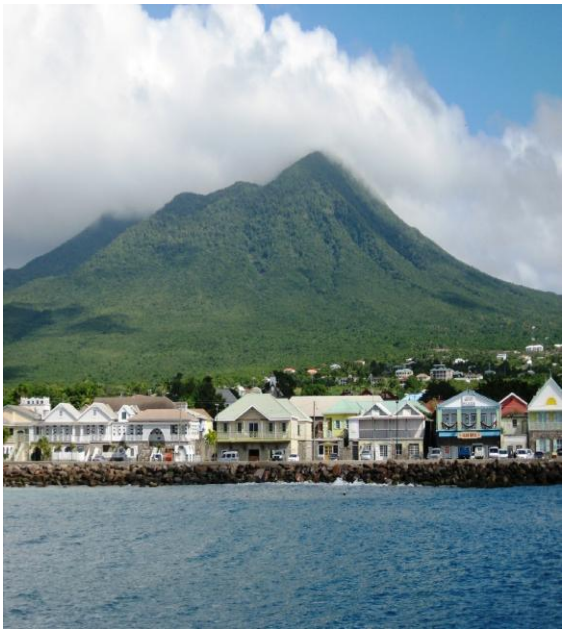
GLOBAL AIDS RESPONSE PROGRESS
2014 REPORT



ST. CHRISTOPHER (ST. KITTS) & NEVIS
NATIONAL AIDS PROGRAMME

National AIDS Programme, St. Kitts & Nevis

Country Progress Report

To the Secretary General of the United Nations

On the United Nations General Assembly Special Session

Reporting Period: January 2013 – December 2013

Submission Date: March 31, 2014

Ministry of Health

St. Kitts & Nevis

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Acknowledgements

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic(s)
ART	Antiretroviral Therapy
ARV	Antiretroviral
CARPHA	Caribbean Public Health Agency
CHAA	Caribbean HIV/AIDS Alliance
CRIS	Country Response Information System
HIV	Human Immunodeficiency Virus
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSM	Men who have Sex with Men
NHP	National HIV Programme
NAS	National AIDS Secretariat
NACHA	National Advisory Council on HIV and AIDS
NACU	Nevis AIDS Coordination Unit
NGO	Non-Government Organization
OECS	Organisation of Eastern Caribbean States
OVC	Orphans and Vulnerable Children
PLHIV	Persons Living with HIV

PMTCT	Prevention of Mother to Child Transmission
S&D	Stigma and Discrimination
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counseling and Testing

I. Status at a Glance

Stakeholder Participation in the Reporting Process

To inform the Global AIDS Response Progress Report, stakeholders from a cross-section of the two islands were engaged. The report and data input were validated by the Chief Medical Officer, Health Information Unit, Clinical Care Coordinators and the National AIDS Program Coordinator. Technical support was received from the Caribbean Public Health Agency (CARPHA).

Documents reviewed to inform the report included:

- National Strategic Plan (2010-2014),
- Monitoring and Evaluation Plan (2010-2014),
- National HIV Reports 2013,
- Measuring Stigma and Discrimination in Health Care Settings in St. Kitts and Nevis Survey (2012/2013),
- Surveillance Report 2013.

Status of the Epidemic

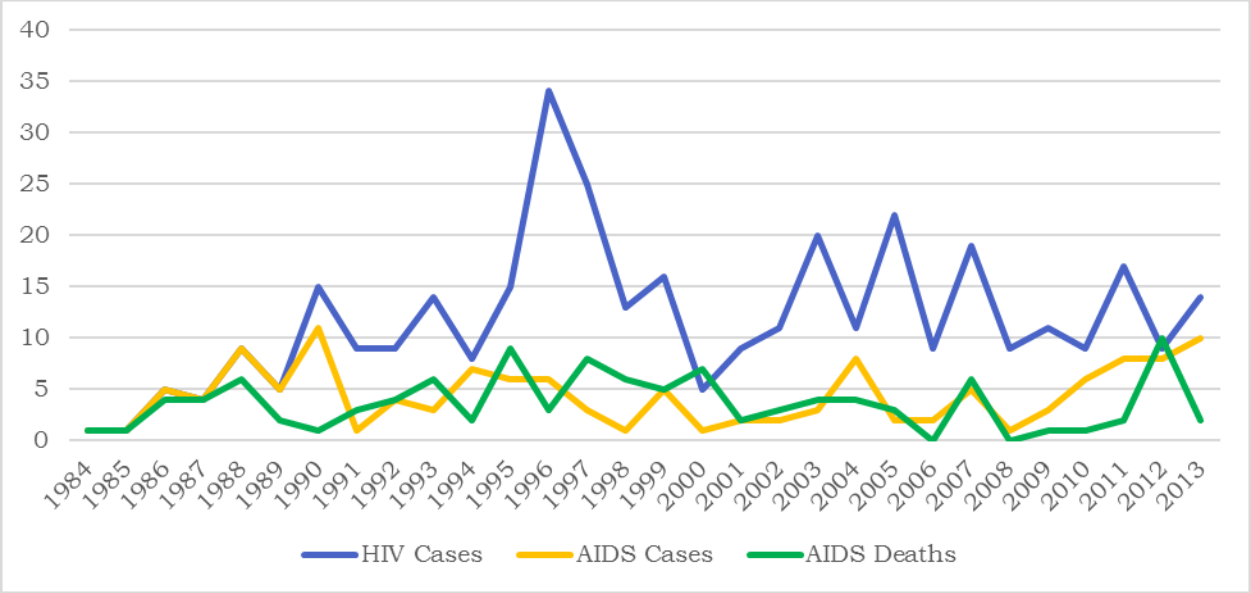
In St. Kitts and Nevis – as elsewhere in the Caribbean – HIV and AIDS has emerged as a major public health and socio-economic problem affecting all walks of society, including vulnerable and most-at-risk groups.

The most recent census in 2011 estimated the population of the twin island federation to be 53,000. The Gross Domestic Product was estimated at 918 million United States Dollars (purchasing power parity) with an economy mainly based on tourism and financial services.

The first case of HIV and AIDS was reported within the federation in the year 1984. Over the period 1984 to 2013, a cumulative total of 358 HIV cases were reported to the Ministry of Health, a cumulative prevalence rate of 0.5 %.

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

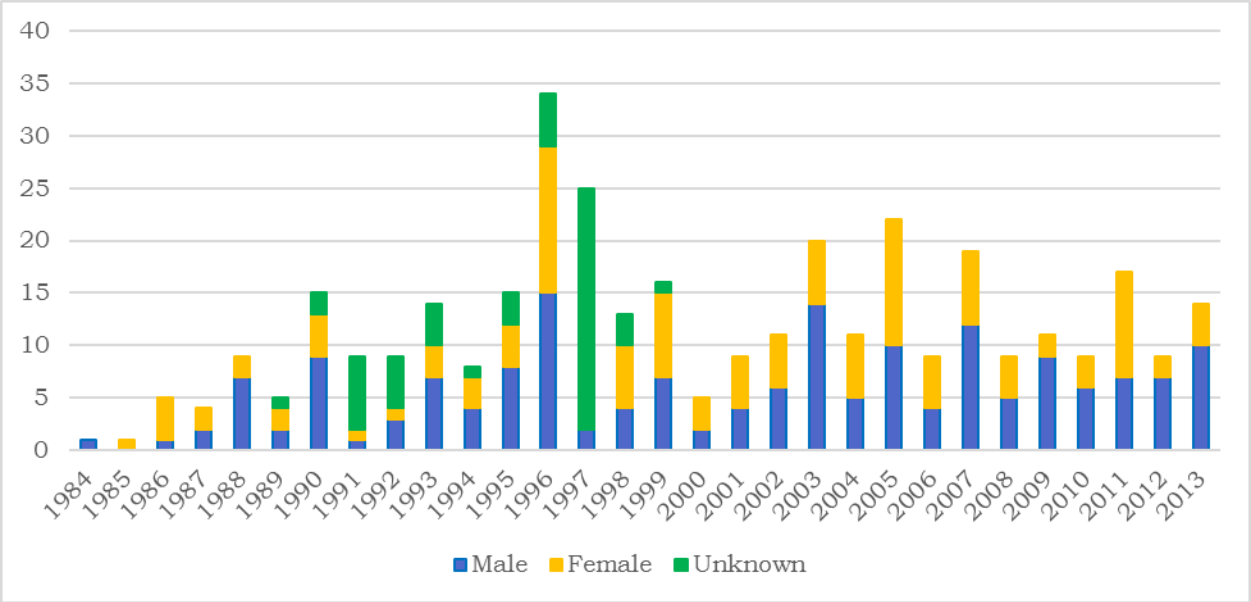
Figure 1: Incidence of HIV Positive Reports and HIV-Related Deaths in St. Kitts & Nevis, 1984-2013



Since the first reported incident of HIV and AIDS there has been significant variability in the incidence rates of HIV. There was a marked rate of 34 new cases in 1996, rising sharply from 15 in 1995 and falling 25 in 1997 the highest rates over the period. In 2000 new cases fell to 5 the lowest since the first cases were recorded. There were 9 and 14 new cases of HIV reported in 2012 and 2013 respectively (see Figure 1), and 10 and 2 HIV-related deaths reported. However, concerns of underreporting exist due to issues of stigmatization of family members as well as failure of the monitoring and evaluation (M&E)

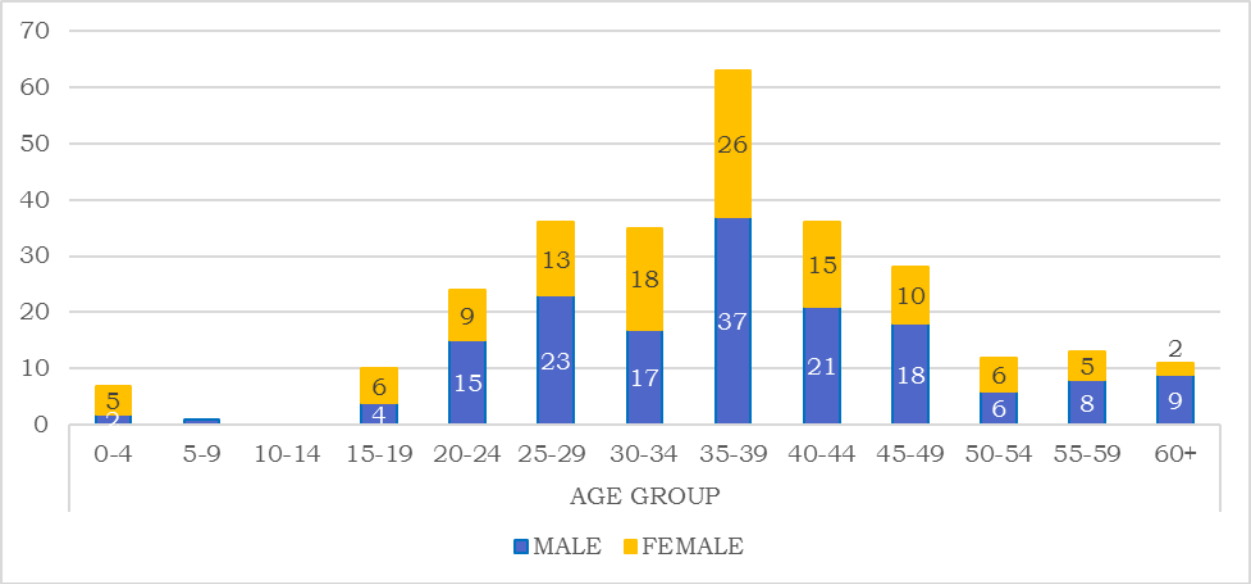
system to link coded names to death certificates. The introduction of case based surveillance will assist with this.

Figure 2: Incidence of HIV Positive Males and Females in St. Kitts and Nevis 1984-2013



From 1984 to 2013, HIV and AIDS have been found to be more prevalent in males than females with a cumulative ratio of 1.3:1 for HIV positive diagnosis and 2.4:1 for AIDS diagnosis (see Figure 2). In 1997, an unusually high number of 'unknown' cases was recorded.

Figure 3: HIV Reported Cases by Age Group and Gender Cumulative Total 1984-2013



Between 1984 and 2013, except for the 0-4 years, 15-19 years, 30-34 years, and 50-54 years age groups, the age and gender distribution among HIV reported cases showed that the prevalence rate for men was higher in most age categories (see Figure 3). The 35-39 age cohort, represented 63 of the 358 cases or approximately 18% of all reported cases. Approximately 66% of HIV cases fell between the ages of 20 and 49.

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

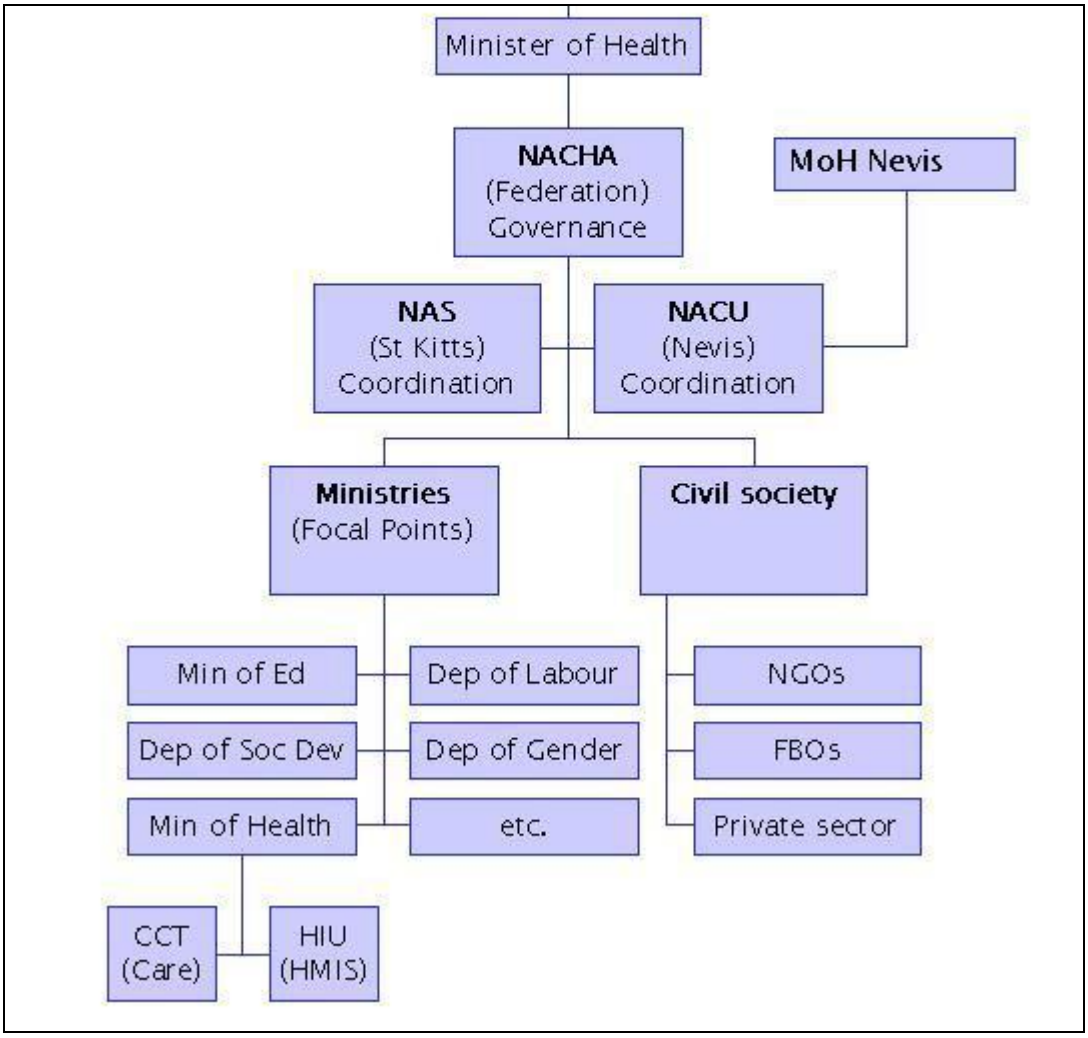
Policy and Programmatic Response

The National AIDS Programme of St. Kitts and Nevis is accountable to the National Advisory Council on HIV and AIDS (NACHA) which has been operational since 2005. This body comprises representation from Civil Society, Persons Living with HIV (PLHIV) and the Government, and has its mandate from the Office of the Prime Minister. NACHA's roles and responsibilities include the coordination of the national response to HIV/AIDS through its implementing partners, the development of national strategic and operational plans and the monitoring and evaluation of the national response.

Two secretariats exist for coordination, technical direction and information provision, the National AIDS Secretariat (NAS) and the Nevis AIDS Coordination Unit (NACU). The sister

isle Nevis, occupies three mandatory plus an ex-officio seat on the NACHA ensuring appropriate representation of the two islands. The organogram in Figure 4 shows structure of the national AIDS response for St. Kitts and Nevis.

Figure 4: Structure of the National AIDS Programme



HIV continues to be a priority for the Government of St. Kitts and Nevis as demonstrated in its efforts to mitigate the impact of the virus on the infected and affected. These efforts are directed by the National Strategic Plan (2010-2014). As the decline in financial resources resonates with the Caribbean region, the Government has strengthened its efforts ensuring the sustainably of the national response to HIV/AIDS. Support of the response is visible through programme management and coordination, the provision of treatment and care of PLHIV and prevention activities such as outreach Counselling and Testing, Information, Education and Communication materials. Provisions are being made

to scale HIV prevention and testing through Point of Care Rapid Testing in non-laboratory settings where persons can receive same day results and the MARPs can assess services.

Civil Society and non-heatlh ministries involvement and commitment continues to be limited despite efforts to engage their participation. To a large extent the national response to HIV/AIDS is driven by the Ministry of Health and other organisations directing, affecting or catering to persons affected. Economic constraints continue to affect the scaling up or intensifying of activities, leaving the response operating at minimum. Being recognized as a "high income" country has seen a reduction in external support available to country.

HIV programmes continue to be a part of the integrated health system. While this lends to sustainability, it also has its challenges of overburdening staff within health to provide more with the minimum resources. Such deficiencies include reduction in behaviour change communication activities, research and data informing activities, and innovative projects or programmes to encourage and maintain positive behaviour. During 2013, the National AIDS Programme benefitted from financial and technical support from the Health Policy Project and Futures Group (USAID) to attend to the issue of stigma and discrimination. This included the training of trainers to become facilitators in stigma reduction. Stemming from data informed by a 2012/2013 "Measuring Stigma and Discrimination (S&D) in Health Care Settings in St. Kitts and Nevis" survey, S&D reduction workshops were organized targeting all levels of health care workers. A total of 566 health care workers were trained in S&D recognition and reduction. The cadre of workers included Auxiliary Workers, Nurses, Emergency Medical Technicians, Laboratory, Radiology and Pharmacy Technicians, Environmental Health Officers, Office Support Staff, Physicians and Administrators.

Additionally, 1,317 students benefitted from health education sessions on HIV/STI and S&D reduction. These included students in primary, secondary and tertiary level institutions. Work places and other organisations such as faith based and community organisations were also educated. The total number of these people trained was 467.

A high level of political commitment exists, particularly at the level of the Prime Minister. Civil Society Organizations though minimal are incorporated into various aspects of the programme. The Ministry of Labour as one of the more active Line Ministries, led the development of the National Workplace Policy and is pursuing its full implementation in the public and private sectors in the near future.

Global AIDS Indicator Data Overview

Targets	#	Indicator	Indicator Value	Notes
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015 *General population*	1.1	% of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	51.48% N=202 (2010)	Same as last reporting
	1.2	% of young men and women aged 15-24 who have had sexual intercourse before the age of 15	13.86% N=202 (2010)	Same as last reporting
	1.3	% of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	15.19% N=454 (2010)	Same as last reporting
	1.4	% of adults aged 15-49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse	53.6% N=69 (2010)	Same as last reporting
	1.5	% of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Data relevant but not available	The question in the BSS was not specific to the time period of 12 months. The actual VCT data Is 1361/1707 which is 79.7%
	1.6	% of young people aged 15-24 who are living with HIV	0 (5/14 1 Female & 4 Males (2013) 35.7% - Actual Routine Reported cases data)	The Value is 0%, which was derived from the Antenatal Clinic data but the actual routine reported Case data reports 5/14 of which 1 female and 4 males, 35.7% in 2013.
Sex workers		The data for indicators 1.7,1.8,1.9 and 1.10 are relevant but not available	Data relevant but not available	Same as last reporting
Men who have sex with men		The data for indicators 1.11, 1.12, 1.13, 1.14 are relevant but not available	Data relevant but not available	Same as last reporting
Testing and Counselling	1.15	% of health facilities that provide HIV testing and counselling services	80% N=20 (2011) 2013	Same as last reporting
	1.16	Number of women and men aged 15 and older who received HIV testing and counselling in the past 12 months and know their results	178 (2011) 1361 (2013)	Not GARP indicator
Sexually Transmitted Infections	1.17	% of women accessing ANC services who were tested for syphilis at first ANC visit	Data relevant but not available 367/502 73.1%	Not GARP indicator
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015	2.1	The data for indicators 2.1, 2.2, 2.3, 2.4, 2.5 are not applicable	Data not applicable	Same as last reporting
Target 3: Eliminate	3.1	% of HIV-positive pregnant women who receive antiretrovirals to reduce the risk	100% N=3 (2011)	NO cases for 2013

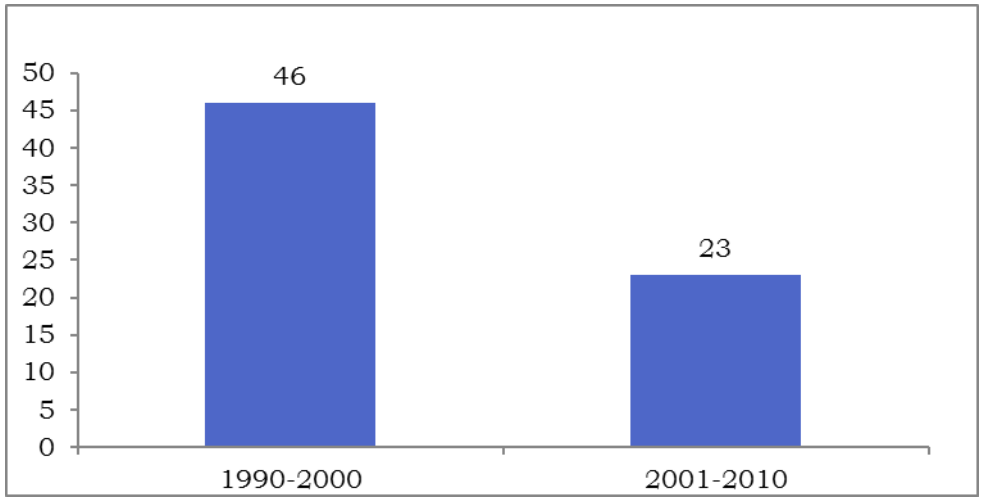
mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths		of mother-to-child transmission	N=0 (2013)	
	3.2	% of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Data relevant but not available	NO cases for 2013
	3.3	Mother-to-child transmission of HIV (modeled)	Data relevant but not available	
	3.4	Pregnant women who know their HIV status	465 N=548 (2011) N=390 (2013)	
	3.5	% of pregnant women attending ANC whose male partner was tested for HIV in the last 12 months	Data relevant but not available	
	3.6	% of HIV-infected women assessed for ART	100% N=3 (2011) N=0 (2013)	NO cases for 2013
	3.7	Infants born to HIV-infected women receiving ARV prophylaxis for prevention of mother-to-child transmission.	100% N=3 (2011) N=0 (2013)	NO cases for 2013
	3.8	Infants born to HIV-infected women who are provided with ARV	0 N=0 (2011) N=0 (2013)	NO cases for 2013
	3.9	% of infants born to HIV-infected women started on CTZ prophylaxis within 2 months of birth	100% N=3 (2011) N=0 (2013)	NO cases for 2013
	3.10	Distribution of feeding practices for infants born to HIV-infected women at DPT3 visit	N=3 All were replacement breast feeding (2011) N=0	NO cases for 2013
	3.11	Number of pregnant women attending ANC at least once during the reporting period	548 (2011) 502 (2013)	
	3.12	% of health facilities that provide virological testing serves for diagnosis of HIV in infants on site or from dried blood spots	0 N=0 (2011) N=0 (2013)	NO cases for 2013
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015	4.1	% of eligible adults and children currently receiving antiretroviral therapy	98% N=51 (2011) 90.9% N=50	
	4.2	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	100% N=7 (2011) 37.5% N=3 (2013)	A total of 7 where 3 is still currently on treatment, 2 died and 2 lost to follow up
	4.3	Number of health facilities that offer ARV	N=2 (2011) 2013	
	4.4	% of health facilities dispensing ARV that have experienced a stock-out of at least one required ARV in the last 12 months	0 N=2 (2011)	
	4.6	% of adults and children enrolled in HIV care and eligible for CTX	96.2% N=52 (2011) Data	

			relevant but not available	
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015	5.1	% of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	0 N=0 (2011) 2013	
	5.2	Number of health care facilities possessing ART services for PLHIV with demonstrable infection control practices that include TB control	N=2 (2011) 2013	
	5.3	% of adults and children newly enrolled in HIV care starting IPT	Data not relevant	Data not available. Still have the problem of Doctors not reporting.
	5.4	% of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	Data relevant but not available	
Target 6: Reach a significant level of annual global expenditure (US$22.24 billion) in low- and middle-income countries	6.1	Domestic and international AIDS spending by categories and financing sources	See appendix	
Target 7: Critical Enablers and Synergies with Development Sectors	7.1	National Commitment and Policy Instruments	See appendix	
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Data relevant but not available	
	7.3	Current school attendance among orphans and non-orphans aged 10-14	0 (2011) 2013	
	7.4	Proportion of the poorest households who received external economic support in the last 3 months	Data relevant but not available	

II. Overview of the AIDS Epidemic

The year 1984 marked the first HIV/AIDS case in the Federation of St. Kitts and Nevis. Since then there has been a steady increase in number of new cases. Between 1984 and 2013, there were 358 documented cases of HIV infection of which 133 progressed to AIDS.

Figure 5: HIV-Related Mortality by Decade 1990-2010



During the same time period 110 persons died from AIDS-related illnesses. The annual prevalence of AIDS-related deaths has remained at 5 or less for the last 10 years (2002-2011), with 10 and 2 deaths recorded in 2012 and 2013 respectively. When compared to the previous decade, there is a decrease by one-half in the HIV-related deaths (see Figure 5). In spite of the concerns regarding underreporting, this decline can be reasonably attributed to improved treatment access, increase in campaigns encouraging persons to get tested as well as the availability of free anti-retroviral therapy within the Federation.

Due to the variability in the reported number of cases between years, no clear trend can be described from the annual reported number of HIV cases. In 2012 and 2013 respectively, there were 9 and 14 reported HIV cases, representing incidence rates of 17.3 and 32 per 100,000 populations.

In the last two years (2012 and 2013), 17 males and 6 females were tested positive for HIV. There is a preponderance of males who are infected with the disease.

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

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

In 2013, 5 persons living with advanced HIV disease were accessing medical care from a cross-section of physicians. Of this number, 50 were receiving anti-retroviral therapy (ART). St. Kitts and Nevis has made significant progress in ensuring that persons living with HIV/AIDS are able to receive free of charge anti-retrovirals and supplements necessary to live healthy and productive lives.

From 2012 to 2013 there has been a 56% increase in the number of new HIV infections reported, from 9 new cases in 2012 to 14 new cases reported in 2013 (see Figure 2). There was also a 25% increase in the number of AIDS cases from 2012, where 8 cases were reported,to 2013, where 10 cases were reported (see Figure 1). However, after a spike in 2012 where 10 AIDS-related deaths were reported, 2013 saw an 80% decrease in AIDS-related deaths, with 2 cases of deaths reported (see Figure 1).

III. National Response

VCT Efforts

VCT efforts continue to be a major thrust of the National AIDS Programme. HIV Rapid Testing continues to be offered at regular intervals in communities and on national designated days. In 2013, 1,919 persons were counselled and tested compared 1,890 in 2012. Testing continues to be dominated by females, however, more males are presenting with HIV (2012 & 2013 HIV data).

Figure 6: Overall Counselling and Testing Uptake for 2012 & 2013

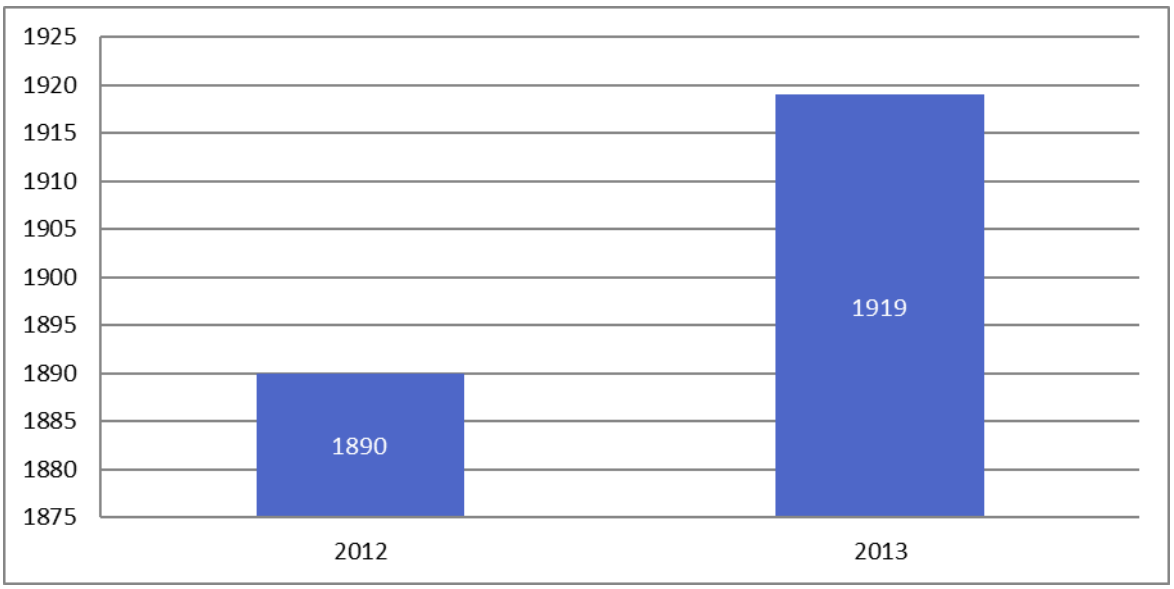


Figure 7: Counselling and Testing Uptake by Gender

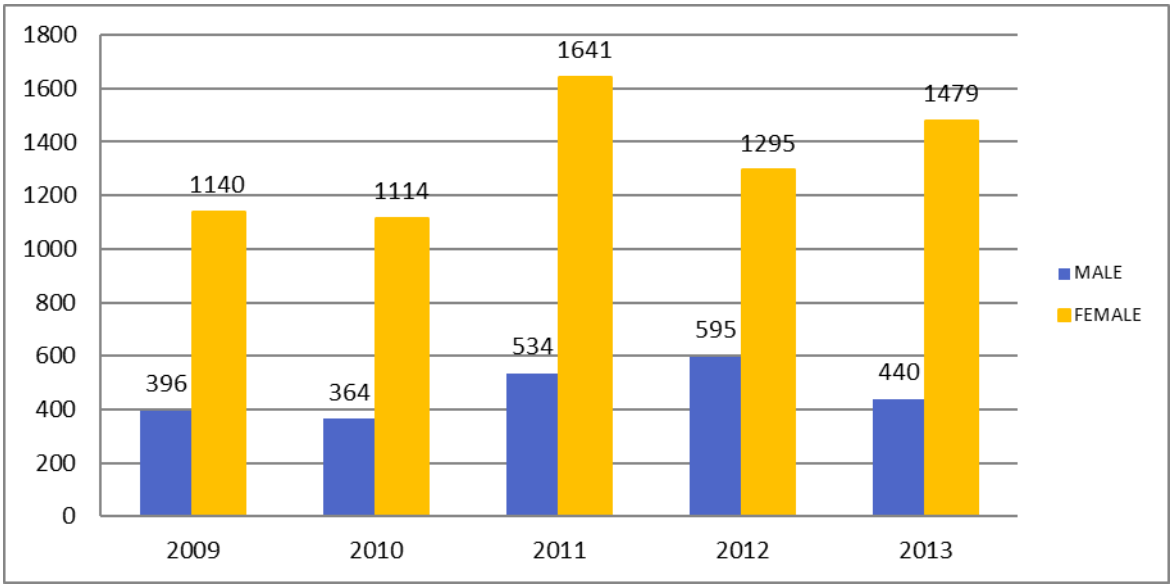
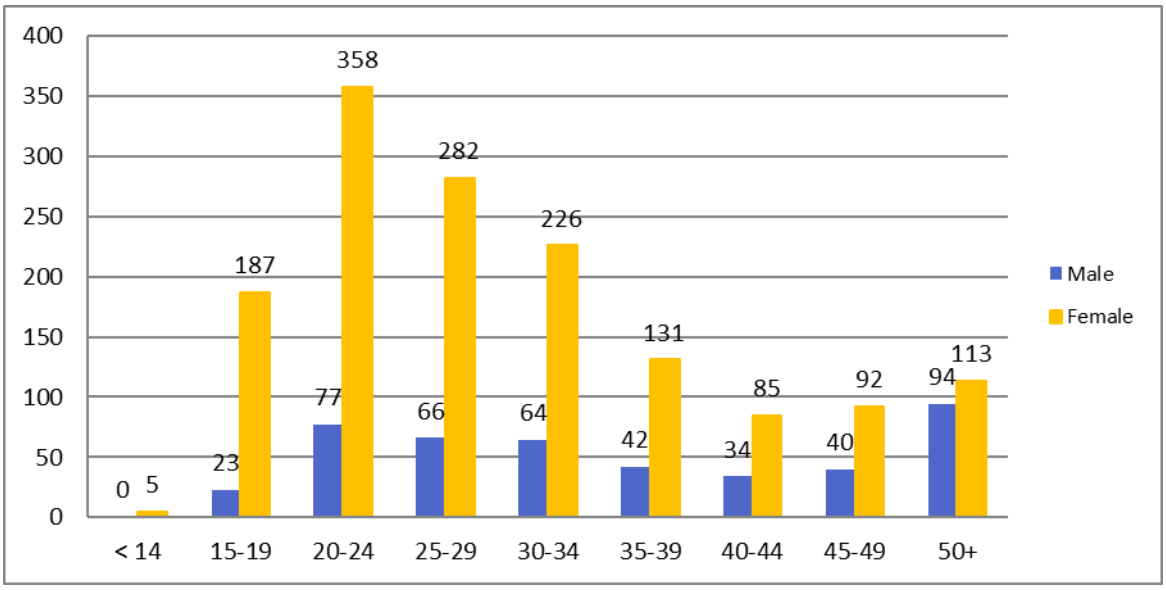


Figure 8: Counselling and Testing Uptake by Age and Sex (Period)



Gender Issues

Data presented on an annual basis continues to show that more women are testing and accessing health services. Strategies are being identified to address the gap, whereby service will be designed to cater to the specificities of men and increase their access to care, including HIV testing. These strategies include meeting men in their own settings, environments and in places of leisure.

The National AIDS Programme continues to collaborate and strategize with the Department of Gender Affairs to identify and address issues as they surface. Enacted legislation and policies protecting the rights of the women continue to be seen as major achievements in addressing gender equality. The Minister of Health and Gender Affairs, as a female is a strong proponent of advancing the status of women, addressing their specific issues and demonstrating the highest level of political will.

The Ministry of Gender Affairs leads this cause by offering of gender based services including counseling, mediation, legal and social assistance for victims of gender based abuse and violence. This Ministry also works closely with the Special Victim Unit who has been trained in assessing and responding to domestic and gender based violence. This Unit comprises trained persons within the police and fire departments, nurses, school guidance counselors, an ombudsman, other government employees, the private sector, faith-based and civil society organizations.

MARPs

Information on the sero-prevalence of Men who have Sex with Men (MSM) in St. Kitts and Nevis continues to be at best presumptuous as there is still limited data to inform the National Programme on the number of HIV positive MSM within the Federation. MSM programming continues to be at best generalized through the National AIDS Programme. Partnership with the Caribbean HIV AIDS Alliance (CHAA) and others continues in addressing the gaps of reaching MARPS. One such strategy is the engagement and support of the Doctorate in Public Health/Caribbean Regional Training and Technical Assistance Project to equip the NAS and Ministry of Health prevention team with basic behavioural

research skills including skills to execute the Priority for Local AIDS Control Efforts to provide the evidence for conducting site based interventions with the most vulnerable. This activity is scheduled to take place in 2014.

The National AIDS Secretariat through the Ministry of Health is also working towards increasing testing among MARPs to provide data through Point of Care Testing. Having such a system in place will enable MARPs to access testing in environments that they are comfortable. Additionally data about incidence among MARPs can be available to inform the National Programme.

Treatment, Care and Support

Treatment, care and support for PLHIV are managed through both the private and public sectors. A clinical management team comprising of various expertise oversees the comprehensive management of PLHIV. The team is managed by Clinical Care Coordinators on both islands. ART is made available free of cost to all PLHIV and is accessible at two points of service. However, patients have the freedom to seek medical care at any physician of their choice.

Patients are tracked through a standardized paper-based system. While having some merits, this mechanism has proven to be challenging in the collection of data from some physicians. Despite trainings and orientations to the system, there still exist inadequate data input which makes it difficult to ensure clinicians are adhering to standardized care and management to PLHIVs.

Efforts are being made to address the gaps in the care, treatment and support programme where a new Clinical Care Coordinator has been appointed. Plans are in place for the development and integration of an HIV/STI plan and to continually reorient and train clinicians on this. Additionally, HIV/STI/TB Case based surveillance will be implement by third quarter 2014. Partnership has been brokered with the Department of Social Welfare who is committed to providing nutritional and care packages for PHLIV in need. The Ministry of Health and others have been trained in providing psycho-social support and helping PLHIV to better adjust and manage their illness.

IV. Best Practices

Following the review of key findings in a 2012 survey to measure Stigma and Discrimination in health care facilities in St. Kitts and Nevis, the Ministry of Health and the National AIDS Programme through the support of the USAID/Health Policy Project, emabarked on a training intervention to ensure that all levels of workers in both private and public health facilities, were adequately trained in identifying, addressing and reducing S&D in health facilities.

The trainings were specifically tailored to the varying levels of workers. The methodology is comprised of:one day interactive workshops and utilised strategies including group work, trigger scenario vidoes, illustrative pictures, games, personal refelction and introspection. Topics covered included: Basic HIV Facts; Understanging Human Rights; Challenging S&D in workplaces; and, Naming HIV and Key Population S&D. At the conclusion of the workshop participants were encouraged to sign a Charter for Change and work together crafting their understanding and vision of a health facility without stigma.

Post-training evaluations indicated that participants felt that the training had a positive impact on helping them better understand, identify, address and challenge S&D.

In addition to this training, the MoH and National HIV Programme (NHP) tackled S&D in health care settings by hosting a one-day training and consultative workshop on Codes of Conduct within Health Facilities. This activity was also undertaken with support of USAID/Health Policy Project. Through this session a Code of Conduct Posters aimed at informing the general public of the expected behaviour of the health facility staff were developed. The posters encourage the public to report S&D violations and/or complement facilities and staff as examples of good practice. The posters are expected to be publicly displayed in the near future. An evaluation will be conducted through the NHP.

V. Major Challenges and Remedial Actions

Programme Coordination And Management	
Challenges	**Remedial Actions**
Inadequate human resources to effectively coordinated national response.	Ministry of Health gives consideration and attention to the recruitment of additional staffing for the National AIDS Programme. Where recruitment is not possible or limited consideration needs to be given to time sharing arrangements among trained staff to provide the necessary skills and services required.
Absence of strong civil society involvement and presence in national response.	Needs assessment of civil society organisations. Development of civil society engagement plan.
Inadequate line ministries "buy in" and involvement.	Mandatory Cabinet approved inclusion of HIV/STI line item in ministries annual budget.
Inadequate skilled and appropriated human resource.	Competency evaluation and training plan for staff to be developed.
Limited financial resources to fully operationalize HIV Strategic Plan.	Sustainability and donor transition plan be developed.

Policy And Legislation	
Challenges	**Remedial Actions**
Absence of legislation on S&D (re: health status and sexual orientation).	The enactment of legislation that repeals laws which discrimate and supports stigma especially among MARPS.

Prevention	
Challenges	**Remedial Actions**
Inadequate and absence of key sero-prevalence data on vulnerable populations.	The conceptualising and implementation of interventions to address MARPs.
Lack of structured programmes for out of school youths.	The development and implementation of sustainable programmes in partnership with other stakeholders such as Departement of Youth, Education and other Civil Society Organisations.
Lack of Prevention Plan to coordinate prevention activities and effective behaviour change.	Development and implement of Prevention Strategy/Plan to guide prevention activities.

Treatment, Care And Support	
Challenges	**Remedial Actions**
Poor standardization of care and treatment to PLHIV.	The provison of Continual Medical Education to sensitize clinicians on emerging HIV issues and updates. Regualr training and promotion of National Policies and manuals.

Monitoring And Evaluation	
Challenges	**Remedial Actions**
Inadequate M&E structure and Unit.	Restructuring of Unit with requisite staff and skills to improve the demand for data and strategic information.

VI. Support from Development Partners

Key Support Received

Support Received in 2013	Implementing Partners	Developing Partner
Technical and financial assistance to conduct National Health Accounts and HIV Sub-Accounts	• University of West Indies HIV/AID Response Programme • PEPFAR	PEPFAR
Technical and financial assistance to conduct S&D reduction training with health facility staff	• Health Policy Project	USAID

Further Support from Development Partners

Support is required in developing and implementing research for MARPs, strenthening behaviour change strategies and in reaching key populations.

Data gaps still exist especially for MARPS. Support is needed working with other Eastern Caribbean States to formulate a Research Agenda and corresponding plan for addressing the research and data gaps to provide vital information to inform the national response.

Behaviour change modification strategies also need support. The available data indicates that there is wide spread knowledge on HIV transmission and that persons are able to combat HIV myths and misconceptions, but knowledge is not resulting in people practicing safer sex (using a condom and testing for HIV and STIs). This area is critical for strenthening of the national response is to reduce the incidence of HIV.

The NHP is of the view that support is needed in targeting specific populations using social and communication strategies that are impactful and and leadto behaviour modification.

VII. Monitoring and Evaluation

The Twelve (12) components of a Monitoring & Evaluation System outlines the necessary elements of a functioning system. An assessment of the St. Kitts & Nevis Monitoring & Evaluation Unit and programme was conducted in (2010) with the assistance of the Caribbean Health Research Centre (CHRC), now part of CARPHA. Below details the findings and current situation of the St. Kitts Monitoring & Evaluation System.

Component 1: Organizational Structure

The Ministry of Health in both St. Kitts and Nevis has specific persons assigned to perform the M&E functions for the HIV Programme. HIV partner organizations do not have dedicated M&E focal points of M&E Officers. The exception is the CHAA which has an external M&E officer to fulfill the M&E requirements associated with that project. Other organizations have focal points who contribute to the M&E system through facilitating the collection and reporting of data to the HIV focal point at the National AIDS Programme. The current M&E staff complement is based on fiscal and organizational realities of the country. At present, there is insufficient staff and requisite expertise to fulfill the HIV/AIDS M&E functions in St. Kitts and Nevis.

Component 2: Human Capacity for HIV M&E

Official M&E posts have not been created in St. Kitts. There are therefore no career paths for M&E. There has been no formal assessment of human capacity for M&E and consequently no capacity development plan. The M&E capacity of selected staff members has been developed utilizing support from M&E technical support agencies in the region. The technical requirements of M&E posts, functions and structure are well understood at the policy level. There is also strong support for the development of human capacity for M&E. Consequently, the M&E Officer has benefitted from several M&E training opportunities, preceptorships and mentorship programmes.

Component 3: Partnerships

There are no national M&E or Health Sector Technical Working Groups in St. Kitts and Nevis. The M&E plan provides guidance on the roles and the responsibilities of the HIV/AIDS M&E Technical Working Group in addition to its structure and composition. Discussions are currently being held with regards to the composition of a comprehensive Technical Working Group to monitor and evaluate the entire Health Systems.

Component 4: M&E Plan

The St. Kitts and Nevis M&E Plan will expire in 2014 and a new plan will be developed. This plan will focus on monitoring the HIV Programme along with the entire health system. It is anticipated that this responsibility will fall under the domain of the Health Planning Unit of the Ministry of Health. This new plan will complement the revision and development of the new HIV National Strategic Plan which also expires in 2014. The M&E Plan will focus on monitoring donor and international agencies with great emphasis on national indicators and priorities.

Component 5: Costed National M&E Work Plan

The new M&E Plan for the HIV Programme and Health will be costed and a two-year Implementation Plan will be developed in the first instance.

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

Stakeholders at all levels are familiar with M&E and its importance. There is currently wide acceptance of M&E as a part of a good functioning health system. Some areas of Health, for instance the National AIDS Programme, are more advanced in the actualizing of M&E functions. The Ministry of Health will address this through the development and broad dissemination of the comprehensive M&E Plan. Efforts have been made to train persons outside of the National AIDS Programme/Secretariat in basic M&E and it is anticipated that many of those participants will be able to benefit from advance M&E training in the not too distant future with the support of CARPHA.

Component 7: Routine Programme Monitoring

In St. Kitts and Nevis, limited written guidelines exist for procedures regarding the recording, collection, and collation of data at national and health facility levels, however,

these guidelines are donor-specific (GFATM and UNGASS). Double-counting is minimized through the use of a national client coding system. While this coding system is used consistently within the public sector, there is inconsistent use of the code among private sector providers. No existing system of enforcement is available to facilitate routine use of the code among private sector physicians or private sector providers of laboratory services. Standardized forms for data recording and collection are used among some providers of services in St. Kitts and Nevis. VCT data is reported separately by the National AIDS Secretariats of St. Kitts and Nevis. Steps are underway to harmonize data collected for HIV Care and Treatment Patient Monitoring through the use of HIV/STI/TB Case Based Surveillance.

Component 8: Surveys and Surveillance

At the Ministry of Health, a limited inventory of HIV related surveys exists within the Federation of St. Kitts and Nevis. A repository of these surveys does not yet exist within the National AIDS Programmes of St. Kitts or Nevis. While survey-based indicators are included in the M&E Plan, related surveys are still to be completed for the current reporting on these indicators. Efforts are being made for the consideration of a ***Research Agenda*** and support of the Health Information Unit to coordinate and implement surveys as required and financially viable.

Component 9: Databases

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

Component 10: Supportive Supervision and Data Auditing

To date, no written manuals or protocols exist for supportive supervision and auditing of routine HIV service data. However, verification of the quality, accuracy, and completeness of routine monitoring data is conducted by the M&E Officer of Nevis and the data entry clerk of St. Kitts performing M&E functions. Supportive supervision is conducted as part of the routine data collection process particularly for preparation of the quarterly report to the Organisation of Eastern Caribbean States (OECS). Data auditing is conducted primarily at the National HIV AIDS Secretariat, Clinical Care Coordinator and the Chief Medical Officer. Specific to HIV reporting this process is synchronized with the time frames set for the submission of quarterly reports to the OECS.

Component 11: Research and Evaluation

There is currently no inventory of research and evaluation conducted in St. Kitts and Nevis. A strategy for commissioning research and evaluation within the Federation does not exist. While the Chief Medical Officer has the authority to review and approve research projects, there is no coordination/oversight body nor is there an ethics review committee. The Caribbean Health Research Council has provided support to St. Kitts with its Essential National Health Research activities in the past. Research in the Federation is largely externally driven and supported and thus tends to adhere to international standards and guidelines.

Component 12: Data Dissemination and Use

The area of data dissemination and use continues to be a challenge in St Kitts and Nevis. With the development of the comprehensive M&E Plan it is anticipated that there should be greater stakeholders' participation and involvement and the challenge of data flow, dissemination and use would be address. This would satisfy stakeholders whereby they would be a part of the process.