational assessment were able to conduct interviews with only 23 men who have sex with men. This sample size was inadequate for a quantitative assessment to be made, however qualitative responses were garnered from some of the participating MSM (*see Box 2)*.

Box 2: Qualitative data derived from the situational analysis conducted on the vulnerable population in SKN

A large number of MSM (n=17) responded that they were using condoms with their partners, but when probed 'Do you use condoms every time 'the interviewers notes begin to document comments such as: "Well, I use condoms with him, but when I learn him more [and] he learn me more, then we didn't use them much…"'

Indicator 20 & 21
% of injecting drug users reporting the use of a condom the last time they had sexual intercourse
% of injecting drug users reporting the use of sterile injecting equipment the last time they injected

In our local setting the number of injecting drug users are thought to be minimal and while emphasis is placed on prevention strategies for the other modes of transmission, little emphasis is placed on prevention strategies for injecting drug users as a specific sub-population.

e) Care and support

The main types of care required for persons infected and affected by HIV & AIDS include home-based care, psychosocial intervention and nutritional care. The broader needs of PLWA and their carers, including home and community care, nutritional, psychosocial and pastoral needs have not been assessed and addressed thus far.[15] The NCPI solicited the perceptions of the stakeholders and PLHIV on the level of care received.

Home-based care

All the participants of the NCPI agreed that the people in need do have access to home-based care, but some thought that its provision was not of immediate importance as the persons who may require home-based care is a small population and such persons are hospitalized. Efforts are being made to involve FBOs in the caring of PLHIV at this level.

Psychosocial Intervention

Psychosocial interventions are required from diagnosis to disclosure, and subsequent treatment and support from family and friends as well as the impact on carers. The participants in the NCPI from Part A (government officials) indicated that the people in need do not have access to psychosocial support for people living with HIV and their families, but those from Part B (civil society) indicated the people in need do have access to psychosocial support for PLHIV and their families but were often hesitant to access these services.

Nutritional care

Nutritional care is currently being provided through a programme by the Ministry of Health/NAP involving the support group for PLHIV. The participants in Part A of the NCPI indicated the majority of persons in need do not have access to nutritional care.

National Commitment and Programme Implementation

The Ministry of Health and the Department of Social and Community Development have made a commitment to increase the quality and coverage of home- and community-based care for chronically ill patients and orphans and for its sustainability the inclusion of the annual national home care programme in the annual health budget.[16] The animators working along with the Caribbean HIV/AIDS Alliance have been instrumental in providing care and support to PLHIV through a referral system.[17]

[15] The draft National Strategic Plan 2009-2013
[16] Draft Strategic Plan 2009-2013
[17] HIV and AIDS data on most at risk populations, country data report for St Kitts and Nevis, Oct 2008-Sept 2009

Linkages between existing policy environment

It has been recommended by the stakeholders during a rapid assessment survey that a general home-based care plan be established that will incorporate PLHIV and there be a further identification of resources, building of a multisectoral team and implementation of this general plan.[18]

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f) Impact alleviation

Impact alleviation focuses on the target of the vulnerable populations and the driving forces propelling the epidemic. Impact alleviation strategies may be measured by observing national indicators and assessing the vulnerable populations and the driving forces propelling the epidemic. The National Response to the AIDS epidemic is a multisectoral, multidimensional approach. Impact alleviation may be measured by observing national indicators, vulnerability of subpopulations, multisectoral approach and project implementation. The death rate and persons in care is not significant for an assessment of the impact based on these national indicators.

This section looks at impact alleviation strategies and utilizes the UNGASS and national indicators to determine any impact on the epidemic.

Impact alleviation strategies

SKN has focused its impact alleviation strategies on addressing the vulnerability of subpopulations and utilizing a multisectoral, multidimensional approach as its national response. There is a noted commitment by the NAP and the Government to decrease the vulnerability of women with the intense marketing of the use of female condoms, decrease of gender-based violence, attention on gender inequality and an increase in the age of sexual consent as a protection for sexual abuse. The Department of Gender has incorporated men in addressing gender inequality and they speak regularly about HIV at all their programmes for both males and females. This approach is extended to the low income women where preventative strategies are particularly targeted at this group.

In an attempt to decentralize the HIV impact, efforts were made to adopt a multisectoral approach. Involvement from these sectors is limited, although efforts to include these groups have increased with quarterly meetings introduced with civil societies and line ministries. Workplace programmes have been introduced by the NAS in St Kitts and NACU in Nevis.

[18] Rapid Assessment for sexual and reproductive health and HIV linkages in St Kitts and Nevis, 2009

Table 12: Expanded response to UNGASS indicators

NO.	INDICATOR	INDICATOR RELEVANCE	DATA MEASUREMENT TOOL	INDICATOR VALUE	COMMENTS
22.	Reduction in HIV Prevalence: % of young people aged 15-24 who are HIV infected.	Data relevant and available	Antenatal Clinic data	2009 = **0.55%** 15-19: 1/90=1% 20-24: 0/93=0%	
23.	Most-at-risk population, Reduction in HIV Prevalence: % of most-at-risk populations who are HIV-infected	Data relevant but not available	Not available	Not available	Data not available; no study conducted
24.	HIV Treatment, Survival after 12 months on Antiretroviral Therapy: % of adults and children with HIV known to be on treatment 12 months after initiation of ARV	Data relevant and available	National Programme Records	2008 **75%** 2009**100%** 2006**100%**	2008: St Kitts=3/4, Nevis=0 2009: St Kitts=2/2, Nevis=0
25.	Reduction in MTCT: % of infants born to HIV-infected mothers who are infected	Data relevant but not available	National Programme Records	2008 **0%** 2009 **0%** 2006 **0%** 2005 **21%**	There is an infant (younger than 18 months) who has a positive HIV antibody result in 2009.

Indicator 22
% of young people aged 15-24 who are HIV infected

The indicator value was 0.55% (1/90). The data was derived from the Antenatal Clinic data its interpretation is limited as the data is derived from mainly females and there is a possibility, based on previous data, that the epidemic may have a higher prevalence in males than females.

Indicator 24

% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

A small number of persons have been placed on HIV treatment for the 2008 (4) and 2009 (2) period, with a compliance rate of 75% and 100% respectively. Therefore a trend analysis could not be undertaken.

Use of and adherence to ARVs in St Kitts is dependent upon social support, management of side effects and barriers to treatment which is perceived as stigma and discrimination. The NAP in St Kitts and Nevis has recognized the importance of adherence to ARV and two persons attended an HIV Drug Resistance Meeting held in Trinidad to develop „decisions indicators' for early warning of drug resistance. Indicators were agreed upon to be utilized by doctors to indicate if clients will benefit from treatment.

Indicator 25

% of infants born to HIV-infected mothers who are infected

In 2009, there was an infant (less than 18 months of age) who has a positive HIV antibody result; however a diagnosis cannot be made based on the antibody results until 18 months of age.

V. Best practices

a) Maximizing civil society in preventative strategies

The NAP has been faced with difficulty defining the nature of the HIV epidemic in St Kitts and Nevis in the absence of sero-prevalence studies and with a high level of stigma and discrimination driving the epidemic. It was not only difficult to define the target population, but also to access subpopulations thought to be at the most risk (CSW, MSM). As a result NACHA had to be innovative in their preventative efforts.

The Caribbean HIV/AIDS Alliance since its inception in SKN has made significant inroads in targeting the most at risk populations (CSW, MSM, and PLHIV). Unlike the CHAA, the MoH has been faced with challenges relating to breaches in confidentiality, stigma and discrimination. Recognizing that implementing a legal framework to facilitate the institution and amendment of policies and plans designed to target the areas and effecting changes in perceptions and ehavior modification is an evolving and lengthy process, the NAP attempted to maximize the present structures in place whilst still focusing on these ehavior modifications.

To this effect, the NAS have relied heavily on the work done by the CHAA to target these subpopulations. The NAS have also worked hand in hand with referrals made by the CHAA and have taken it a step further by offering VCT services directly to this group. The CHAA has been making steady progress in accessing this group. The NAS has collaborated with the NAP in the following ways:

- Assisting in offering VCT services to PLHIV
- Participation in workshops for PLHIV
- Increased attempts to test persons who would not regularly be tested by introducing community testing and a palpable presence at festivals, fairs and carnival.

The following benefits are expected:

1. A better understanding of the prevalence rate of the MARPs thus facilitating a more accurate definition of the epidemic.
2. Maximization, instead of duplication, of efforts geared towards targeting of the MARPs, thus demonstrating cost effectiveness and promoting efficiency.
3. Acquisition of data for the most-at-risk populations in the UNGASS indicators.

The CHAA has identified the specific needs for HIV prevention programmes. They conducted a situational assessment to identify the MARP, an intervention feasibility assessment to decide the feasibility and relevance of a part intervention and a FBO assessment to determine the barriers and facilitations in implementing HIV programmes.

b) Targeting men through outreach programmes

Although the prevalence of men who are HIV positive are greater than females, fewer males are being tested.

The NAS and NACU have embarked on an outreach programme aimed primarily at targeting men. The following strategies were implemented in 2008 & 2009:

- Special Fathers Day VCT
- Mass media campaigns developed to target men and their roles/responsibilities
- Promoting involvement of men in the PMTCT programme by renaming it the PPMTCT (Prevention of Partner to Mother to Child Transmission Services). This involved the production and dissemination of posters and brochures for distribution in the Health Centres *(see annex 2*).
- Assisting in HIV and STI sessions at the Gingerland Men's Health Clinic.

Table 13 illustrates that more males were able to get tested and know their results from the outreach programmes. In 2008, 77% (223/288) of the men tested were from outreach programmes and in 2009, 59% (166/280) of the men were tested from outreach programmes.

Table 13: Number of persons receiving VCT and know their results from 2007-2009

VCT	2007		2008		2009	
	male	female	male	female	male	female
Health Centres	56	178	51	436	78	580
Private Practitioners	N/A	N/A	14	42	36	84
Outreach Programmes	N/A	N/A	223	366	166	235
Total			**288**	**844**	**280**	**899**
			1132		**1179**	

Efforts are continuing to improve the scope of the outreach programmes to encompass greater numbers of males being newly tested.

c) Targeting vulnerable women

According to the Situational Analysis on the vulnerable population in St Kitts and Nevis, the general trend towards the "feminization" of HIV and AIDS has become a concern in St Kitts and Nevis. During the November 8 Meeting on Prevention Activities and Strategic Information Needs for Vulnerable Populations, stakeholders expressed their concern on the increased susceptibility of Kittitian and Nevisian women to HIV and AIDS due to social, economic and cultural reasons. For this reason, this assessment interviewed a number of "at risk women" and they were classified into two distinct groups:

- Women who are economically disadvantaged and might rely on men for economic support
- Women who are married and therefore might not have the power to make sexual decisions.

These distinct groups have been targeted through programmes already implemented or about to be implemented. The SISTA project[19] (**S**isters **I**nforming **S**isters about **T**opics on **A**IDS) is a social skills training intervention aimed at reducing HIV sexual ehavior among African Americans women at highest risk. It is being adapted to the St Kitts setting and is being facilitated in conjunction with CHAA, targeting industrial site female workers who have been recognized as economically disadvantaged.

„Project Viola' is a formal support programme for teenage mothers which allow young mothers to complete their mainstreamed education. It was started by the Department of Gender Affairs in 1997 and as a result of its success; the project has become a best practice for UNICEF in the region.

Teenage mothers traditionally were economically disadvantaged as their pregnancies disallowed continuance of mainstreamed education. In St Kitts and Nevis, teenage pregnancies may result in increased susceptibility to HIV/AIDS as they too may become economically disadvantaged later in life. Project Viola covers the cost of daycare for mothers returning to high school and, upon request, provides assistance to purchase other basic needs for the child and mother[20]. The teen mothers programme assists with social and financial support. In 2007, approximately 100 girls have benefited from this programme in St Kitts and one thus far has opted to return to school in Nevis.

The Dept of Gender is in the process of formulating a proposal for adolescent mothers, with a focus on SRH, to expand the services offered by Project Viola.

[19] www.effectiveintervention.org
[20] Siteresources.worldbank.org

d) Men's clinic at Gingerland Health Centre

It was the brainchild of Community Nurse Lorraine Archibald to introduce a Men's Clinic at the Gingerland Health Centre after noting that men were not accessing health care services within the community or at other health facilities due to a myriad of reasons, including some men's hesitancy in being seen at a health facility and the health services offered were not conducive to their working hours. . The Clinic was designed to utilize a multisectoral approach in sensitizing men about issues relating to their general health including the transmission of HIV and other STIs.

The Men's Clinic was introduced in 2006, and its membership has been increasing (*see figure 13*). Emphasis was placed on sensitizing the general population and men in particular about the launch of the clinic through numerous extensive outreach programmes and the media These include a physical presence at the places that men hang out e.g. marketplace, clubs, bars; offering free health screening; the use of promotional items e.g. posters and pamphlets; and incorporation of other groups to raise awareness of its existence e.g. churches, St Georges Community Improvement Club and the Gingerland Diabetes Association..

Figure 13: One of the session at the Men's clinic at the Gingerland Health Centre

The attendance at the clinic has been significant. There has been increased numbers of condoms dispersed since the initiation of the clinic (3888 male condoms were distributed from Oct 2008 to Sept 2009) and more men are generally interested in their health safety and practices. A remaining challenge is the low VCT uptake at these clinics, despite concerted efforts by the health professionals.

From 2009, this programme has expanded to include the adolescents from the Gingerland Primary and Secondary Schools who are also being educated on Men's Health Issues which include HIV/AIDS and STIs. This is geared at encouraging the practice of good

health seeking behaviours, improve knowledge about health related issues and facilitate expanded education to their peers, family and others.

This has been recognized as a Best Practice on a regional level and with the assistance of PAHO, additional health care providers were trained to offer services to men in 2007. Presentations were requested in 2009 at a Men's Health Workshop in Barbados and in 2010, to persons around the Caribbean for possible adaptation at a regional level.

e) Enthusiasm generated for workplace programmes

The development of workplace polices in St Kitts and Nevis through the Ministry of Labour was an initiative of the International Labour Organization (ILO). With the assistance of PANCAP, the Caribbean was able to institute workplace programmes whilst awaiting the development of a regional workplace policy.

Nevis has been able to generate profound enthusiasm for the presence of workplace programmes. After meeting the designated target of 17 programmes implemented in the workplace, they were able to target 10 additional workplaces between June to September 2009.

Success in instituting the workplace programmes were based in part to the high level of involvement of the media in advertising this programme through their news items and pictures of the educational sessions on the evening news cast on television; assertive actions taken by the coordinator by visiting the workplaces and discussing the advantages of workplace programmes; demonstrating the use of female and male condoms and dental dams, distributing condoms; and the use of innovative marketing strategies aimed at generating interest and encouraging individuals to reduce their risk of contracting HIV and promotion of reductions in stigma and discrimination.

Out of the HIV/AIDS Workplace Programme, NACU is strengthening the Nevis HIV/AIDS Committee. Focal points from the workplace were invited to a meeting during the month of March and it is expected that such meetings will be held on a quarterly basis.

VI. Major challenges and remedial actions

a) Progress from 2006

The progress made on a significant number of key challenges in the 2007 UNGASS Country Progress Report is outlined in the table below (*see table 12)*:

Table 14: Progress made from 2007 UNGASS report to 2010 UNGASS report

Key challenges	2007 UNGASS report	2010 UNGASS report
Estimating prevalence data among young people	There has never been a population based sero-prevalence study to enable the government to estimate prevalence data among young people.	Based on the high uptake of PMTCT, the ANC estimates have been used to conclude that the prevalence rate in the youth is not yet generalized.
Effecting a multisectoral approach	It has been particularly challenging maintaining interest and engaging non-health sectors in the planning and implementation of HIV/AIDS related activities. To date Sectoral plans from key line ministries have not been submitted and the Ministry of Health remains the key implementer of activities.	There has been an introduction of quarterly meetings with line ministries and civil society, the production of a draft strategic plan by the MoE, activities implemented by the Department of Youth and the Department of Gender Affairs have tried to incorporate HIV in their sessions.
Care of PLHIV by NGOs	NGOs are few and of limited organizational and technical capacity; faith based organizations do not yet address community care needs of PLHIV.	Efforts are being made by the Caribbean HIV/AIDS Alliance to address care for PLHIV.
Targeting of MSM and CSW	There are criminal laws on the books for buggery and prostitution. This serves to drive the population underground, which makes it more difficult to identify and educate these groups.	The Caribbean HIV/AIDS Alliance has been targeting this group. There has been a teaming up of the NAS and the CHAA for VCT services.

Key challenges	2007 UNGASS report	2010 UNGASS report
Accessing condom services through the non-traditional modes	Services in the area of HIV/AIDS would have to move outside of the traditional mode, in order to provide the level of confidentiality necessary for the comfort of users in a very small society.	Distribution of condoms to civil society organization including FBOs. Placement of condom vending machines supported by NAS/NACU in strategic 'hot spots'.

b) Challenges faced during the reporting period and concrete remedial actions

The following challenges were faced throughout the reporting period that hindered the national response in general, and the progress towards achieving the UNGASS targets in particular. This is supported by concrete remedial actions that are planned for the next five years to ensure achievement of the UNGASS targets[21] *(see table 15)*.

Table 15: Key challenges faced during the reporting period and planned remedial actions

Key challenges	Inhibition of the national response and progress towards achieving the UNGASS targets	Concrete remedial actions planned
Stigma and discrimination	Drives the MARP (MSM, CSW, and PLHIV) underground and limits preventative strategies geared towards this population.	Development of anti-discrimination and confidentiality policies and guidelines and training of health sector workers in such protocols.
Absence of sero-prevalence studies	Limits defining the epidemic and the development of a concrete plan and programmes targeting high risk populations	Generating reliable information on the epidemic in St Kitts and Nevis through undertaking a national population based survey (with biological & BSS components) on issues related to

[21] Adapted from the draft National Strategic Plan 2009-2013

Key challenges	Inhibition of the national response and progress towards achieving the UNGASS targets	Concrete remedial actions planned
		HIV/AIDS/STI and TB.
Minimal behavioural surveillance	This limits the knowledge of the impact of ehavior modification strategies	An assessment of risk ehavior and vulnerabilities.
Calculation of estimates	Difficulties exist in determining the HIV prevalence rates in the populations and effectiveness of ARV in a country driven by stigma and discrimination.	A national population survey will provide an understanding of the drivers of the HIV epidemic and key base line data to facilitate better targeting and more effective resource use for the national response. The plan will also work towards strengthening the routine programme monitoring.
Limited involvement by line ministries and civil societies	It is difficult to provide preventative, care and support and treatment strategies to PLWA and the other population in an environment with socioeconomic constraints. A multisectoral approach is not only cost effective, but limits duplication of efforts.	Engaging and supporting faith-based groups to move beyond abstinence into projects to address taboos, stigma and discrimination and to provide community care to PLHIV. Strengthening organizational as well as technical capacity of civil society organizations, including NGOs, FBOs, and private sector. Supporting relevant ministries and departments to mainstream HIV in their own strategies, work plans and budgets, through strategic planning support.
Limited monitoring and evaluation infrastructure	Difficulty in assessing if the UNGSSS targets are being met with reversal in the spread of the disease.	Improving 2nd generation surveillance to monitor outcome and impact indicators of the national programme, and improve monitoring of services to track 'universal access' targets. A national M&E unit and the formulation of a draft M&E plan are in progress

Key challenges	Inhibition of the national response and progress towards achieving the UNGASS targets	Concrete remedial actions planned
Underutilization of the Human Rights desk	In a legal environment which is not supportive to the MARPs and a high prevalence of stigma and discrimination,	The Human Rights Desk to address issues of discrimination to encourage PLHIV to be more open about their status enabling more effective programme planning and implementation.

VII. Support from the country's development partners

a) Key support from development partners

The key support from the development partners has been significant. The support for activities held in St Kitts for the period 2008-2009 are illustrated in Table 16. Further support for additional activities held out of SKN is shown in Annex 3.

Table 16: Support from development partners[22]

Date	Development partners	Support
March 2008	UNFPA	Promoting female condom usage
June 2009	UNFPA	Promoting Behaviour Change through Edutainment
May-June 2009	UNFPA	Promoting integration and linkages of SRH and HIV/STI
Nov 2009	UNFPA	Promoting awareness and Prevention Services among out-of-school youths
Jan 2008/2009	UNAIDS	Supporting Strategic Planning Process
Jan 2008/2009	CHRC	Supporting development of M&E framework
	UNESCO	MoE 5 day policy development and strategy planning workshop
	CARICOM	Training for youth
	UNICEF	Resources for teachers
2008-2009	Global Fund	Availability of an OECS grant targeting care and treatment actions
	UNAIDS	Provision of project funds to support Global Fund Implementation
	Global Fund, Jhipeigo, CHART	Training for PITC and VCT

[22] The data is derived from the stakeholders participating in the reporting process.

b) Actions desired from development partners

The following actions is desired by development partners to ensure achievement of the UNGASS targets (*see table 17)*

Table 17: Actions desired from development partners[23]

Indicator #	Actions needed from development partners
5 **% of HIV-positive pregnant women who received ARV to reduce the risk of mother-to-child transmission**	Increased focus on eradicating stigma and discrimination
7 **% of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results**	Institute rapid testing
8 **% of most-at-risk populations who received an HIV test in the last 12 months and who know their results**	Reduce stigma and discrimination and promote VCT in Caribbean HIV/AIDS Alliance
9 **% of most-at-risk populations reached by preventative programmes**	Continue focus on prevention programmes
10 **% of orphaned and vulnerable children whose households received free basic external support in caring for the child**	Improve M&E surveillance. HIV deaths will then be linked with the diagnosis and therefore increasing accessibility to HIV orphans
11 **% of schools that provided life skills-based HIV education within the last academic year**	Increase the capacity of all teachers in lifeskills education programmes and promote and finance refresher courses
13 **% of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**	Promote educational strategies for out-of-school youth.

[23] Data is derived from the draft National Strategic Plan and from the interviewing process during the preparation of the report.

VIII. Monitoring and Evaluation environment

a) An overview of the current monitoring and evaluation (M&E)

There is a draft Monitoring and Evaluation plan (2009-2013) for St Kitts and Nevis and the main objective is to have one national M&E plan with a functional M&E unit. The plan was drafted by the staff of the Ministry of Health (MOH) with the technical support from the Caribbean Health Research Council (CHRC) and serves as a basis for the development of a comprehensive Monitoring and Evaluation (M&E) System which is aligned to the National Strategic Plan (NSP) 2009 – 2013.

Presently, the current surveillance system relies on the reporting of HIV and AIDS by laboratories (public and private sector) and provides only a portion of all infections is captured. The M&E priorities were not determined through a national M&E assessment and are mainly driven by national priorities and donor reporting requirements from external organizations. The Health Information Unit maintains a coded registry of all cases reported.

b) Challenges faced in the implementation of a comprehensive M&E system

Constraint to data use:

Problems contributing to limited availability of information include missing data in the HIV/AIDS forms submitted by physicians, lack of follow-up with HIV positive clients and insufficient participation among private sector providers in 2006. The information that is readily available does not follow to the important nodes in the system. One of the present challenges is the absence of a formal mechanism for line ministries and civil sector organizations to routinely report programme information to the NAS and many private practitioners are still reluctant to submit data.

Technical assistance needs:

Although there is substantial technical capacity within the NAS, there remain some key areas where external support has been requested. Technical expertise is required in database development and management at the national level[24] and the HIV programming

[24] UNGASS 2006

will benefit for increased local capacity for conducting surveys and data feedback to ground levels[25].

M&E priorities:

The M& E priorities are not determined through a national M&E system assessment, but priorities are often driven by donor reporting requirements from external organizations with minimal inclusion of national indicators. The UNGASS report for 2006 noted that the National Programme is often bombarded with requests for data and it is often overwhelming for the staff responding to the myriads of requests. It has been suggested that agencies meet and decide on a comprehensive set of global indicators to measure the progress in various areas. This has since improved significantly.

Inclusion of civil society

The national M&E committee or working group that meets regularly to coordinate M& E activities does not include representation from the civil society. Groups of PLHIV usually report to the NAS.

Operationalization of the draft M&E plan

Elements of the plan are presently being utilized and ensuring that more buy in at the level of the community health centres and medical practitioners and other point of service personnel in the health sector remains a challenge.

Data from marginalized groups

Data from marginalized groups remain a challenge as assessing data from these groups, although improving, continues to be a challenge perceived to be due to stigma and discrimination.

c) Remedial actions planned to overcome the challenges

- The presence of a communication tool which will convey to partners and external stakeholders the kinds of information being generated to track programme implementation and measure programme effectiveness and to clearly identify based on evidence, opportunities for collaboration.

[25] UNGASS 2010

- Development of a system in which analysis forms an essential component, one which is not only performed routinely but which feed data back to the source as well as to programme managers.

d) The need for M&E technical assistance and capacity-building

There is a need for improvements in the capacity of the Health Information Unit such as improved skills with development of databases, computerization of data collection tools.

Annex 1.

List of stakeholders participating in the report writing process:

The following persons are acknowledged for their contribution to the UNGASS reporting process 2010:

Preparation of the report

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Provision of data

Ms Londya Lennon	Data Entry Clerk, M&E Officer

Technical assistance

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Ms Juletta Fyfield	Health Educator/Civil Society Organization
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Ms Patricia Wilkes	Civil Society Organization
Rev Fr Isaiah Phillip	Chairman of St Kitts Christian Council
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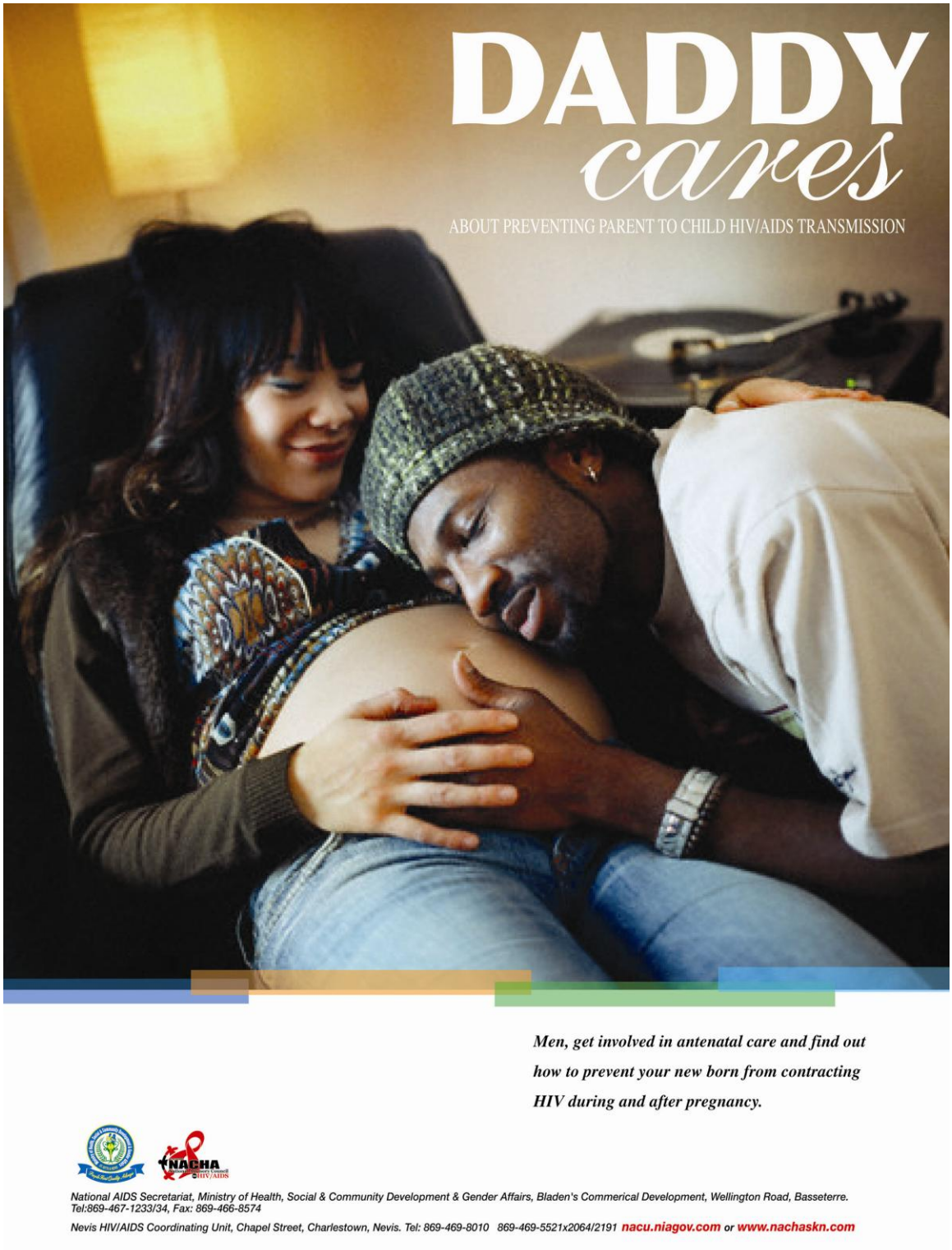
The views expressed are those of the stakeholders participating in the formulation of the UNGASS 2010 Report.

This document was reviewed and approved by the Permanent Secretary, Ministry of Health, Social Services, Community development and Gender Affairs.

Elvis Newton, MPH
March 31, 2010

Success is not measured by what a man accomplishes, but by the opposition he has encountered and the courage with which he has maintained the struggle against overwhelming odds. – *Charles Lindbergh*

Annex 2



TRAINING PROGRAMMES	PERIOD OF ACTIVITY	VENUE	SPONSOR
Monitoring & Evaluation Software Training Workshop	20-23 January 2009	Bahamas	CHRC/UNICEF/UNAIDS

Harmonized Approach to Cash Trangles to Implanting Partners and an Overview o0f its Implications	28-30 January 2009	Jamaica	United Nations
TB& HIV Initiative- Management of TB&HIV	10-12 March 2009	Jamaica	ChART/UNAIDS
12th Ordinary Meeting of the Regional Coordinating Mechanism PANCAP	22-28 April 2009	St. Lucia	PANCAP
CHLI Leadership Training Programme	1-3 April 2009	Jamaica	CHLI
HIV Planning Meeting for Health Sector in the Caribbean	8-12 March	Santo Domingo	PHCO/UNAIDS/UNICEF
Workshop on Developing a Framework on Stigma & Discrimination Reduction & Behaviour Modification	30-31 March 2009	Trinidad	PANCAP
Pharmacovigilance Workshop	April 16 2009	St. Lucia	OECS/HAPU
Regional Data Analysis	15-17 April	St. Lucia	OECS/HAPU
PEPFAR Consultative Meeting	29-30 April	St. Lucia	USAID
Workshop on Ways to support the needs for the Provision of HIV Related Laboratory	22-24 April 2009	Barbados	PAHO
Training of Trainers Workshop	2-4 June	Trinidad and Tobago	CHART
An activity for behavioural -Impact Integrates Marketing Communication Planning Methodology Workshop	8-13 June 2009	St. Lucia	
KABP Survey Workshop	21-22 May 2009	St. Lucia	OECS/HAPU
A refresher workshop for VCT trainers to enhance the skills of the trainers for delivery of quality VCT trainers	27-29 May 2009	St. Lucia	OECS/HAPU
13th Ordinary Meeting of Regional Coordinating Mechanism (PANCAP)	17-18/09/2009	Guyana	PANCAP
Epidemiology Trends in HIV Epidemic in the C/bbean & Current Strategic Responses Required at the National & Regional Levels	24-30/10/2009	Grenada	
OECS Regional Coordinating Mechanism Meeting	October 02 2009	Dominica	PANCAP
Regional Trainer of Trainer Workshop	20-25/09/2009	Jamaica	UNICEF
8th Annual General Meeting & Capacity Building Workshop of the C'bbean Coalition of National AIDS Programme	27-28/10/2009	Grenada	PANCAP/CCNAPC
One Day Pharmacovigilance Workshop	October 01 2009	S.Lucia	OECS/HAPU
Prevention of HIV Drug Resistance in the C'bbean	20-22/10/2009	Trinidad & Tobago	OECS/HAPU
Regional UNGASS Workshop	20-23/10/2009	Trinidad & Tobago	UNAIDS
Validation Workshop for Draft HIV/AIDS Anti Stigma & Discrimination Tool Kits	12-13/10/2009	Trinidad & Tobago	CARICOM SECRETARIAT
Strengthening Blood Banks Meeting	30/11-2/12/2009	St.Lucia	PAHO
Second Training in Preparation of the 2010 UNGASS Reporting	14-15/12/2009	Guyana	UNAIDS
Annual Programme Review Meeting 2009 Barbados	December 02 2009	Barbados	UNFPA
Clinical Mentoring Planning Meeting	7-8 December 2009	Antigua	OECS/HAPU
OECS Clinical Mentoring Programme- Mentoring of Mentors' Workshop		Barbados	OECS/HAPU

Annex 3