



National HIV/AIDS Strategic Plan

Saint Kitts and Nevis

2009–2013



Content

Executive Summary

Abbreviations

1. Introduction
2. The HIV/AIDS Situation and Response Analysis
 - 2.1 Epidemiology
 - 2.2 Factors for Vulnerability
 - 2.3 Response Analysis
 - 2.4 Priorities for the next 5 Years
3. Guiding Principles for the National HIV/AIDS Response
4. National Goals and Strategies
5. Major Activities and Implementers per Strategy
 - 5.1 Strategy 1: Prevention
 - 5.2 Strategy 2: Care, treatment and support
 - 5.3 Strategy 3: Advocacy, policy development and legislation
 - 5.4 Strategy 4: Generating and using strategic information
 - 5.5 Strategy 5: National program coordination and management
6. National Monitoring and Evaluation Framework
 - 6.1 Objectives of the National M&E plan
 - 6.2 HIV, STI and behavioural Surveillance
 - 6.3 Health Management Information System and activity reporting
 - 6.4 Research
 - 6.5 Roles and responsibilities
 - 6.6 Dissemination of strategic information
7. Implementation of the National Response
 - 7.1 Roles and responsibilities
 - 7.2 Operational Plan and annual joint review

- 7.3 Decentralisation
- 7.4 Involvement sectors and civil society
- 7.5 Capacity building

- 8. Financial Management of the Response
 - 8.1 Financial management
 - 8.2 Tentative costs of the NSP 2009-2013
 - 8.3 Resource mobilisation

- 9. Annexes
 - 1. National Programme Core Indicators
 - 2. Operational plan 2008
 - 3. Organogram
 - 4. References

Executive Summary

HIV/AIDS has the potential to erode the social and economic gains of a small island developing state if effective strategies are not employed to prevent new infections and provide care, treatment and support to persons infected and affected by this disorder. This provides the rationale for according it a national priority and working vigorously to realize international and regional commitments to mitigate against its impact.

The available data on the local epidemic is limited however it is believed that the prevalence of HIV is probably low in the general population and yet to be determined for vulnerable but hard to reach groups such as men who have sex with men (MSM) and commercial sex workers (CSW). A number of factors have been identified in the local context that increase risk and vulnerability to HIV. These include preponderance of multiple concurrent partnerships fuelled by gender norms/expectations and the prevailing practice of transactional sex. Other factors include homophobia and an unsupportive policy and legislative environment that negatively influence health seeking behaviour.

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 used to strengthen the health sector as a whole and allow for effective delivery of comprehensive care and treatment for persons infected with HIV while improving the overall capabilities of the system. Investments have occurred to upgrade 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 antiretroviral medications are available to all those who meet the clinical criteria for treatment. 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 plan 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. In addition to prevention of new infections, treatment, care and support for PLWHA, programme coordination and management; emerging strategies include the generation and use of strategic information and advocacy for policy development and legislation.

Abbreviations

ANC	Antenatal Client	NeHAC	Nevis HIV/AIDS Committee
ART	Antiretroviral Treatment	NGO	Non-Governmental Organisation
ARV	Antiretroviral Medicines	NSP	National Strategic Plan
BSS	Behavioural Surveillance Survey	OECS	Organization of Eastern Caribbean States
CAREC	Caribbean Epidemiology Centre	PAHO	Pan American Health Organisation
CARICOM	Caribbean Community & Common Market	PANCAP	Pan-Caribbean Partnership on AIDS
CCT	Clinical Care Team	PLWA	People Living with HIV/AIDS
CHD	Community Health Department	PMTCT	Prevention of mother to child transmission
CHRC	Caribbean Health Research Council	PSI	Population Services International
FACTTS	Facilitating Access to Confidential Testing, Treatment & Support	SAT	Self-Assessment Tool
FBO	Faith-Based Organisations	SNHAG	Saint Kitts/Nevis HIV/AIDS Group
FHI	Family Health International	STI	Sexually Transmitted Infection
GFATM	Global Fund for AIDS, Malaria and TB	SW	Sex Worker
GoSKN	Government of St Kitts & Nevis	TA	Technical Assistance
HIU	Health Information Unit	UNAIDS	Joint United Nations Programme on HIV/AIDS
HMIS	Health Management Information System	UNGASS	United Nations General Assembly Special Session on HIV/AIDS
HSS	HIV Sentinel Surveillance	UWI	University of the West Indies
ILO	International Labour Organisation	VCT	Voluntary Counselling and Testing
LMIS	Laboratory Management Information System	WB	World Bank
MOE	Ministry of Education		
MOH	Ministry of Health		
MSM	Men who Have Sex with Men		
NACHA	National Advisory Council on HIV/AIDS		
NACU	Nevis AIDS Coordination Unit		
NAS	National AIDS Secretariat		

1. Introduction

The Federation of Saint Kitts and Nevis is affected by the global HIV/AIDS epidemic, and the government is committed to respond vigorously to the impact of HIV on social development. The Government of Saint Kitts and Nevis (GoSKN) responds to HIV and AIDS as part of its commitment to the Millennium Development Goals, and in the context of specific international agreements and commitments on HIV and AIDS, including the UNGASS Declaration of Commitment, the CARICOM Regional Strategic Partnership on AIDS (PANCAP).

The National HIV/AIDS Strategic Plan (NSP) 2009–2013 provides an overview of the priorities and strategies for the next 5 years. The NSP expands on former national strategies, drawing on lessons about the causes and consequences of the epidemic as well as lessons about the national response to HIV/AIDS. During the course of 2007, several assessments and participatory review processes took place, including assessments with support of World Bank (ASAP) and UNAIDS (CHAT) tools. A national consultation meeting with participation of all relevant stakeholders, including people affected by HIV and AIDS, identified priorities for the next 5 years.

The audiences for this strategy include all stakeholders in the response, including government ministries and departments, civil society organisations and service providers, as well as development partners.

2. The HIV/AIDS Situation and Response Analysis

2.1 Epidemiology

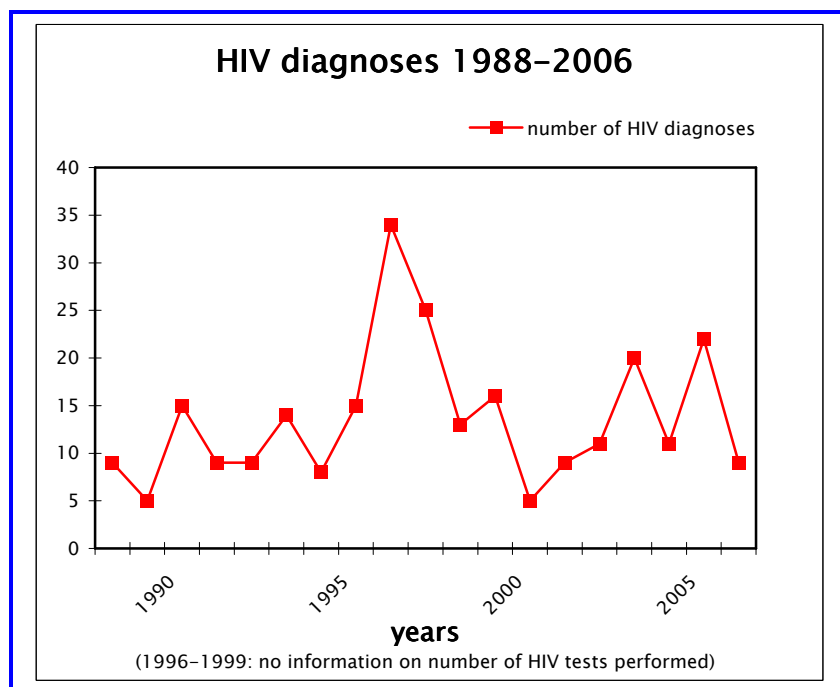
There is no evidence for a generalised or concentrated epidemic in Saint Kitts and Nevis. The precise extent of the HIV and AIDS epidemic is not known, because the required (2nd generation) epidemiological surveillance is not implemented¹, and HIV and AIDS cases are underreported in the health sector due to stigma. CAREC estimates that the Caribbean regional epidemic is serious, but may have peaked in 2003. Unlike neighbouring counties, Saint

¹ CAREC, 2002, 3rd generation surveillance recommendations

Kitts and Nevis does not experience a ‘generalised epidemic’ (defined as more than 1% of the adult population infected with HIV, the virus that causes AIDS)². There is also no evidence for a ‘concentrated epidemic’, i.e. prevalence of more than 5 % in certain most-at-risk groups, such as sex workers (SW) or men who have sex with men (MSM). One study in 2005 found 2.4% of St. Kitts/Nevis prisoners living with HIV³.

HIV and AIDS incidence has remained stable since 1988. The Ministry of Health (MoH) reports 280 HIV diagnoses as of July 2007, since the first HIV diagnosis in 1984⁴. In 2006, nine (9) people tested HIV positive, out of a total of 4,028 tests done in the Central Laboratory, i.e. 0.21%. It is not known for which reason these 9 positive tests were done⁵: most HIV tests are ordered for symptomatic patients; other reasons include screening of blood donors; voluntary testing (VCT) among people with past exposure, or pregnant women and their partners; and compulsory HIV tests for insurance or citizenship application, pre- employment or upon admission into prison.

Two new AIDS diagnoses were reported to the MoH in 2006, bringing the total number to 92, since 1984. Underreporting of AIDS diagnoses is likely, because of stigma and treatment seeking abroad. As of July 2007, 55 people with advanced HIV disease are



under medical supervision, of which 31 receive ART⁶.

² CAREC, 2007, regional epidemiological update

³ Boison et al, 2005

⁴ MoH, 2007.

⁵ Health Information Unit, 2006 Annual Report

⁶ Health Information Unit, 2006 Annual Report

STIs are relatively common in Saint Kitts and Nevis⁷. STI prevalence is a proxy for HIV prevalence, because of the similar transmission pattern.

Unfortunately, there are also few STI prevalence data, because most STI are treated outside the government health services, and because most STIs are not diagnosed in the Central Laboratory, but managed symptomatically. Yet, STI prevalence seems to be relatively high compared to the OECS region: in 2006, 5% of young people (15–24) and 10% (25–49) of adults reported STI symptoms in the preceding year⁷.

2.2 Factors for Risk and Vulnerability

HIV is spread in Saint Kitts and Nevis predominantly through unprotected sex, especially among groups of people with concurrent sexual partnerships.

Concurrent partnership are conducive for HIV spread because people with HIV are most infective to others relatively soon after their own infection⁸.

People or groups prone to unprotected sex and/or anal sex are most vulnerable to infection. In Saint Kitts and Nevis, sex workers (SW) and women who engage in transactional sex with multiple partners and men who have (anal) sex with men (MSM), may be vulnerable for HIV infection. Injecting drug use is very uncommon.

Sexual risk behaviour takes place in a socio-economic and cultural context, and several factors increase the vulnerability to HIV infection. In Saint Kitts and Nevis, a double standard is applied for women versus men when it comes to sexual behaviour and promiscuity in particular: women are supposed to be faithful to one partner, but men are allowed, and encouraged by their peers, to have multiple partners. Thus, even women who are faithful to one partner may be at risk for HIV infection.

Male to male sex appears to be much more common in Saint Kitts than acknowledged, according to the behavioural surveillance. Yet, homophobia is rampant. The stigma associated with male-to-male sex leads some homosexuals to have a female partner as an alibi, thus putting her at risk. Also, the illegal status of ‘buggery’ drives MSM underground, thus impeding access to health education and STI/HIV treatment.

⁷ CAREC/FHI, BSS 2005

⁸ Viral concentration peaks in bodily fluids soon after infection, to decrease due to the immune response. Viral load remains low but increases later as the immune system deteriorates.

Transactional sex is common among women, and among some men¹⁰. Transactional sex is probably more common than commercial sex, and may be more risky, as condom use is higher during commercial sex than with casual sex (see text box)¹¹. Transactional sex may be correlated with low economic status, but is not limited to poor women only.

Young people may be vulnerable to HIV infection, but not all young people: only those who are sexually active and have unsafe sex. Behavioural surveillance indicated that many young girls and boys are subjected to forced sex, which obviously makes them vulnerable¹². Teenage pregnancies are very common¹³, and there are many anecdotal reports of (illegal) abortions, thus indicating wider sexual and reproductive health needs of young people. Current debate on whether to increase the age of consent for sexual intercourse from 16 to 18 may also play a factor in increasing youth vulnerability to HIV/AIDS.

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Behavioural surveillance:

Key findings⁹ for St Kitts & Nevis:

- Many adult men buy sex (18%), but condom use with sex workers is high (85%)
- More men report casual partners (59%), but with girlfriends less often use a condom (71%)
- Almost as many women have casual partners (53%), but compared to men are much less likely to use condoms (31%)
- One in ten girls, and many boys (7%) are physically forced to have sex, the first time
- Male-to male sex is relative common for the region (10%)
- Although two thirds of the population are generally accepting towards people with HIV, 85% would not buy food from a food seller with HIV
- Symptoms of STI are relatively high for the region (for men, 8% discharge, 4% sores)
- Almost half (47%) of the HIV tests are compulsory.

Cultural taboos around HIV, sex and sexuality are barriers to access sexual health services. Saint Kitts and Nevis are relatively small and close-knit island communities, resulting in stigma and discrimination. Some people are

⁹ All findings are for the last 12 months, unless mentioned otherwise.

¹⁰ CAREC/FHI, 2007, BSS

¹¹ CAREC/FHI, 2007, BSS

¹² CAREC/FHI, 2007, BSS

¹³ Health Information Unit, 2006 Annual Report

reluctant to admit (and seek support to change) risky behaviours; young people are reluctant to buy condoms; few people access VCT or STI treatment, for fear of breach of confidentiality. Some AIDS patients don't want to get their ARV from the pharmacy, or even seek care abroad.

Public policies and legislation health seeking behaviours, and HIV prevention and care services. The federal constitution denounces discrimination on the basis of gender and race, but currently not on disease status or sexual orientation. Sectoral anti-discrimination and pro-confidentiality policies can restore clients' confidence and increase access to early HIV testing or STI treatment. On the other hand, regulations enforcing compulsory testing and criminalisation of male-male or commercial sex drive the most vulnerable groups away from prevention workers.

2.3 Response Analysis

The national structure for an expanded response has been built, but capacities still need to be strengthened. The Federal government established the organisational structure for the response, including a National Advisory Committee on HIV and AIDS (NACHA). Two secretariats exist for coordination, technical direction and information provision, the National AIDS Secretariat (NAS) and the Nevis AIDS Coordination Unit (NACU). NAS and NACU are severely stretched, in terms of staff numbers and expertise mix.

Public sector and civil society are more involved, but more partners and broader involvement is needed. The ministries of health and education effectively address HIV, as do the departments of gender, labour & youth. Yet, HIV/AIDS activities have not been mainstreamed into their own workplans and budgets, and thus remain dependent on external HIV funding. Other ministries, such as tourism and defence can also mainstream HIV prevention. Civil society organisations, including PLWHA and MSM organisations, churches and companies are involved in HIV prevention and care services. Yet, there are gaps: NGOs are few and of limited organisational and technical capacity; faith based organisations (FBOs) do not yet address community care needs of PLWHA.

Prevention education takes place, but needs to become evidence based and better targeted. Now that awareness and knowledge levels are high, general population information campaigns need to be more evidence based and focus on remaining myths and misconceptions. Besides, prevention

interventions need to target the most-at-risk populations better, moving towards research driven behaviour change interventions, probably relying more on interpersonal and peer communication than mass media. Life skills-based HIV and sexual health education in the school system is necessary and promising, but has never been evaluated in the local context for effectiveness.

VCT service coverage is broad, but demand remains low. The MoH set up VCT services in 21 sites, including all health centres and hospitals. There are national VCT days, and a cadre of trained counsellors. Yet, VCT protocols are slow and involve many health professionals, resulting in delayed results, and perceptions of low confidentiality.

Medical management of people with HIV and AIDS is of high quality, but broader needs of PLWA remain under-addressed. Antiretroviral treatment (ART) is available free of charge, thanks to external (GFTAM) funding, and coverage for people with advanced HIV disease is high. The MoH –developed protocols for management of HIV and opportunistic infections exist, and provide assistance and supervision to clinical care providers. FACTTS, a PLWHA group has been in existence since 1999, but stigma prevents most PLWA to join, and impedes its effectiveness as a self-support or activist group. The broader needs of PLWA and their carers, including home and community care, nutritional, psychosocial and pastoral needs have not been assessed and/or addressed so far.

The needs for supportive public policies and legal reform have been assessed, setting the stage for concerted advocacy action. Compulsory HIV testing is common for cases of insurance, citizenship and work permits. Discrimination of PLHIV and people with same sex behaviour exist, and could hinder an effective response. Through the CARICOM initiative, a legal and human rights assessment has resulted in several clear recommendations for legal reform, policy development, capacity building and monitoring. NAS established a human rights desk with external support, but disappointing demand (due to fear for disclosure) calls for alternative strategies to address cases of discrimination on the basis of HIV status.

Management of the national programme has improved, with the support of technical assistance and international funding, but needs to be sustained and expanded. The GoSKN secured external funding for the national response through a loan from the World Bank and a grant from the Global Fund (through the OECS). Funding from both sources will terminate during the NSP

period, so NAS needs to ensure sustainability of the national programme, through resource gap analysis and a resource mobilisation strategy and plan. NAS drafted an M&E framework for the national programme, and sent three project officers for M&E training. NAS needs to finalise this framework, develop an implementation plan and take the lead in coordinating the collection, analysis and dissemination of strategic information (including evidence) to programme managers and policy makers. The most important component of the National M&E Framework will be to establish 2nd generation surveillance to monitor impact (HIV prevalence) and outcomes (behavioural change) of the national response.

2.4 Priorities for the next 5 Years

On the basis of the above analysis of the epidemiological situation and progress of the response, stakeholders at the national consultation identified the priorities for the national response in the period 2009–2013¹⁴:

1. Improve 2nd generation surveillance to monitor outcome and impact indicators of the national programme, and improve monitoring of services to track ‘universal access’ targets. The first step will be an assessment of risk behaviour and vulnerabilities.
2. Target prevention to those at the highest risk, including but not limited to sex workers and MSM.
3. Target men with messages about responsible male behaviour, to address vulnerability of women.
4. Address discrimination in the health sector through development of anti-discrimination and confidentiality policies and guidelines; training of health sector workers in such protocols; and monitoring of adherence to protocols.
5. Engage and support faith-based groups to move beyond abstinence into projects to address taboos, stigma and discrimination and to provide community care to PLWA.
6. Strengthen organisational as well as technical capacity of civil society organisations, including NGOs, FBOs, and private sector.
7. Support relevant ministries and departments to mainstream HIV in their own strategies, workplans and budgets, through strategic planning support.

¹⁴ NAS, 2007, report of the conational stakeholder consultation

8. Develop a continuum of care services, based on expressed needs, expanding from the clinical care protocols.
9. Safeguard sustainability of HIV/AIDS services beyond current donor funding, through resource mobilisation and moves towards greater efficiency in programming.
10. Address Adolescent Sexual and Reproductive Health Services that are youth friendly.

3. Guiding Principles for the National HIV/AIDS Response

The following guiding principles underlie the National Strategic Plan, and serve as cross cutting concerns.

1. **Respect for human rights.** The Federation of Saint Kitts and Nevis is signatory to international treaties on universal human rights – civil rights, rights of women, rights of the child. All national HIV/AIDS related strategies, policies and services shall respect human rights for all, including people living with, vulnerable for, or affected by HIV.
2. **No discrimination.** Discrimination reduces access to health and social services, and reduces quality of life. The constitution of Saint Kitts protects all citizens from discrimination on the grounds of gender, age, etc. The National HIV/AIDS Strategy extends protection from discrimination to disease status, sexual behaviour and sexual orientation.
3. **No coercion.** Forcing HIV prevention and care services upon people risks being harmful, ineffective, and/or deterring, especially in a context of stigma and discrimination. HIV testing should never be mandatory except in justifiable circumstances, and no HIV test shall be undertaken without informed consent and the possibility to opt out.
4. **Gender equity.** Gender inequalities and double standards affect women's relational options, and negotiable power for safer sex. Women, especially girls, are also biologically more susceptible for HIV infection. HIV/AIDS strategies and policies shall acknowledge and address gender inequalities.

5. **Prevention and care strategies shall be based on evidence.** The NSP encourages formative research, needs assessments to inform preventions and care strategies and interventions. Communication materials and messages must be based on audience segmentation, pre-testing and evaluation. In general, effective evaluation is encouraged.

6. **Inclusion and participation of all relevant stakeholders.** Services are more likely to be relevant and effective if they are designed, implemented and evaluated with participation of those most affected. The National Strategy promotes greater and meaningful participation of people infected and affected with HIV/AIDS (GIPA).

7. **Accountability and transparency.** To promote coordination of the national response, all partners shall be accountable, not only to their funder, but also to the beneficiaries of the services, and each other. To do so, implementing partners shall be transparent about their programmes, progress and challenges.

4. National Goals and Strategies

The dual goals of the national HIV/AIDS strategy are:

1. To reduce the spread of HIV infection
2. To reduce the impact of HIV/AIDS on individuals, family and the community.

The five HIV/AIDS strategies to achieve the national goals are:

1. Prevention of HIV infection
2. Care, treatment and support for people with HIV and AIDS
3. Advocacy, policy development and legislation
4. Generating and using strategic information
5. National program coordination and management

5. Major Activities and Actors per Strategy

The following chapter provides an overview of the major activities that must be undertaken in each of the five strategic areas, to achieve the national goals. For each activity, the main, responsible actor is mentioned, even if activities rely on collaboration of several players. More detailed activities and collaborators will be determined and agreed upon every year, and will be described in annual operational plans.

5.1 Strategy 1: Prevention

By 2013, Saint Kitts and Nevis will have achieved the following results:

1. 80% of prisoners and other most-at-risk population will be reached with prevention interventions
2. 90% of all people express supportive attitudes towards people with HIV
3. 50% of men report condom use in all sexual encounters
4. 30% increase in delaying of first sexual encounter.

In order to prevent HIV transmission in most-at-risk groups and general population, implementing partners will undertake the following major activities:

- NAS will develop an “HIV/AIDS communication strategy” on the basis of formative audience research
- NAS will contract NGOs to reach more most-at-risk group, including MSM and male and female sex workers, with behaviour change communication
- PSI will undertake male and female condom social marketing for general and most-at-risk populations
- NAS will contract out multimedia campaigns for the general population, to address myths and misconceptions about HIV and promote supportive attitudes
- MoE will scale up quality and coverage of HIV/sexual health education, through the health and family life programme, in primary and secondary schools
- Dept of Gender will increase quality and coverage of HIV prevention interventions for teen mothers, men, and low-income women

- Depts of Social Development, Gender Affairs and Youth will facilitate the economic and emotional well being of low-income women and men, reducing the need for transactional sex for economic survival.
- Dept of youth will address out of school youth through sports and other innovative initiatives
- Dept of Labour will promote and propose workplace policies and interventions
- Private sector firms will design and implement workplace programmes
- Church groups will increase awareness, knowledge and compassion among their congregation members
- MoH will increase access to and quality of PMTCT services
- MoH will increase early diagnosis and treatment of STI in the public and private sector
- MoH will maintain safe blood supply and promote voluntary donation
- MoH will develop and implement protocols to reduce infections in health care settings.
- Ministry of Legal Affairs and Justice to enact Legislation (Increased age of Consent, and Spousal Rape) to protect young males and females from forced sexual encounters, and protecting women from forced sexual encounters within their Union.

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5.2 Strategy 2: Care, treatment and support

By 2013, Saint Kitts and Nevis will have achieved the following results:

1. At least 90% people with HIV eligible for ART will receive treatment
2. At least 90% of people diagnosed with HIV access appropriate care and support services

In order to improve the quality of life of people with HIV and those affected, implementing partners will undertake the following major activities:

- NAS will develop a “National Continuum of Care Strategy”, based on a needs assessment, describing a broad range of care and support services for PLWA, and referral mechanisms.

- MoH (Clinical Care Team) will increase quality and access to clinical management of HIV, opportunistic infections and AIDS, in the context of the continuum of care
- NAS will engage churches to provide community care and pastoral support
- MOH and Dept of Social and Community Development will increase quality and coverage of home and community based care for chronically ill patients and orphans
- MoH will work with PANCAP/CARICOM and others to sustain procurement of ART
- NAS will support PLWHA groups to increase access to mutual support and self-help
- MOE, Depts of Gender Affairs and Youth will encourage greater male participation in care work for those infected with HIV.

5.3 Strategy 3: Advocacy, policy development and legislation

By 2013, Saint Kitts and Nevis will have achieved the following results:

1. Less than 10% of people with HIV report barriers to access of health and social services
2. Government policies & legislation prevent compulsory testing.
3. Government policies & legislation ensure equal rights of all people irrespective of disease status or sexual behaviour (including the health sector, education sector and workplace).

In order to create a supportive public policy environment for HIV prevention and care, implementing partners will undertake the following major activities:

- NACHA will develop and propose a 'national HIV policy', and a legal reform agenda on the basis of recommendations from the CARICOM legal assessment
- MoH will develop and monitor supportive health sector policies and protocols, including anti-discrimination and confidentiality protocols for health workers.
- The Dept of Labour will submit proposals for the enactment of Equal Opportunity in Employment Act, and Occupational Health and Safety Act to Cabinet and monitor implementation
- Min of Justice will enact legislation (e.g. increased age of consent to make consistent with age of maturity which is 18, spousal rape) to

protect young males and females from forced sexual encounters, and to protect women from forced sex within their Union

- Relevant ministries and departments (education, gender, labour etc.) will develop supportive policies, strategies and protocols, and monitor their application
- NAS will evaluate the Human Rights desk, and support alternate mechanisms to monitor and address cases of HIV/AIDS related discrimination
- NAS will support the national PLWA network to increase its role as interest group

5.4 Strategy 4: Generating and using strategic information

By 2013, Saint Kitts and Nevis will have achieved the following results:

1. An HIV and STI surveillance system exists and has generated trend data on prevalence
2. Formative research has identified and mapped most-at-risk populations and their prevention needs.

In order to ensure that policy makers and programme managers have the information they need to improve prevention and care services, implementing partners will undertake the following major activities:

- NAS will finalise the National HIV/AIDS M&E Framework and Implementation Plan
- MOH will work with OECS and CAREC to commission a second round of BSS, and for this round include most-at-risk populations. Formative research will be needed to identify and map most-at-risk groups to be included in the surveillance
- MOH will collaborate with the division of youth and UNFPA to address out-of school youth including ASRH
- MOH will integrate biological markers (HIV and VDRL) into behavioural surveillance.
- MOH will improve STI surveillance and include STI into the HIV/AIDS surveillance reports.
- MOH will undertake a baseline and follow up HIV/STI survey among antenatal clinic attenders, through unlinked anonymous HIV testing of all blood samples collected at the Central Lab.

- MoH will update and implement Health Management Information Systems (HMIS) for HIV/AIDS/STI, VCT and PMTCT services, and report annually on public and private sector service uptake
- MOH will ensure that all health centres have software and hardware, and receive training for service coverage recording, analysis and reporting.
- The Clinical Care Team will monitor and report treatment outcomes for HIV/AIDS patients to the MoH Health Information Unit
- NAS will develop an 'HIV research strategy' including research agenda, ethical review procedures, and dissemination strategies for research findings, with TA from CHRC, UWI and other partners.
- NAS will develop and disseminate an annual progress report for the national programme, and separate progress reports for development partners where needed

5.5 Strategy 5: National program coordination and management

By 2013, Saint Kitts and Nevis will have achieved the following results:

1. A fully staffed and equipped Secretariat to coordinate the response
2. Implementing partners (ministries and NGOs) have identified technical support needs and have improved their HIV/AIDS competence
3. Sufficient external and domestic resources to implement annual workplans

In order to ensure that the national response is managed effectively and efficiently, implementing partners will undertake the following major activities:

- NAS will develop annual national workplans and budgets on the basis of the NSP; monitor implementation; and report quarterly to NACHA on progress
- NAS will schedule quarterly meetings with all implementing partners to facilitate joint planning and implementation and to share strategic information
- NACU will schedule quarterly meetings with all implementers in Nevis
- NAS will call, organise and record regular meetings of NACHA and other relevant committees
- NAS will support government ministries to mainstream HIV into sectoral policies, strategies, workplans and budgets

- NAS will finalise a ‘capacity building needs assessment’; develop annual technical assistance (TA) plans; coordinate TA from regional/international technical agencies; and report on progress and outcomes of capacity building
- NACHA will assess resource needs for implementation of the NSP 2009–2013; develop a resource mobilisation strategy; and undertake fundraising activities with development partners and the GoSKN

6. National Monitoring and Evaluation Framework

This chapter describes the objectives and main issues for M&E and strategic information. In line with the ‘three ones principle’, the NSP 2008–2013 will have one, national M&E framework for the national response. Till date, there was limited information, based in service statistics (incl. HIV screening) but no (second generation) surveillance, as recommended by CAREC. A National M&E Framework will be finalised in 2008 with urgency to remedy this, on the basis of an earlier draft¹⁵, and this chapter.

6.1 Objectives of the National M&E Framework and Implementation Plan

The objectives of the M&E framework are:

1. To provide accurate and timely information to policy makers and programme planners
2. To monitor and report on core and additional indicators for impact, outcomes, outputs and inputs of the national HIV/AIDS programme¹⁶.

6.2 HIV, STI and behavioural sentinel surveillance

Second-generation surveillance is a crucial to monitor core indicators for impact and outcome¹⁷. Surveillance is a crucial component for the evaluation of national HIV/AIDS programmes¹⁸. It measures HIV prevalence and changes in behaviours, attitudes and knowledge, through repeat cross-sectional surveys in general and most-at-risk populations.

¹⁵ MOH/NAS, 2006, working paper on the national M&E system for HIV/AIDS

¹⁶ See Annex 1 for national programme core and additional indicators

¹⁷ See Annex 1 for national programme core indicators for impact and outcome

¹⁸ CAREC 2002, Third generation surveillance guidelines

Biological surveillance includes HIV as well as syphilis, because STI prevalence is higher, and trends therefore more easily interpreted. Biological surveillance among antenatal clinic (ANC) attenders (representing the sexually active general population¹⁹) can be repeated annually, using blood samples already collected for ANC syphilis/screening. The sample can include all pregnant women, approximately 600–700 per year. For most-at-risk groups, biological surveillance is most practically and meaningfully combined with behavioural surveillance.

Behavioural surveillance will be a regular (3–5 year) repeat of the 2005 baseline BSS done with 6 OECS states²⁰. The next BSS will include most-at-risk populations besides the general population (based on vulnerability mapping) and will integrate HIV & syphilis testing. Funding and TA for the BSS will be needed, and requested from USAID and CAREC/CHRC/FHI respectively.

6.3 Health Management Information System and health facility surveys

National programme output and process indicators, i.e. service coverage and quality, is monitored through activity reporting. Laboratory and Health Management Information Systems (LMIS and HMIS) already exist in the public health service, and generate regular information on the number of clients, treatment outcomes, etc. MoH will update the LMIS and HMIS to capture relevant service statistics for HIV/AIDS/STI management and prevention services. Health Centres and the Central Laboratory will need IT support (software, hardware and training) to facilitate reporting. NGOs and private sector health services will also report to NAS on service delivery, through a simple and user-friendly reporting system, to facilitate compliance. One-off health facility/school/workplace surveys to assess quality of service delivery.

Feed back of service coverage information to service providers is crucial for reporting compliance and service improvement. NAS is responsible to collect, analyse and disseminate information, through 6-monthly updates.

¹⁹ HIV prevalence among ANC tends to overestimate the prevalence in the general population, but this is easily remedied when measure trends instead of point prevalence

²⁰ CAREC, 2007, BSS report

6.4 Research

The third major component of national M&E framework is research. The objectives of AIDS research are broader than for the other two components, and include formative and evaluative research. The methodologies can be more varied, including qualitative and quantitative methods. The areas of research could be biomedical, as well as social behavioural research. Due to this wide spectrum, the NAS will establish a National AIDS Research Advisory Board, and agree research priorities every 1–2 year, on the basis of NSP implementation. Guidelines on research ethics are crucial in AIDS research; therefore all research proposals will be reviewed nationally, with regional TA if needed.

6.5 Roles and responsibilities

NAS is responsible for overall M&E framework and research implementation plans. The Health Information Unit of the MOH is responsible for HMIS design, collection, analysis and reporting, but will be supported by NAS for HIV specific HMIS. All implementing partners are responsible to share their progress reports, and their data with NAS, so that NAS can include them in national programme progress reports.

6.6 Dissemination of strategic information

NAS will develop several information products to disseminate information, because the ultimate purpose of generating strategic information is to provide it to policy makers and programme planners, so they can improve the national response. First, NAS and MOH will develop a 6–monthly service coverage report, based in HMIS, LMIS and activity/progress reports from private sector, NGOs and ministries, targeted to service providers. Second, NAS will develop a national programme progress report every year, for stakeholders, government and donors. NAS will develop specific donor reports, e.g. for WB or GFATM, including expenditures and progress. Finally, NAS will pro–actively share research findings through its resource centre and website. In order to disseminate strategic information as efficiently as possible, and increase transparency, several channels will be used, including reports, websites, list–serves, and international or regional conferences.

7. Implementation of the National Response

This chapter explains how the NSP will be implemented. It covers roles and responsibilities of the several stakeholders; how the NSP will be translated into annual operational plans, how partners will be supported to improve their technical capacities, and how the necessary resources will be identified and raised to cover the cost of the national HIV/AIDS response.

7.1 Roles and responsibilities

Distinct roles in the national programme are a) governance and overall direction; b) coordination and technical leadership; c) implementation and service delivery; and d) resource mobilisation. The National Advisory Council on HIV/AIDS (NACHA) is responsible for overall direction, oversight, policy development and resource mobilisation. NACHA members include representatives from government and civil society, and NACHA advises the cabinet and Prime Minister. Development partners (GFATM, WB, UN agencies etc.) provide financial resources or technical assistance to the national programme.

The National AIDS Secretariat (NAS) is responsible for coordination of all implementing partners, for developing operational plans and budgets on the basis of the NSP, and for monitoring progress. NAS reports to the NACHA and development partners on progress. The Nevis AIDS Coordination Unit (NACU) has similar responsibilities, but only for the national programme activities and partners in Nevis. NACU is also accountable to NACHA, but Nevis progress reports are included in the national progress reports by NAS.

All implementing partners are responsible to execute activities under their mandate, for example service delivery, training, research etc. Implementing partners include public sector departments and service providers; civil society organisations (NGOs, FBOs, private companies, media, etc.); researchers; training institutes, etc. They are responsible to share information, and report on their progress to the rest of the partners, through NAS.

7.2 Operational Plan and annual joint review

The NSP will be implemented through annual, detailed Operational Plans, which spell out detailed activities under each strategy; timing of activities; main responsible organisation; and cost and funding source. NAS is responsible to develop an Operational Plan, and propose it to NACHA for approval. Operational plans are finalised in the last quarter of each year. NAS develops operational plans on the basis of a joint progress review, and plans of all implementing partners.

Progress of the national programme towards the objectives of the NSP will be reviewed annually with participation of all relevant stakeholders. The ‘annual joint review’ takes place in the second quarter of each year, on the basis of the annual progress report. The joint annual review will result in recommendations for next year’s priorities and implementation arrangements. At mid term (2010), the Joint Annual Review will focus on review and adjustment of the NSP strategies.

7.3 Decentralisation

Authority over the national response on Nevis is decentralised to the government of Nevis. NACU is responsible for actual coordination, and works closely with NAS. The Nevis HIV/AIDS Committee (NeHAC) has major public and private sector implementing partners as members, and supports the NACU. NACU is accountable to NACHA, which has members from Nevis.

7.4 Involvement of government sectors and civil society

HIV/AIDS is a development issue; therefore several non–health sectors are involved in the national, multisectoral HIV/AIDS programme. Given the low prevalence of HIV, only relevant ministries and departments need to get involved besides MoH: i.e. education, gender, labour, defence, tourism and prisons. Ministries are responsible 1) to assess the impact of HIV on their workforce and mandate; 2) to mainstream HIV/AIDS prevention and care into their strategies and workplans; and 3) to develop supportive sectoral policies to reduce vulnerability. NAS provides initial support and funds for strategic planning, but ministries should mainstream HIV services into their budgets.

Civil society organisations (NGOs, FBOs and private sector) are very important for service delivery for prevention, care and support, complementing and expanding government services. NGOs are expected to work with most-at-risk populations who do not or cannot access government services, and to advocate for safeguarding human rights in policy development and service delivery. FBOs are expected to reach out to their congregation members, address stigma and discrimination in the church setting; to target prevention messages to female members; to extend prevention messages beyond abstinence; and to provide pastoral and community care to people with HIV. Private companies are expected to develop non-discriminatory workplace policies and workplace programmes. For profit organisations are expected to finance their own programmes. Finally, civil society takes an active part in the governance of the response as members of the NACHA.

7.5 Capacity building

In order to increase the effectiveness of HIV prevention and care, most implementing partners can benefit from technical and/or organisational support. NAS will regularly assess capacity building needs; assess available opportunities for technical assistance (TA); and coordinate capacity building. Capacity building needs have been expressed in recent reports²¹: human resource development is a need for NAS as well as other stakeholders. Organisational development support is a need for some of the newer NGOs, including FACTTS and SKNAG.

Several regional and international TA agencies already provide support to the national response. These include CAREC, CHRC, UWI, UN technical agencies, FHI, MEASURE etc. On the basis of NSP priorities and expressed TA needs, NAS will request them to provide further support. NAS will also raise additional external financial and technical support to undertake capacity building of implementing partners.

²¹ MEASURE, 2007, health service providers survey & CHRC, 2004, assessment of the national response

8. Financial Management of the Response

8.1 Financial management

The majority of financial resources for the national response come from development partners, the GoSKN and private donations. At the time of NSP development, the major donors to the national programme are the World Bank (4 m US\$ loan), GFATM (1.8 m US\$ grant) and GoSKN (2 m US\$). NAS is responsible to report on expenditure of donor and government resources, with support from the Ministry of Finance.

Presently, NAS manages a grant facility for implementing partners, to undertake activities that comply with NSP priorities. For the longer term, ministries are encouraged to mainstream HIV/AIDS activities into their own budgets, and report on expenditures internally. Similarly, NGOs and FBOs are encouraged and supported to raise their own resources.

8.2 Tentative costs of the NSP 2009–2013

The tentative cost of the NSP 2009–2013 is between 8–10 million US\$. This is a rough estimate, based on the cost estimate for the NSP 2002–2007 (8.6 m US\$)²² and past expenditures of GF and WB funds (less than 1 m US\$/year). Each year, this estimate will be updated on the basis of available information. Compared to the earlier cost estimate (where 50% of the costs were for care services), current epidemiological projections do not predict a massive increase in AIDS patients, and ART has become cheaper. On the other hand, prevention services needs to scale up, especially for hard to reach groups, and through more intensive interpersonal methods. Contracts for regional organisations to implement IBBS (Integrated Biological and Behavioural Surveillance), mass media campaigns, or capacity building, as planned in the NSP, may add significantly to the costs.

The budget for the 208 operational plan is based on actual budgets of implementing partners and funding commitments.

²² CHRC, 2004, assessment of the national HIV/AIDS programme

8.3 Resource mobilisation

NACHA is responsible for resource mobilisation for the national response. As the current funding for the national response will come to an end in 2009 (WB) and 2010 (GFATM), NACHA will estimate the resource gap, and develop a resource mobilisation strategy. This strategy will include regional (OECS/PANCAP) joint planning and proposal development, in order to access certain development funds that Saint Kitts and Nevis would not qualify for on its own. NAS will support NACHA in the implementation of resource mobilisation activities.

9. Annexes

1. National Core Indicators
2. Operational plan 2009–13 [see separate document]
3. Organigram and mapping of the national response
4. References

Annex 1. National Programme Core & Additional Indicators

Note:

These include the Universal Access Indicators and (2010) targets as developed jointly in 2007

National Indicator ²³	Data	Reporting	Target		
	source	frequency	2007	2010 ²⁴	2013
Core Indicators					
Prevention					
HIV prevalence among young males and females(15–24)*	HSS ²⁵	3 years	<1%	<1%	<2%
STI (RPR) prevalence among ANC	HSS	Annual	NA	<2%	<2%
HIV prevalence among SW/MSM*	HSS	3 years	NA	<1%	<1%
STI (RPR) prevalence among SW/MSM	HSS	3 years	NA	<1%	<2%
% Young people (15–24) who have had sexual intercourse before the age of 15*	BSS	3 years	22%	15%	15%
% Adults (15–49) who have had sexual intercourse with more than one (non-marital, non-cohabiting ²⁶) partner in the last 12 months*	BSS	3 years	46%, 23% ²⁷	44% 20%	42% 18%
% Adults (15–49) who had more than one (non-marital, non-cohabiting) sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse*	BSS	3 years	56%, 52% ²⁸	60% 58%	62% 60%
% SW reporting the use of a condom with their most recent client*	BSS	3 years	NA	70%	80%
% men reporting the use of a condom the last time they had anal sex with a male partner*	BSS	3 years	NA	20%	25%

²³ Asterix (*) denotes UNGASS indicator

²⁴ From Universal Access target setting exercise 2007

²⁵ Sub sample of young ANC

²⁶ Note that the BSS questionnaire is more specific than the UNGASS indicator

²⁷ BSS data needs to be reanalysed to combine the 15–24 and 25–49 age groups

²⁸ BSS data needs to be reanalysed to combine the 15–24 and 25–49 age groups

National Indicator ²³	Data	Reporting	Target		
	source	frequency	2007	2010 ²⁴	2013
% Young people (15–24) who both correctly identify ways of preventing the sexual transmission of HIV <u>and</u> reject major misconceptions about HIV transmission*	BSS	3 years	52%	65%	80%
% SW/MSM who both correctly identify ways of preventing the sexual transmission of HIV <u>and</u> reject major misconceptions about HIV transmission*	BSS	3 years	NA	65%	80%
Care & support					
%Men and women with HIV known to be on treatment 12 months after initiation of ART*	HMS	2 years	97%	100%	97%
#/% PLWA currently receiving care and support according the national protocols ²⁹	HMS	Annual	55/300 ³⁰	65%	75%
#/% people with advanced HIV infection receiving antiretroviral therapy*	HMS	Annual	30/30 ³¹	80%	80%
% Men and women who received an HIV test in the last 12 months and who know their results*	BSS	3 years	6,16% ³²	80%	95%
% SW/MSM who received an HIV test in the last 12 months and who know their results*	BSS	3 years	NA	80%	95%
% Respondents with accepting attitudes towards PLWA ³³	BSS	3 years	5%	10%	15%
Additional national programme indicators ³⁴					
Prevention service coverage					
#/% SW/MSM reached with HIV prevention programmes*	BSS / NGO reports	3 years Annual	NA NA	85%	95%

²⁹ Comprehensive care includes medical, social, psychological & material support

³⁰ Assuming 300 people with HIV total (≈ 1% adult population)

³¹ assuming 10% of total PLWA have advanced HIV infection

³² BSS data needs to be reanalysed to combine the 15–24 and 25–49 age groups

³³ See range of questions OECS BSS 2005

³⁴ Note: additional specific output indicators for major activities are provided in annual implementation plans.

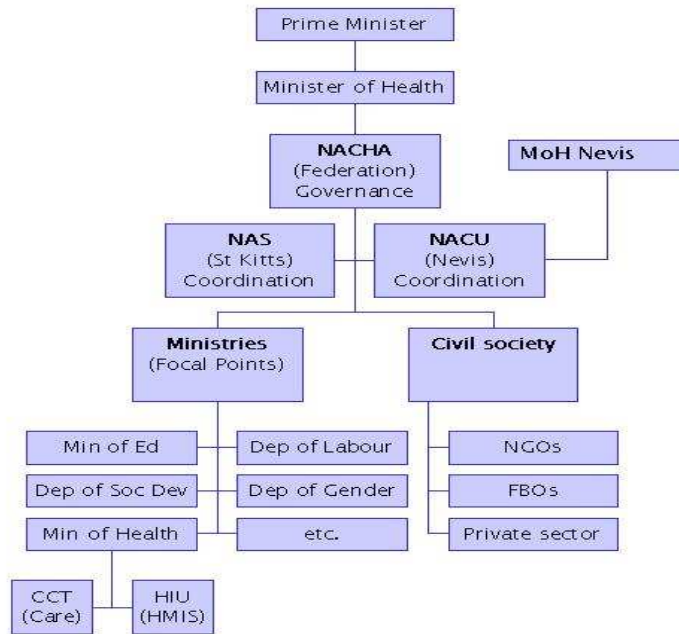
National Indicator ²³	Data	Reporting	Target		
	source	frequency	2007	2010 ²⁴	2013
#/% of pregnant women accepting HIV test as part of PMTCT services	HMIS	Annual	220/49% ³⁵	85%	95%
# (male/female) condoms sold/distributed free	NAS & PSI	Annual	183,000 ³⁶	300,000	500,000
% of persons 15–24 using a condom with every sexual encounter					
% Schools that provided life skills–based HIV education within the last academic year	NAS report	2 years	?	70%	80%
Policy, coordination and management					
# ministries that actively implement a gender integrated HIV/AIDS action plan	NAS report	Annual		3	5
# Large employers that have gender integrated workplace policies and interventions*	NAS report	Annual		3	5
AIDS spending by categories and financing source*	NAS report	Annual			

³⁵ MoH data St Kitts only, Jan–Oct 2007. Nurse O'Brien France, pers. comm.

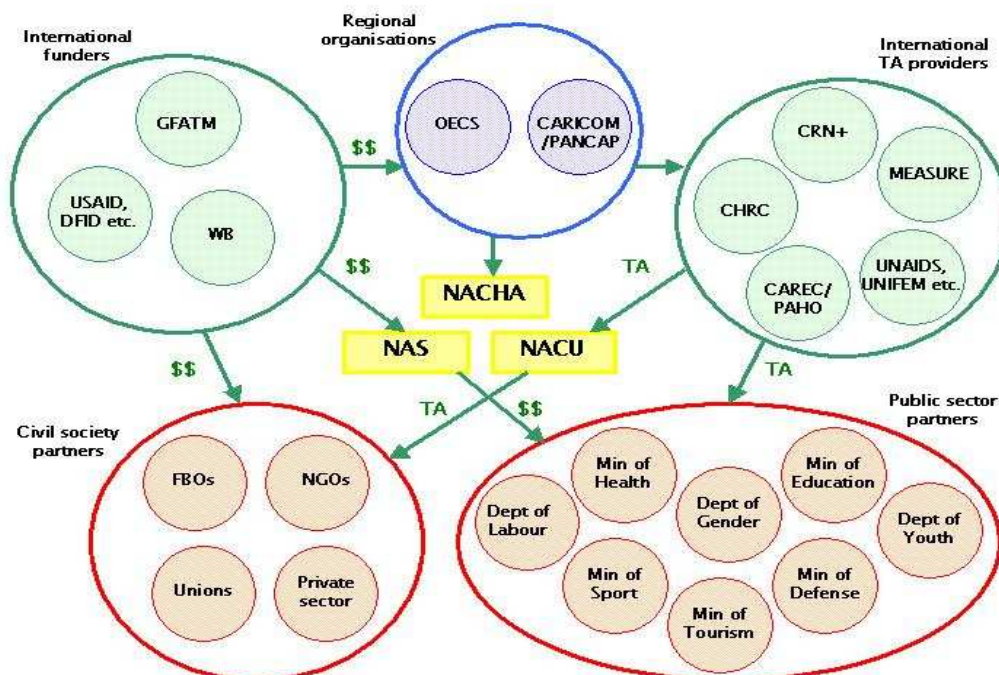
³⁶ 2006 – Universal Access Targets

Annex 3A. Organogram National AIDS Programme

National AIDS Programme, Saint Kitts & Nevis



Annex 3B. Mapping stakeholders of the National Response



Annex 4. References

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