UNGASS 2010 Saint Lucia

UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON HIV and AIDS (UNGASS)

Country Progress Report
Saint Lucia

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Background

Saint Lucia is an island state located in the Eastern Caribbean, approximately 40 km south of Martinique and 32 km north of St. Vincent. Saint Lucia has a land mass of approximately 616 sq km[1] and a population size estimated at 170,649. In 2008-2009, the island was divided into 8 health regions namely: Anse-la-Raye/Canaries, Babonneau, Castries, Dennery, Gros-Islet, Micoud, Soufriere/ Choiseul and Laborie/ Vieux-Fort. English and French-Creole are the official languages in the country. Saint Lucia is a member of the Organisation of Eastern Caribbean States (OECS), the Caribbean Community and Common Market (CARICOM), the Organisation of American States, the Commonwealth of Nations, and the United Nations.

HIV and AIDS in Saint Lucia falls within the category of concentrated, low prevalence epidemics. During the late 1980s and early 1990s the disease was characterized by relatively low levels of infection among STI patients and little, if any infection among pregnant women and blood donors. Trends in HIV transmission are linked to increased poverty and social disintegration, with significantly higher levels of HIV now being identified in a number of vulnerable population groups.

While HIV infection continues to be characterised as being transmitted largely through sexual intercourse, in the Saint Lucian context this includes:

- transactional sex where no cash is exchanged but gifts are given and support supplied,
- sex for drugs (crack cocaine) transactions and
- more traditional sex work (exchanges for cash) either by primarily foreign women working in brothels, “gentlemen clubs” or strip clubs or locals working the streets.

In addition, there is a hidden but assumed to be substantial population of men having sex with men exclusively (MSM) and men having sex with men and women (MSMW) being both receptive and insertive with other men and insertive with their female partners. It is

[1] CIA Fact Book, Estimates as of July 2009

believed that the MSMW behaviours have contributed to the feminisation of the epidemic in Saint Lucia where the male/ female ratio has moved from 75% / 25% to almost 58% /42%.

As sex work, male on male sexual contact[2] and crack use are heavily stigmatised and for the most part illegal this significant but neglected aspect of the epidemic remains largely unexplored.

Unlike most of the region where more women are being infected and incidence rates outstrips that of men[3]. In Saint Lucia, the data reveal a higher increase in HIV incidence among males over females.

Except for prisoners and cocaine crack users, there have not been studies conducted recently to determine HIV prevalence among the groups driving the epidemic. This has resulted in a lack of adequate data to estimate the current HIV and AIDS prevalence in the country. Despite this and based on the current number of people living with HIV (PLHIV), from the National Register, we have calculated a prevalence of approximately 0.28%; which is likely to be a gross underestimation. This can be attributed to the lack of adequate data on most at risk populations, data indicating that a significant amount of individuals are being first diagnosed at advanced stages of the disease and the lack of broad coverage and targeted services within our voluntary counselling and testing program. Therefore, it is believed that a significant number of individuals remain undiagnosed.

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

[3] UNAIDS/WHO, 2009 AIDS Epidemic Update

Stakeholder Involvement in the Reporting Process

In addition to an extensive desk review of available literature, a number of meetings and interviews were conducted to gather the data that was used to populate the indicators and compile this report. Although the intention was to meet with Government Officials as a group, consultations were held with participants individually to facilitate varying work schedules. In addition, they made themselves accessible for further questioning and to clarify issues.

A similar approach was taken with participants from Civil Societies and Line Ministries. In addition though, consultations were held with teams more often than individually. The outcome of those consultations was used to refine the final report. A list of the participants of those meetings is attached as Annex 1

UNGASS 2010 - Summary Report - Saint Lucia

Code	Indicator	Status	
Government HIV and AIDS Policies			
1	AIDS Spending	Completed	
National Programme Indicators			
3	Blood Safety	Completed	
4	HIV Treatment: Antiretroviral Therapy - 2006	Completed	
4	HIV Treatment: Antiretroviral Therapy - 2007	Completed	
5	Prevention of Mother-to-Child Transmission - 2006	Completed	
5	Prevention of Mother-to-Child Transmission - 2007	Completed	
6	Co-Management of Tuberculosis and HIV Treatment	Completed	
7	HIV Testing in the General Population	Completed	
8	HIV Testing in Most-at-Risk Populations - Sex Workers	Completed	No data available
8	HIV Testing in Most-at-Risk Populations - Men Who have Sex with Men	Completed	No data available
8	HIV Testing in Most-at-Risk Populations - Injecting Drug Users	Completed	
9	Most-at-risk Populations: Prevention Programmes - Sex Workers	Completed	No data available
9	Most-at-risk Populations: Prevention Programmes - Men Who have Sex with Men	Completed	
9	Most-at-risk Populations: Prevention Programmes - Injecting Drug Users	Completed	No data available
10	Support for Children Affected by HIV and AIDS	Completed	
11	Life Skills-based HIV Education in Schools	Completed	
11	Life Skills-based HIV Education in Schools	Completed	
11	Life Skills-based HIV Education in Schools	Completed	
Knowledge and Behaviour Indicators			
12	Orphans: School Attendance - Part A	Completed	
12	Orphans: School Attendance - Part B	Completed	
13	Young People: Knowledge about HIV Prevention	Completed	
14	Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers	Completed	No data available
14	Most-at-risk Populations: Knowledge about HIV Prevention - Men Who have Sex with Men	Completed	No data available
14	Most-at-risk Populations: Knowledge about HIV Prevention - Injecting Drug Users	Completed	
15	Sex Before the Age of 15	Completed	
16	Higher-risk Sex	Completed	
17	Condom Use During Higher-risk Sex	Completed	
18	Sex Workers: Condom Use	Completed	No data available
19	Men Who Have Sex with Men: Condom Use	Completed	
20	Injecting Drug Users: Condom Use	Completed	No data

			available
21	Injecting Drug Users: Safe Injecting Practices	Completed	No data available
Impact Indicators			
22	Reduction in HIV Prevalence	Completed	
23	Most-at-risk Populations: Reduction in HIV Prevalence - Sex Workers	Completed	No data available
23	Most-at-risk Populations: Reduction in HIV Prevalence - Men Who have Sex with Men	Completed	No data available
23	Most-at-risk Populations: Reduction in HIV Prevalence - Injecting Drug Users	Completed	
24	HIV Treatment: Survival After 12 Months on Antiretroviral Therapy	Completed	
25	Reduction in Mother-to-child Transmission. Percentage of infants born to HIV-infected mothers who are infected	Completed	

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UNGASS Indicator Data – Overview Table

Indicator # and Name		Achievements (2009)	Notes
#3	Blood Safety #3 Percentage of donated blood units screened for HIV in a quality-assured manner	100% of blood screened	
#4	HIV Treatment: Antiretroviral Therapy #4 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	124 Individuals on ARVs; 65 females and 59 males	No models exist to determine estimated population with advanced HIV infection
#5	Prevention of Mother to-Child Transmission #5 Percentage of HIV-infected pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission	75% of HIV+ women receiving ARV (N=8)	
#6	Co-Management of Tuberculosis and HIV Treatment #6 Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	100% of HIV-positive incident TB cases received treatment for TB and HIV (N =1)	
#7	HIV Testing in the General Population #7 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	36%	Recent survey has not been conducted hence data is reflective of UNGASS 2008
#8 SW	HIV Testing in Most-at-Risk Populations - Sex Workers #8 Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	No Data Available	Indicator Relevant
#8 MSM	HIV Testing in Most-at-Risk Populations - Men Who Have Sex with Men #8 Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	100% among participants surveyed	
#8 DU	HIV Testing in Most-at-Risk Populations - Injecting Drug Users #8Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	17%	Injecting drug users are not endemic to Saint Lucia, therefore data from the survey on crack cocaine users are reported

#9 SW	Most-at-risk Populations: Prevention Programmes - Sex Workers #9 Percentage of most-at-risk populations reached with HIV prevention programmes	No Data Available	Indicator relevant
#9 MSM	Most-at-risk Populations: Prevention Programmes - Men Who Have Sex with Men #9 Percentage of most-at-risk populations reached with HIV prevention programmes	100% among participants surveyed	
#9 DU	Most-at-risk Populations: Prevention Programmes - Injecting Drug Users #9 Percentage of most-at-risk populations reached with HIV prevention programmes	No Data Available	Indicator relevant only for crack cocaine users
#10	Support for Children Affected by HIV and AIDS #10 Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child	83% (N=47)	
#11	Life Skills-based HIV Education in Schools #11Percentage of schools that provided life skills-based HIV education in the last academic year	59% of all schools	Teachers have been trained but life skills education was not taught in some schools in the last academic year
#12	Orphans: School Attendance #12Current school attendance among orphans and non-orphans aged 10–14	Orphans -100% non-orphans 72%	
#13	Young People: Knowledge about HIV Prevention #13 Percentage 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	A range of 73% to 98% correctly answered the questions	59 % of the persons answered Questions # 3,4,5 correctly
#14 SW	Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers #14 Percentage 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	No Data Available	Indicator relevant
#14 MSM	Most-at-risk Populations: Knowledge about HIV Prevention - Men Who Have Sex with Men #14 Percentage 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	No Data Available	Indicator Relevant
#14 DU	Most-at-risk Populations: Knowledge about HIV Prevention - Injecting Drug Users #14	15%	Injecting drug users are not endemic to

	Percentage 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		Saint Lucia, therefore data from the survey on crack cocaine users are reported
#15	Sex Before the Age of 15 #15 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	26% ALL 32% males 20% females	Recent survey has not been conducted hence data is reflective of UNGASS 2008
#16	Higher-risk Sex #16 Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	35.4% ALL 41.8% males 25.2% females	Recent survey has not been conducted hence data is reflective of UNGASS 2008
#17	Condom Use During Higher-risk Sex #17 Percentage of women and men aged 15–49 who have had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse	44.8% ALL 48.3% males 39.1% females	Recent survey has not been conducted hence data is reflective of UNGASS 2008
#18 SW	Sex Workers: Condom Use #18 Percentage of female and male sex workers reporting the use of a condom with their most recent client	No Data Available	Indicator relevant
#19 MSM	Men Who Have Sex with Men: Condom Use #19 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	63%	
#20 DU	Injecting Drug Users: Condom Use #20 Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	No Data Available	Indicator relevant only for crack cocaine users
#21 IDU	Injecting Drug Users: Safe Injecting Practices #21 Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	No Data Available	Indicator not relevant
#22	Reduction in HIV Prevalence - Youth #22 Percentage of young people aged 15–24 who are HIV-infected	0.37%	Recent survey has not been conducted hence data is reflective of UNGASS 2008
#23 SW	Most-at-risk Populations: Reduction in HIV Prevalence - Sex Workers #23 Percentage of most-at-risk populations who are HIV-infected	No Data Available	Indicator Relevant
#23 MSM	Most-at-risk Populations: Reduction in HIV Prevalence - Men Who Have Sex with Men #23 Percentage of most-at-risk populations who are HIV-infected	No Data Available	Indicator Relevant

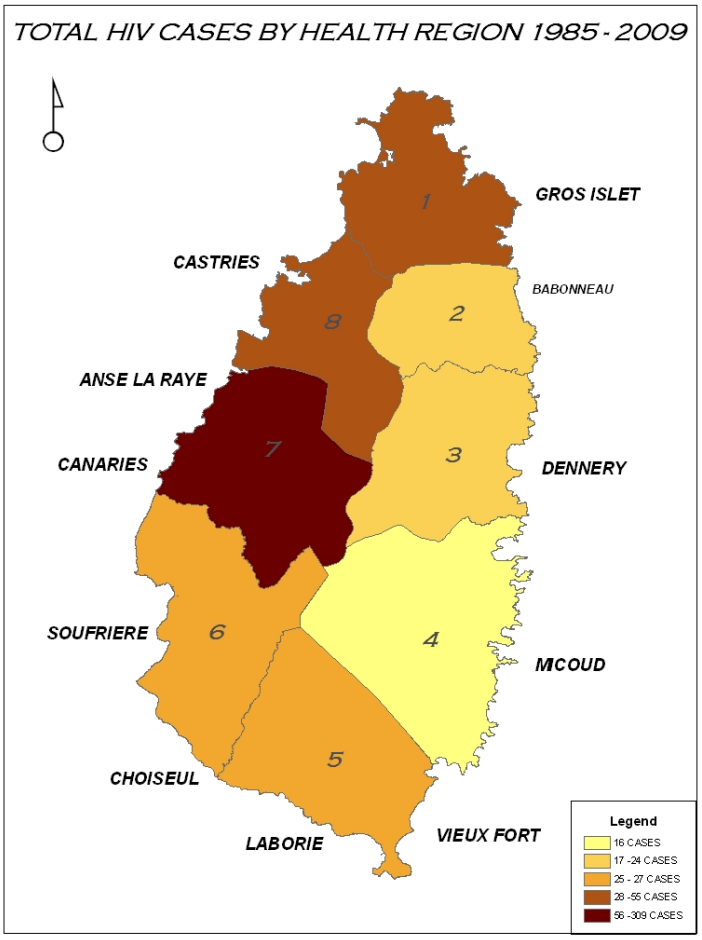
#23 DU	Most-at-risk Populations: Reduction in HIV Prevalence - Injecting Drug Users #23 Percentage of most-at-risk populations who are HIV-infected	6%	
#24	HIV Treatment: Survival After 12 Months on Antiretroviral Therapy #24 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	100%	
#25	Reduction in Mother-to-child Transmission # 25 Percentage of infants born to HIV-infected mothers who are infected	0%	

Overview of the AIDS Epidemic in Saint Lucia

Overall Trends

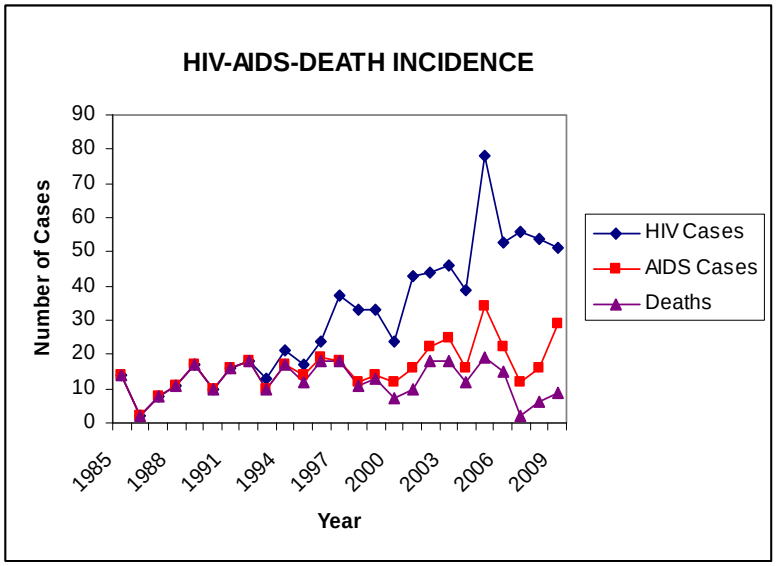
Since the first case of HIV was diagnosed in Saint Lucia in 1985, a total of 760 HIV cases have been reported through December 31 2009. Distribution of the incidence across the island reveals higher numbers in the north and northerly western regions, which includes the capital and areas with greater economic activity.

FIGURE 1: HIV INCIDENCE BY HEALTH REGIONS



Of these cases, a total of 314(41.3%) cases have died. The country experienced a steady increase in HIV diagnosis, including a sharp increase in 2006 due to improved reporting and an increase in testing. While the trend for new HIV cases is beginning to show a decline, there is an increase in number of AIDS cases and number of deaths over the past 3 years. Figure 2 below illustrates the trends of HIV, AIDS and deaths in Saint Lucia.

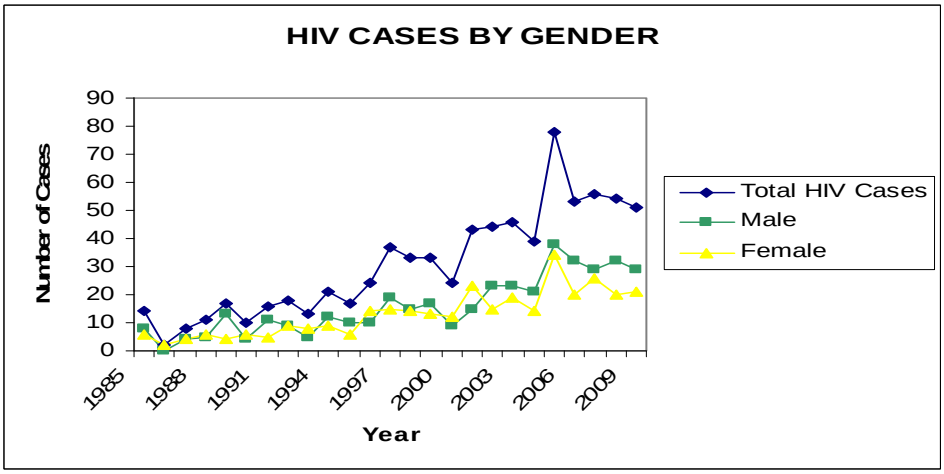
FIGURE 2: HIV, AIDS & DEATH CASES 1985-2009



Source: NAPS Database, 2009

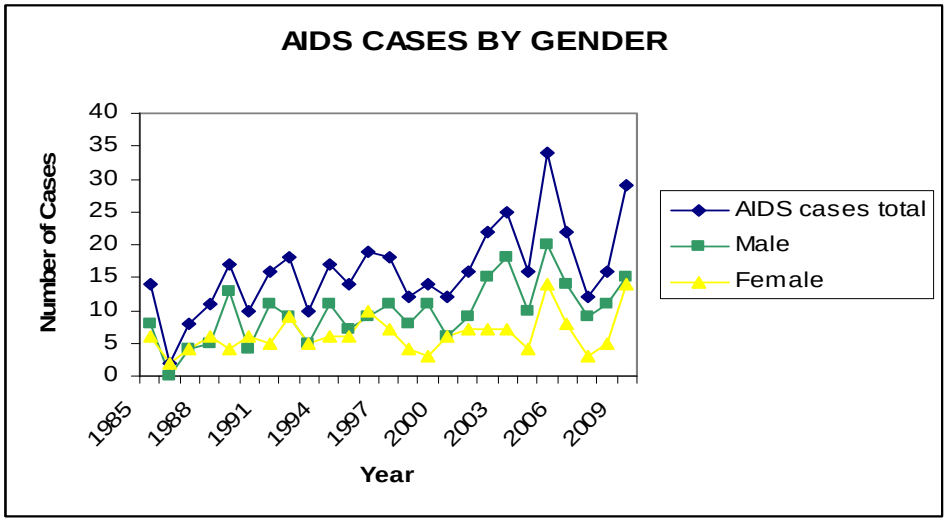
In the past 8 years, diagnosis of new HIV cases has been consistently higher among males. Overall diagnosis of new HIV cases in the past 4 years has been declining; however since 2007 we have seen a significant increase in AIDS cases with a corresponding increase in deaths among both genders. Figure 3, 4 & 5 below show the trends of HIV and AIDS diagnosis as well as deaths amongst both sexes over time.

FIGURE 3: HIV DIAGNOSIS BY GENDER



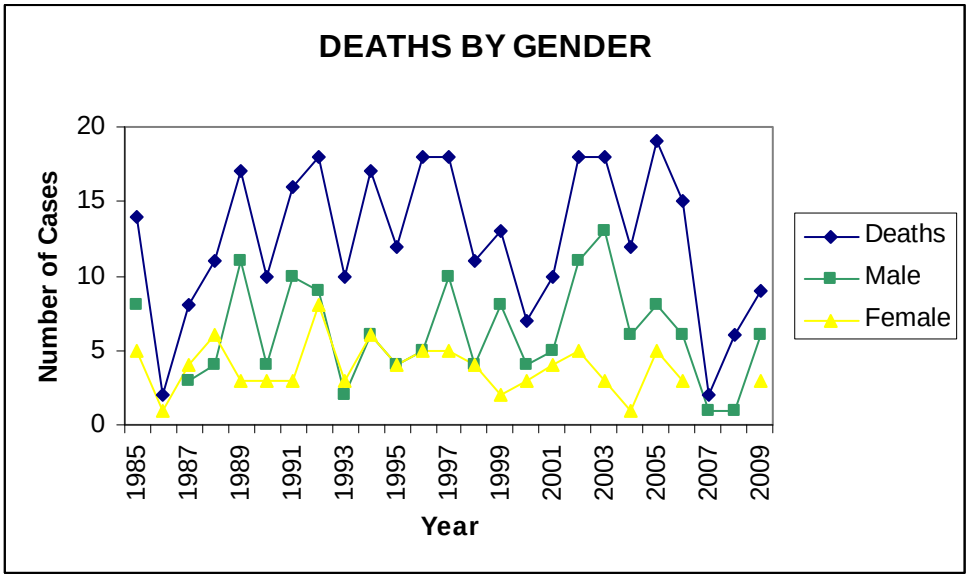
Source: NAPS Database, 2009

FIGURE 4: AIDS DIAGNOSIS BY GENDER



Source: NAPS Database, 2009

FIGURE 5: DEATHS BY GENDER

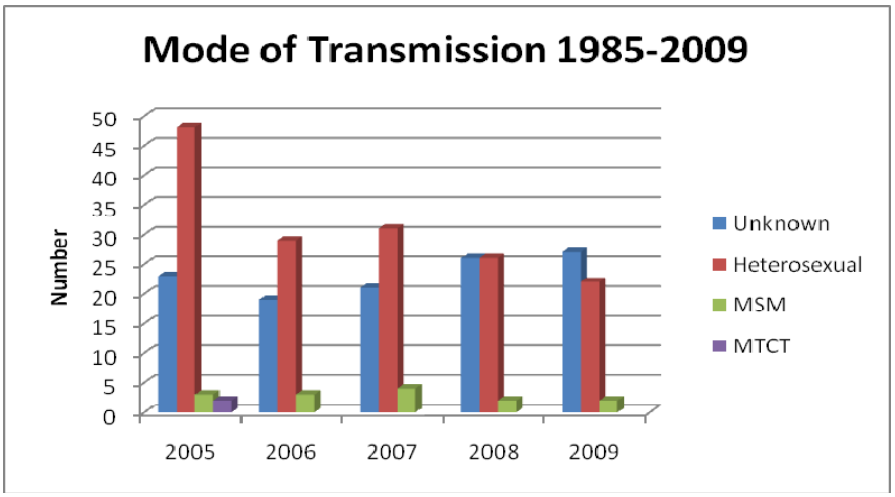


Source: NAPS Database, 2009

Heterosexual transmission accounts for 44% of all reported cases, while close to 50% of the mode of transmission remains unknown. This trend has been relatively consistent over the past few years. However, data within the past two years suggest that reporting on the mode

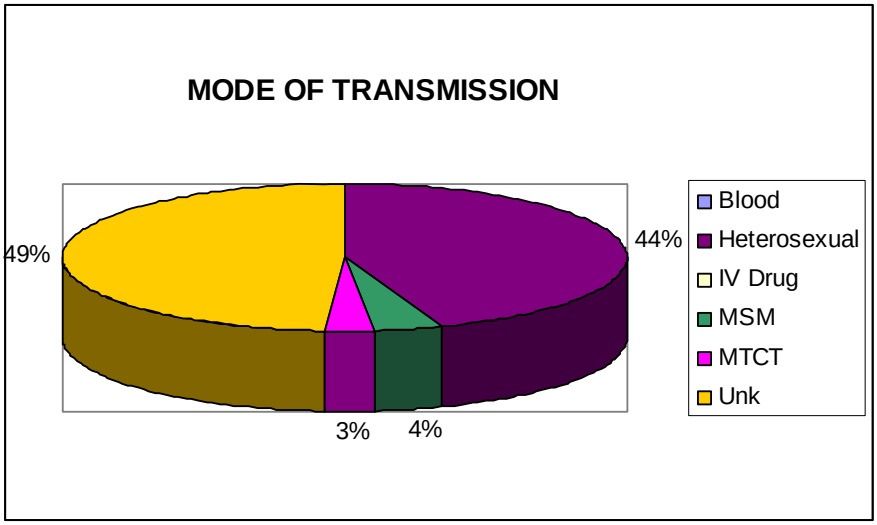
of transmission is increasingly becoming more challenging. Figures 6 and 7 illustrate the trends in mode of transmission.

FIGURE 6: MODE OF TRANSMISSION 1985-2009



Source: NAPS Database, 2009

FIGURE 7: MODE OF TRANSMISSION 1985-2009



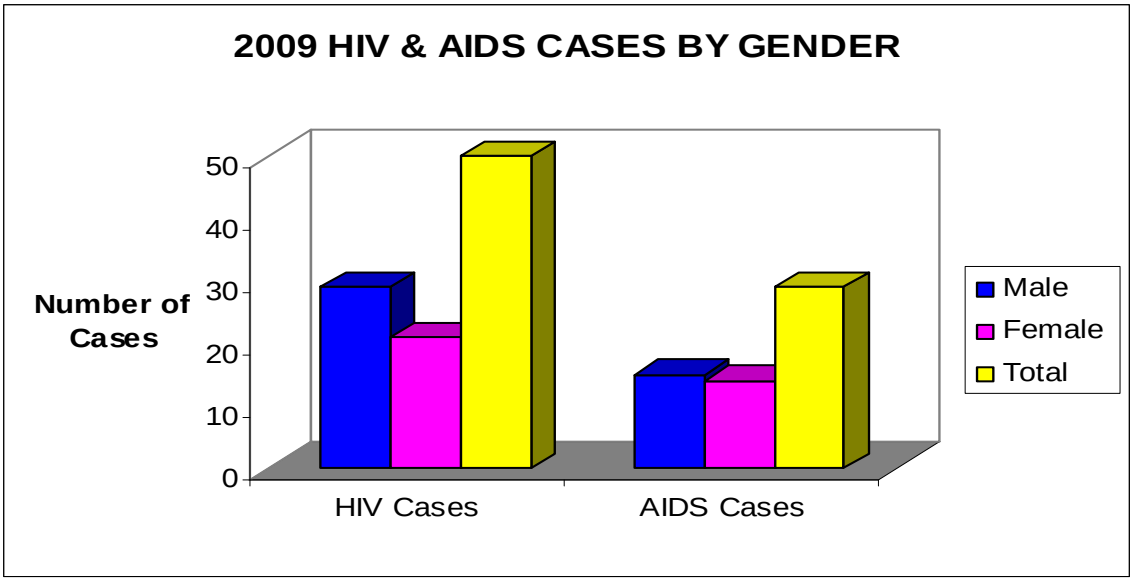
Source: NAPS Database, 2009

HIV & AIDS Diagnosis in 2009

In 2009, the country reported 51 new cases of HIV. There were more males (58%) than females (42%) diagnosed with HIV. Males also represented a slight majority 52% vs. 48%

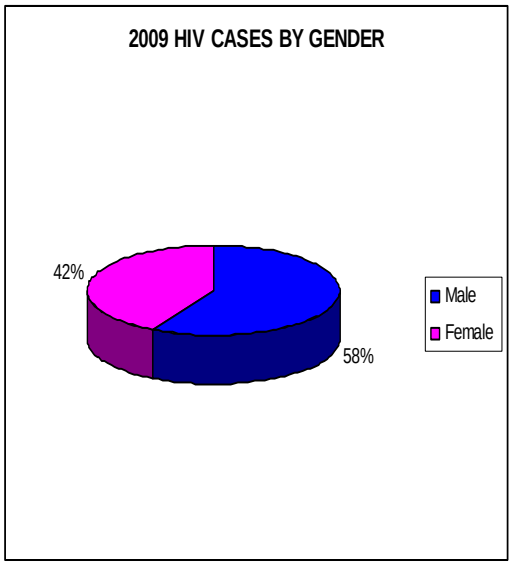
of the AIDS diagnosis when compared to women in 2009. Figures 8 through 10 outline the new HIV and AIDS diagnosis by gender.

FIGURE 8: 2009 HIV & AIDS CASES BY GENDER



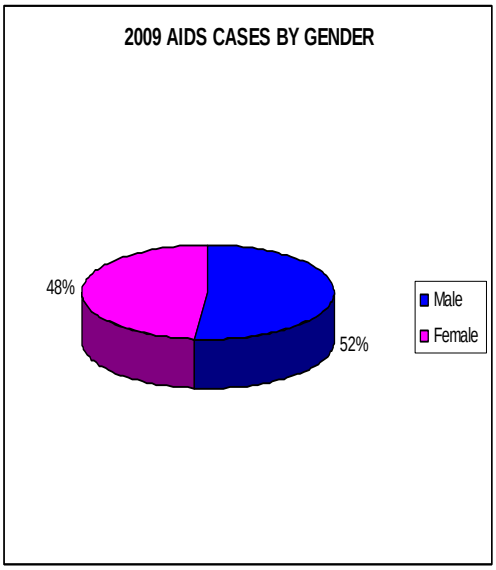
Source: NAPS Database, 2009

FIGURE 9: HIV CASES BY GENDER



Source: NAPS Database, 2009

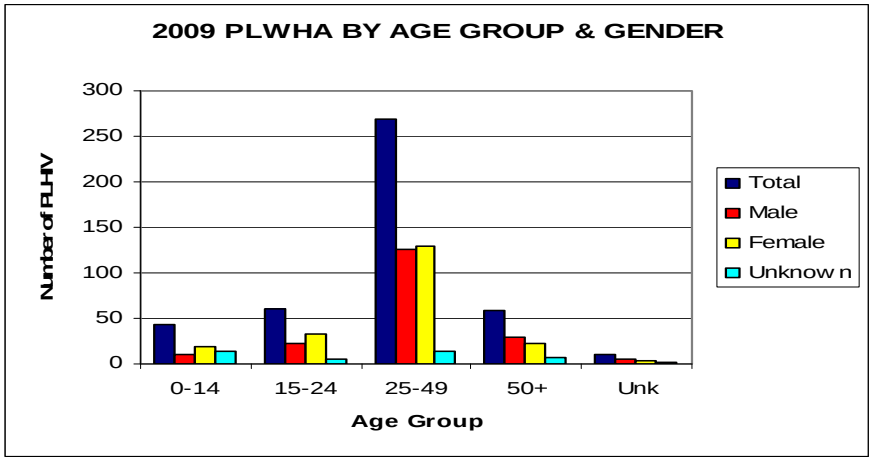
FIGURE 10: AIDS CASES BY GENDER



Source: NAPS Database, 2009

The age group with the highest HIV incidence for 2009 continues to be the 25-49 years age group, which recorded 22 cases (43%). Figure 11 illustrates PLHIV cases up to December 2009.

FIGURE 11: 2009 PLHIV BY AGE GROUP & GENDER



Source: NAPS Database, 2009

Behavioural Risk Factors

A survey conducted in 2005-2006 by CAREC in partnership with Family Health International (FHI) indicated that in Saint Lucia 21% of males aged 15-24 years and 44% of males aged 25-49 years used condoms consistently with non-marital, non-cohabiting sexual partners[4]. The same study, conducted among with sex workers (SW) showed that 6% of men aged 15-24 years and 7% of men aged 25-49 years had sex with a SW within 12 months of the survey[7]. Further to this early sexual debut was found in 26% of those aged 15-24 years and 22% of those aged 25-49 years who indicated they had sex prior to the age of 15[7]. Additionally, a rapid assessment using PLACE methodology found that approximately 23% of men and 7% of women reported having two or more partners in the past four weeks from the interview date and of these 61% of the men and 44% of the women reported using a condom the last time they had a sexual encounter[5].

Results from a sero-prevalence survey conducted in 2009 among crack cocaine users revealed about 82% of respondents reporting having unprotected sex, 28% doing so consistently ("always") and just below half doing it "sometimes".

[4] Behavioural Surveillance Surveys (BSS) in Six Countries of the Organization of Eastern Caribbean States (OECS). CAREC & FHI, 2005-2006.

[5] Saint Lucia PLACE Report. Priorities for Local AIDS Control Efforts, September 2007.

In the same study and among those who had vaginal and anal sex during the past 30 days 67% also reported not using a condom during sex; 72% did not use a condom in last "sex for money" or "money for sex" exchange.[6]

Programme Report & Monitoring

The National AIDS Coordinating Council currently chaired by the Minister of Health on HIV and AIDS (NACC) was established in 2005 to have oversight of the National AIDS Programme. The National AIDS Program Secretariat (NAPS) was established in 2005 and became fully functional in 2006 to implement the decisions of the NACC. Their purview extends beyond that Ministry to encompass oversight of the full national response. The National AIDS Programme is the Ministry of Health's response to HIV and AIDS in the health sector and works closely with the NAPS to coordinate the response both within the Ministry and to the other sectors.

The NAPS is functioning Secretariat headed by an NAPS Director as a unit within the Ministry of Health. The NAPS is the coordinating body for all HIV and AIDS efforts and works closely with other government ministries, PLHIV and civil society to implement HIV and AIDS strategies and programmes. It also serves as the focal point for the collection and dissemination of information about HIV and AIDS, other STI and related issues

In keeping with the Strategic Plan for the National Response to HIV and AIDS 2005 -2009, which was developed in 2004, the NAPS has been incorporated into the existing public health infrastructure. Several policies and procedural manuals have been developed to guide the operations of the NAPS. The line ministry and civil society organizations have been able to move the response from a health centred approach to one that is multi-sectoral.

The current national response is largely funded through a World Bank loan, grant and credit agreement covering October 2004 to June 2009 with a year extension to June 2010, valued

[6] Marcus Day. Behavioural and HIV Sero-Prevalence Study of Non-Injection Homeless and Poor Crack Cocaine Users in Saint Lucia, 2009

at a total of US$6.4 million. The National Programme also receives funds from a sub-regional grant covering six O.E.C.S. countries under an agreement with the Global Fund to fight AIDS, TB and Malaria (GFATM). In April 2007, Saint Lucia was one of four countries in the Eastern Caribbean to become newly eligible for a national grant from the Global Fund. The national response is currently organised around four key strategies outlined in the National Strategic Plan (NSP) 2005-2009 (see below). As such, the NSP is currently being reviewed, to inform / direct the programme in the next five years and will include objectives to address MARP's. The outline of the current plan can be seen below.

The Saint Lucia National HIV AND AIDS Strategic Plan 2005-2009

Strategic goal: To reduce HIV transmission and to mitigate the impact of HIV and AIDS on all levels of society

Four broad strategies:

STRATEGY 1: Advocacy, Policy Development
Including advocacy, policy and legislation, poverty reduction, human rights.

STRATEGY 2: Comprehensive HIV AND AIDS care for all PLHIV
Including treatment, care and support; guidelines and protocols; psychosocial care; stigma and discrimination; workplace interventions; community and health systems interventions.

STRATEGY 3: Preventing further transmission of HIV
Including PMTCT, VCT and STI interventions among targeted and vulnerable groups.

STRATEGY 4: Strengthening national capacity to deliver an effective, coordinated and multi-sectoral response to the epidemic.
Including research and surveillance; monitoring and evaluation; empowering the NACC; multi-sectoral coordination and collaboration.

The National AIDS Coordination Council (NACC), the inter-sectoral coordination mechanism established in 2005 has 15 members, 40% of whom represent civil society. It is officially headed by the Prime Minister. A sub committee of the NACC is charged with reviewing and approving funding proposals submitted by civil society and line ministry. It is chaired by the representative of the private sector.

Composition of the NACC

1) Minister of Health, (Chair)
2) Chief Medical Officer, Secretary of the Council
3) Permanent Secretary Health
4) Chief Education Officer (CEO) Ministry of Education
5) Saint Lucia Chamber of Commerce and Agriculture
6) Mini-bus Association
7) President TLC (PLHIV representative)
8) Cabinet Secretary
9) Saint Lucia Red Cross
10) Saint Lucia Planned Parenthood Association
11) AIDS Action Foundation
12) Representative of the Roman Catholic Church
13) Saint Lucia Hotel & Tourism Association
14) National Youth Council
15) Representative of the Media

Staff composition of National AIDS Programme Secretariat

1) Director
2) Line Ministry and Civil Society Coordinator
3) Clinical Care Coordinator
4) VCT/PMTCT Coordinator
5) M & E Coordinator
6) Information Technology Officer
7) IEC Coordinator
8) M & E Officer
9) VCT/PMTCT Assistant

Although the national response is not confined to the health sector, the Ministry of Health continues to be the leading sector in the response. Staffing involved in the HIV response within the Ministry of Health (MOH) include a Director of the National AIDS Programme, a health educator, secretary, two STI nurses, two STI physicians, two social workers and four VCT Providers.

Priority Services for Saint Lucia

Expansion coverage and availability of services HIV testing and counselling

- Increased Coverage and availability of services to enable people to know their HIV status.
- Expansion and decentralized HIV testing and counselling.

The control of sexually transmitted infections to prevent HIV transmission

- Maximizing the health sector's contribution to HIV prevention
- Coverage and availability of services Testing and counselling for pregnant women
- Prevention of mother-to-child transmission of HIV (PMTCT)
- Prevention interventions for MARP drug users
  HIV testing and counselling for TB patients

Impact of treatment on HIV prevention

- Accelerating the scale-up of HIV AND AIDS treatment and care
- Expansion and decentralization of ART and treatment of OI
- Equity of access to treatment: women, children and vulnerable groups
- Access to Antiretroviral therapy for MARP

Strengthening and expanding health systems.

- Decentralized VCT, care and treatment of HIV and OIs

Investing in strategic information to guide a more effective response

- Strengthening of surveillance of the HIV AND AIDS epidemic.

Prevention

In 2009, there were a total of 20430 tests done throughout the island. This reflected a 7% increase over the 2008 figure. According to records, 25% of all the tests done in 2009 incorporated both pre and post test counselling. This figure though may be an understatement since VCT conducted for 'walk-ins' at the Labs are not always reported.

Encouraging clients to return for blood results continue to be challenging for health care workers. Although VCT increased in 2009 from 2008, performance decreased regarding return of clients for results and especially within the two weeks period after the test. (Table 1, Figure 12)

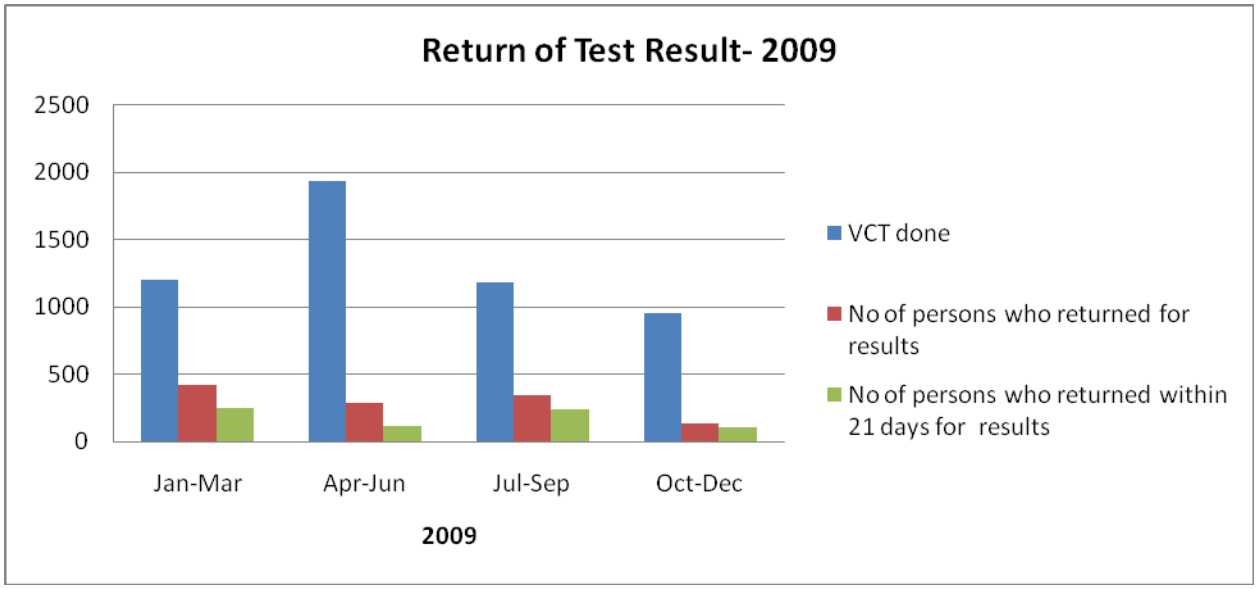
Due to the majority of clients not returning for results in a timely manner, the system needs to take advantage of the pre-test counselling to educate clients on sexual risk reduction practices and to reinforce healthy behaviour practices among the general population and high risk/ vulnerable groups.

TABLE 1: VCT at Health Facilities

	2008		2009	
	Number	**%**	**Number**	**%**
VCT done	1591	100	5271	100
No of persons who returned for results	444	27.9	1198	22.7
No of persons who returned within 21 days for results	329	20.7	713	13.5
No. of persons who did not return for results	1147	72.1	4073	77.3

Source: VCT Database, NAPS

FIGURE 12: Return for HIV Results



Source: VCT Database, NAPS

PMTCT

In 2008, five (5) mothers were registered into the PMTCT programme and one (1) was identified during testing on the labour ward. Out of the five patients who were registered, two delivered in 2009. In 2009, seven (7) mothers were registered into the PMTCT programme and (2) delivered early 2010. Two (2) mothers were identified on the ward after delivery and did not receive ARVs.[7]

[7] Extract from the PMTCT/VCT Coordinator Report, NAPS, 2009

In 2008/2009, a total of thirteen (13) pregnant women received ART prophylaxis during the antenatal period and at delivery. 15 women and their babies were referred to clinical care and paediatrician. Three babies have been tested for deoxyribonucleic acid/polymerase chain reaction (DNA/PCR) to identify the HIV status. So far, during the period 2008-2009, there have been no infants born to HIV infected mothers who are infected.

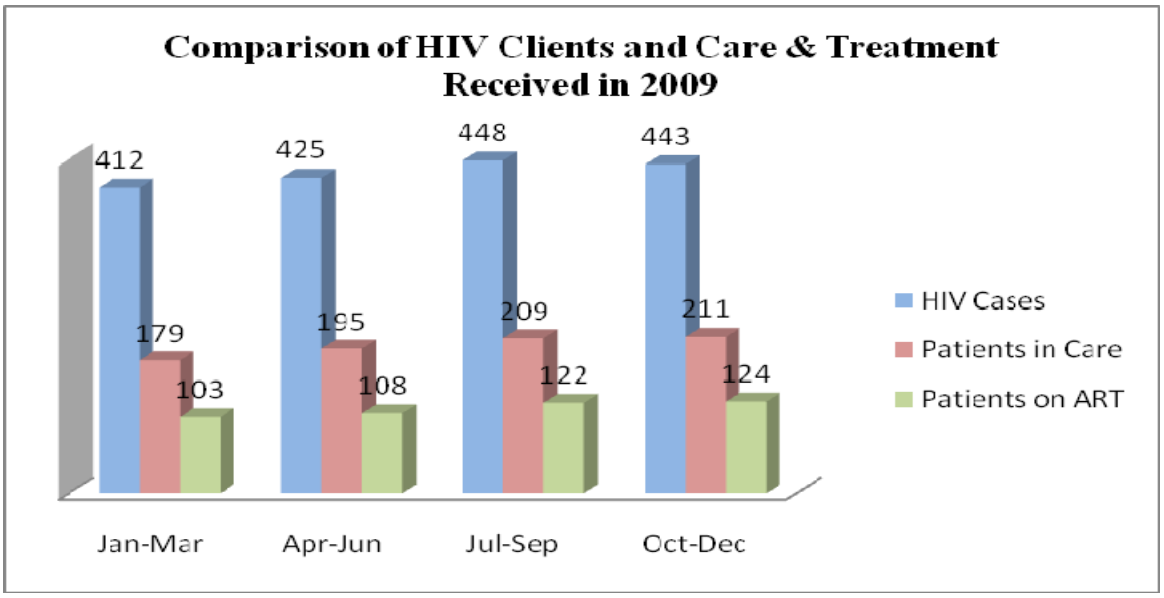
Post Exposure Prophylaxis

Post Exposure Prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP is provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work.

Care & Treatment

Although in care patients continue to increase, patient enrolment into care and treatment continues to be a challenge. Less than 50% of known PLHIV were enrolled into care in 2009 (Figure 13). Despite the fact that some patients access care privately and overseas, some patients are yet to register.

FIGURE 13: Enrollment in Care & Treatment



Patients on ART

The HIV programme has made significant strides in access to care and treatment for HIV Clients. In 2009, there was a 21% increase in clients on ART. Among those on treatment, 86% are on 1st line treatment, while the remaining 14% are on 2nd line treatment. [8] In addition, 100 % of clients have remained on treatment 12 months after initiation.

TABLE 2 Trends in ARV Use

	Clients on ARV					
	2005	**2006**	**2007**	**2008**	**2009**	**Total**
Male	Not available	21	35	51	59	**166**
Female	Not available	29	43	51	65	**188**
Totals	**31**	**50**	**78**	**102**	**124**	**385**

Source: Care & Treatment Database, 2009

Among the age group 0-15years, 3 of the 6 children are on ART and have remained on treatment 12 months after initiation. These successes were achieved though dedicated clinical staff, availability of treatment, as well as decentralizing services for easier access by clients. Monitoring of clients' compliance throughout the lifetime of clients will be possible when the patient monitoring system becomes fully operational.

Multisectoral Coordination & Collaboration

Achievements to date have stemmed from committed CSOs and their responsiveness to Project objectives and opportunities to engage the MARPs including commercial sex workers (CSW), men who have sex with men (MSM) and out-of-school youth.

A number of training activities were conducted to increase requisite knowledge and experience to engage MARPs, to inform policy development, implementation of programmes, and the overall monitoring and evaluation of the programs and projects. They included;

- Capacity assessment and building
- Proposal Writing Trainings
- Strengthening Civil Society HIV & AIDS Response

[8] Extract from the 2009 Report of the Clinical Care Coordinator

- Trainer of Trainers Workshop for HIV Education
- Behaviors Change Communication (BCC) Training
- HIV Group Education
- Public Relations Campaign

Having been exposed to these training, from 2005 to 2008, a total of fifty-four (54) projects were implemented by civil society organizations valued of EC $1.2 million. The profiles of projects implemented were:

- Treatment, care and support: 11
- Prevention: 50
- Strengthening the health sector response: 3

Although no new projects were undertaken in 2009, increased sensitization and participation of HIV and prevention activities has become evident.

Monitoring and Evaluation

The Monitoring & Evaluation department have recorded some achievements in the past two years, including

- Increase in human resource
- Establishing a task force for M & E
- Standardizing tools for data capture
- Installing and utilizing a patient monitoring system
- Training of staff in M & E
- Reviewing reporting protocols
- Incorporating M & E into programmatic activities
- Purchasing and piloting the HMIS

Emphasis during the upcoming months will be on the following;

- Research for the MARPs
- Improved M&E systems
- Strengthening collaboration between the NAPS, Epidemiology Unit and Statistics Departments and focal points of key line ministries.
- Quarterly dissemination of reports to stakeholders
- Building an M & E environment

Human rights

A legal assessment entitled Saint Lucia National Assessment on HIV AND AIDS, Law, Ethics and Human Rights[9] was conducted by the NGO AIDS Action Foundation, with funds provided by PANCAP (CIDA). [Report title: Assessment of Laws and Policy related to HIV and AIDS in Saint Lucia published 2007].Topics reported on included Disclosure, Testing and Confidentiality, Contact Tracing, Education, Universal Safety Precautions (USP), Condom Availability (including schools and prisons, Sex Education, Homosexuality, Advocacy, Stigma and Discrimination, Law Enforcement, SRH services for Minors, Insurance, Economic and Social Issues for PLHIV, Political Leadership and Medical Management.

In an attempt to deal with HIV and AIDS related stigma and Discrimination for PLHIVs, a human rights desk was established in 2007. PLHIVs can bring in complaints which can be addressed through referrals to relevant agencies/ individuals. In 2009, there were a total of 9 complaints filed, the majority relating to stigma & discrimination within households and the community. Based on the number of complaints reported, it is evident that this service it is presently under utilized. Discussions have taken place to increase promotion of this desk, as well as incorporating it into the Ministry of Human Services to address other complaints and not merely HIV and AIDS related stigma and discrimination. This will undoubtedly increase utilization, since the stigma of accessing this Human Rights desk will be minimized.

Collaborative Efforts[10]

In general, teamwork among collaborating partners has been positive. Their collaborative efforts included:

- Planning together/sharing staff during World AIDS Day and other events
- Exchanging IEC materials

[10] Ibid

- Sharing volunteers
- Sharing counsellors for client services
- Exchanging trainers for educational events
- Sharing counsellors and staff for VCT services
- Cross referring clients, based on the needs of clients and the expertise of organizations.
- Some coordination work with legal, shelter, and social services (i.e., family court, women's centre, human services, Cornerstone, St. Lucy's Home, etc.)
- Joining efforts to advocate for the rights of clients

Caribbean Harm Reduction Coalition's (CHRC)

The Caribbean Harm Reduction Coalition's (CHRC) outreach work with crack cocaine users is unique in the Caribbean. A peer educator / outreach worker serves as an adherence counsellor visiting homeless PLHIVs, monitoring medication, providing nutritional support and bringing clients to the clinic for check ups in addition to general prevention outreach. In addition CHRC conducts outreach to encourage homeless crack users to be tested for HIV and collects behavioural and other data in order to develop evidenced based prevention programming.

AIDS Action Foundation (AAF)

Under the umbrella of AIDS Action Foundation private sector organisations including media, financial institutions, wholesale and retail traders, utility companies and the hotel sector have contributed significantly to the fight on HIV and AIDS in Saint Lucia. In return for HIV and AIDS prevention education training the above mentioned institutions has assisted AAF with the following:

- Provision of ARVs
- Development of workplace policy
- Development and airing of HIV prevention messages
- Care and support of PLHIV

V. Achievements & Key Activities undertaken during 2008-2009

- Building human resource capacity at the MOH and collaborating partners
- Decentralised access to prevention & clinical care services
- Increased care and support for PLHIVs
- Access to free medical care (specialty care included) and medications
- Increase in support provided for PLHIV; including training in skill development
- Review of NSP 2005-2009 and development of NSP for 2010-2014
- Scale up of HIV testing
- Refurbishing of STI Clinic at Castries and Vieux Fort (The capital and a major town)
- Increased multisectoral collaboration

VI. Major Challenges and Remedial Actions

Prevention

- Behavioural Surveillance needs to be improved, as the trends and drivers of the epidemic are still not fully understood. This knowledge gap needs to be filled if effective prevention programming is to be carried out.
- The national response would benefit from more strategically targeting initiatives based on an improved understanding of '*vulnerability*' as opposed to simply identifying groups perceived to be '*most at risk*' due to specific, individual behaviours. Most at risk populations in Saint Lucia include crack cocaine addicts and those engaged in activities linked to the tourist industry and exposed to opportunities to engage in high risk behaviours, such as drug taking and transactional sex.
- Radio and television should be used more often for behaviour change communication campaigns; interventions need to be tailored to the Kweyol speaking population.
- Prevention services implemented through the health sector should be further decentralized: only 4 out of 8 health districts have access to VCT in the public sector.
- The involvement of key line ministries in prevention efforts needs to be scaled up.
- Anecdotal data suggests that stigma and discrimination in the health sector remains a big challenge with health care workers still treating HIV patients differently than other patients.
- The challenge of harmonising the assessed needs of a civil society project with the criteria of the NAPS and the restrictive nature of the donor focus.

Treatment, Care and Support

- HIV/STI services are still in the hands of very few overburdened specialists. Further integration of HIV related activities in the health system is required, especially between Sexual and Reproductive Health (SRH) services and the Primary Health Care (PHC) system.
- Although services to PLHIVs have decentralized in the past two years, HIV/STI services are concentrated at the STI Clinic at Victoria Hospital in Castries requiring many HIV patients to travel to the city for treatment and medication.
- Treatment facilities do not adequately serve the needs of the entire population. Acute care services are primarily concentrated in Castries and challenging for rural based populations to access.
- The current staff has the burden of implementing in treatment, care and support while also being involved in running training workshops, clinics, and outreach activities.

- Access to treatment, care and support services is limited due to stigma and discrimination: an effective national campaign could now be designed based on recently available BSS data which help to define the causes of stigma: e.g. continuing fear of contagion through food, and prejudice in the workplace.
- Clinics devoted to VCT and HIV treatment lack space to ensure confidentiality and urgent refurbishing should be considered, even if other locations have to be identified in the medium, long-term.
- Additional community based groups, NGOs, private sector organisations and PLHIV support groups should be empowered to implement service delivery at national and sub-national levels. This could be achieved through targeted capacity building among civil society groups, and increased access to funds to deliver key services including mobile VCT outreach, prevention education, as well as treatment adherence, care and support.
- Clinical management should be integrated with social and community based support systems, through the development of a minimum package of care and support which builds on existing primary health care capacity; promotes condomization as a prevention strategy; and establishes drug regimens to deal with opportunistic infections.

Monitoring & Evaluation

- Legislation to support activities
- Data quality
- Limited human resource
- Weak surveillance systems
- Limited surveys targeting MARPS

VII. Support from the Country's Development Partners

In addition to loan/grant agreements with the World Bank and GFATM/OECS Secretariat, Saint Lucia received technical support and financial assistance for its HIV response from several bilateral and multilateral agencies during 2008-9. Much of this assistance has gone to support and strengthen the health sector. Some of the agencies include;

- AID Inc
- CAREC
- CDB
- CDC
- PAHO
- UNAIDS
- USAID

Annexes

Annex 1: Individuals Interviewed

Name	Position	Representing
Felix St Hill	PS	Ministry of Health
Marcus Day	Director	CDARI
Veronica Cenac	Attorney at Law	AIDS Action Foundation
Joan Didier	Director	AIDS Action Foundation
Nahum Jn Baptise	Director	National AIDS Programme Secretariat
Natasha Lloyd	CSO/LM	National AIDS Programme Secretariat
Dawn Hazell Gills	M&E Officer	National AIDS Programme Secretariat
Erma Jules	M&E Coordinator	National AIDS Programme Secretariat
Cleophas D'Auverge	CCC	National AIDS Programme Secretariat
Margerite Jn Charles	VCT/PMTCT	National AIDS Programme Secretariat
Sonia Alexander	Director (outgoing)	National AIDS Programme, MOH
Pamela Ambrose	Lab Superintendent	Ezra Long Laboratory VH
Rosilia Joseph	Financial Manager	Project Coordination Unit
Calus Monchery	Financial Assistant	Project Coordination Unit
Tara Leonard	Social Worker	Department of Human Services
Sophia Edwards- Gabriel	Focal Point	Ministry of Education
Ms Magdalene Eugene	Focal Point	Ministry of Home Affairs
Mrs Sharon Joseph	Focal Point	Ministry of Communications & Works
Ms Lisa Albert	Representative	Tender Loving Care
Ms Kenita Placide	Representative	United and Strong

Annex 2 Acronyms

AAF	AIDS Action Foundation
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral (drugs)
BSS	Behavioural Surveillance Survey
CAFRA	Caribbean Association for Feminist Research and Action
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community and Common Market
CHRC	Caribbean Harm Reduction Coalition
CBO	Community Based Organisation
CDARI	Caribbean Drug Abuse Research Institute
CCM	Country Coordination Mechanism
CIDA	Canadian International Development Agency
CSO	Civil Society Organisation
CSW	Commercial Sex Worker
DAART	Directly Administered Anti-Retroviral Therapy
DFID	Department for International Development
DOTS	Directly Observed Therapy
EU	European Union
FBO	Faith Based organisation
FSW	Female Sex Worker
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HAART	Highly Active Anti-Retroviral Therapy
HCW	Health Care Worker
HDI	Human Development Index
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IEC	Information, Education and Communication
LAC	Latin America and the Caribbean
MAP	Multicountry HIV AND AIDS Prevention and Control Programme
MARP	Most-at-risk populations
M & E	Monitoring and Evaluation
MOH	Ministry of Health, Human Services, Family Affairs and Gender Relations
MSM	Men who have Sex with Men
MSMW	Men having Sex with Men and Women
MSW	Male Sex Worker
MTCT	Mother-To-Child-Transmission
NACC	National HIV AND AIDS Coordinating Council
NACCHA	National Coordinating Committee on HIV AND AIDS
NAP	National AIDS Programme
NAPS	National AIDS Programme Secretariat

NGO	Non Governmental Organisation
NHSP	National Health Strategic Plan
NYC	National Youth Council
NWU	National Workers' Union
OECS	Organisation of Eastern Caribbean States
OI	Opportunistic Infection
OVCs	Orphans and other Vulnerable Children
PAHO	Pan American Health Organisation
PCU	Project Coordination Unit
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	Persons Living With HIV AND AIDS
PMTCT	Prevention of Mother-To-Child-Transmission
PPP	Public-Private Partnership
RST	Regional Support Team
RCM	Regional Coordination Mechanism
SLMDA	Saint Lucia Medical and Health Association
SLPPA	Saint Lucia Planned Parenthood Association
STI	Sexually Transmitted Infection
SW	Sew Worker
TB	Tuberculosis
TLC	Tender Loving Care
TOR	Terms of Reference
UNAIDS	United Nations Programme on HIV AND AIDS
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USD	US Dollars
UWI	University of the West Indies
VCT	Voluntary Counselling and Testing
WB	The World Bank
WHO	World Health Organisation

Annex 3 Documents Consulted when preparing this report

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