

# UNGASS 2008 Saint Lucia



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

Country Progress Report  
Saint Lucia

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[ungassindicators@unaids.org](mailto:ungassindicators@unaids.org)

Prepared by Dr Marcus Day

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## I. Status at a Glance

### *Background Country Data*

The small island developing state Saint Lucia, with a total land area of 616 sq km and a population of approximately 170,649, is located in the Eastern Caribbean. It is a member of the Organisation of Eastern Caribbean States (OECS), the Caribbean Community and Common Market (CARICOM), the Organisation of American States and the Commonwealth of Nations.

HIV/AIDS in Saint Lucia falls within the category of concentrated, low prevalence epidemics. During the late 1980s and early 1990s the disease was characterized by relatively low levels of infection among STI patients and little, if any infection among pregnant women and blood donors.

The AIDS Epidemic Update 2006 reported an average adult HIV seroprevalence of 1.2% (range 0.9%–1.7%) in the Caribbean region. That report stated that as the epidemics in the region evolve, more women are being infected and the number of new infections among women now outstrips that among men

Currently while HIV infection continues to be characterised as being transmitted largely through heterosexual intercourse, in the Saint Lucian context this broadly includes:

- transactional sex where no cash is exchanged but gifts are given and support supplied,
- sex for drugs (crack cocaine) transactions and
- more traditional sex work (exchanges for cash) either by primarily foreign women working in brothels and dance halls or largely locals working areas frequented by tourists.

In addition there is a hidden but believed to be substantial population of men having sex with men exclusively (MSM) and bi-sexual men who have sex with both sexes. Male bisexuality has created a bridge for the virus to migrate between the sexes. Since female sex work, male on male sexual contact and crack use are heavily stigmatised and for the most part illegal<sup>1</sup> this significant but neglected aspect of the epidemic remains largely unstudied.

### *Status of the Epidemic*

Studies to determine Saint Lucia's HIV prevalence rate have not been conducted. Rates from .22% to .51% have been applied to the epidemic with some quoted prevalence rates high as 1.8% said to represent the top end of the range. With poor surveillance of groups involved in high-risk behaviours, under-reporting due to

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<sup>1</sup> While male on male sexual contact is not illegal, anal intercourse (buggery) continues to be listed in the Criminal Code of 2002 as an offense.

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stigma and local modelling non-existent, we are unable to determine the actual prevalence rate though the available data shows a steady increase of new cases of HIV and AIDS from 1985.

There were 24 individuals with CD4 counts below 200 in 2007 compared to 27 cases of AIDS in 2005. There were 8 (5 males, 3 females) AIDS related deaths recorded in 2007. Of the 63 new HIV cases diagnosed in 2007 slightly over half were (n=32) registered at the clinic.

There is a decline in the number of cases seen in children reflecting an increasing success of the PMTCT programme. Two children under 6 were initiated on ART in 2007.

Sixteen women were patients in the PMTCT programme during 2007, 11 of which received HAART. Of the 16, one woman was diagnosed at delivery, two chose to terminate the pregnancy, two miscarried (one of which had been on HAART). Of the children, five tested negative, four had notations that they had not been tested one was lost to follow-up and at the close of the year three had yet to deliver.

Heterosexual transmission accounts for 25% of all reported cases reported. And while 55% of reported cumulative HIV cases, the mode of transmission is unknown more rigorous data collection at the time of a patient's first visit has reduced this "unknown" category substantially in recent years.

Males not only out rank females in cumulative cases<sup>2</sup> of HIV 50.4% vs. 43.4%, but this margin had increased in new cases in 2007 (57% vs. 41%)<sup>3</sup>. This data counters the trend of the feminisation of the epidemic so widely discussed. While men still out rank females in new cases of HIV, females still predominate in all age groups except the over 45+.

The most impacted group for HIV infection is the age group 25-29 females 7.73% and males 40-44 9.57% (see table in Annex 4).

### *Stakeholder Involvement in the Reporting Process*

In addition to an extensive desk review of available literature, a number of meetings and interviews were conducted to gather the data that was used to populate the indicators and compile this report. In January 2008, prior to the submission of the completed indicators and this report, two consultations were held to present the findings and solicit inputs. The outcome of those consultations was used to refine the final report. A list of the participants of those meetings is attached as Annex 6

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<sup>2</sup> 1985 to present – Figures from MoH NAP statistics

<sup>3</sup> 2007 Draft Clinical Care Report

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### *Policy and Programmatic Response*

The National Coordinating Committee on HIV/AIDS (NACCHA) was established in 2003 to advise and support the National AIDS Programme Secretariat (NAPS). Both the Secretariat and NACCHA are located within the Ministry of Health, Human Services and Family Affairs (MOH). However, their purview extends beyond that Ministry to encompass oversight of the full national HIV/AIDS response. The Secretariat is headed by Director. NAPS is the coordinating body for all HIV and AIDS efforts and works closely with other government ministries, PLHIV and civil society to implement HIV/AIDS strategies and programmes. It also serves as the focal point for the collection and dissemination of information about HIV and AIDS, other STI and related issues

The National AIDS Programme (NAP) is the Ministry of Health's response to HIV/AIDS in the health sector and works closely with the NAPS to coordinate the response both within the Ministry and beyond.

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

An Information and Education Coordinator takes the HIV prevention message to the general public using various means for popular dissemination and an M&E Coordinator tracks the progress of the response and its impact.

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Code	Indicator	Status	
<b>Government HIV and AIDS Policies</b>			
1	AIDS Spending	Completed	
<b>National Programme Indicators</b>			
3	Blood Safety	Completed	100.00%
4	HIV Treatment: Antiretroviral Therapy - 2006	Completed	44.64%
4	HIV Treatment: Antiretroviral Therapy - 2007	Completed	18.75%
5	Prevention of Mother-to-Child Transmission - 2006	Completed	64.29%
5	Prevention of Mother-to-Child Transmission - 2007	Completed	78.57%
6	Co-Management of Tuberculosis and HIV Treatment	Completed	50.00%
7	HIV Testing in the General Population	Completed	36.00%
8	HIV Testing in Most-at-Risk Populations - Sex Workers	Completed	No data available
8	HIV Testing in Most-at-Risk Populations - Men Who have Sex with Men	Completed	No data available
8	HIV Testing in Most-at-Risk Populations - Injecting Drug Users	Completed	100.00%
9	Most-at-risk Populations: Prevention Programmes - Sex Workers	Completed	No data available
9	Most-at-risk Populations: Prevention Programmes - Men Who have Sex with Men	Completed	No data available
9	Most-at-risk Populations: Prevention Programmes - Injecting Drug Users	Completed	No data available
10	Support for Children Affected by HIV and AIDS	Completed	69.00%
11	Life Skills-based HIV Education in Schools	Completed	90.83%
11	Life Skills-based HIV Education in Schools	Completed	96.34%
11	Life Skills-based HIV Education in Schools	Completed	68.97%
<b>Knowledge and Behaviour Indicators</b>			
12	Orphans: School Attendance - Part A	Completed	100.00%
12	Orphans: School Attendance - Part B	Completed	56.80%
13	Young People: Knowledge about HIV Prevention	Completed	59.00%
14	Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers	Completed	No data available
14	Most-at-risk Populations: Knowledge about HIV Prevention - Men Who have Sex with Men	Completed	Missing
14	Most-at-risk Populations: Knowledge about HIV Prevention - Injecting Drug Users	Completed	13.00%
15	Sex Before the Age of 15	Completed	26.00%
16	Higher-risk Sex	Completed	35.40%
17	Condom Use During Higher-risk Sex	Completed	44.80%
18	Sex Workers: Condom Use	Completed	No data available
19	Men Who Have Sex with Men: Condom Use	Completed	73.70%
20	Injecting Drug Users: Condom Use	Completed	No data available
21	Injecting Drug Users: Safe Injecting Practices	Completed	Not relevant
<b>Impact Indicators</b>			
22	Reduction in HIV Prevalence	Completed	0.51%
23	Most-at-risk Populations: Reduction in HIV Prevalence - Sex Workers	Completed	No data available

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23	Most-at-risk Populations: Reduction in HIV Prevalence - Men Who Completed have Sex with Men	No data available
23	Most-at-risk Populations: Reduction in HIV Prevalence - Injecting Drug Users	7.50%
24	HIV Treatment: Survival After 12 Months on Antiretroviral Therapy	98.00%

### UNGASS Indicator Data – Overview Table

Indicator # and Name		Achievements (2007)	Notes
#3	Blood Safety #3 Percentage of donated blood units screened for HIV in a quality-assured manner	100% of blood screened	
#4	HIV Treatment: Antiretroviral Therapy #4 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	72 Individuals on ARVs 40 females and 32 males	No models exist to determine estimated population with advanced HIV infection
#5	Prevention of Mother to-Child Transmission #5 Percentage of HIV-infected pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission	78.6% of HIV+ women receiving ARV	
#6	Co-Management of Tuberculosis and HIV Treatment #6 Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	50% of the estimated HIV+ co-infected with TB received treatment	
#7	HIV Testing in the General Population #7 Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	36%	
#8 SW	HIV Testing in Most-at-Risk Populations - Sex Workers #8 Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	No Data Available	Indicator Relevant
#8 MSM	HIV Testing in Most-at-Risk Populations - Men Who Have Sex with Men #8 Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	No Data Available	Indicator Relevant
#8 DU	HIV Testing in Most-at-Risk Populations - Injecting Drug Users #8 Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	100%	
#9 SW	Most-at-risk Populations: Prevention Programmes - Sex Workers #9 Percentage of most-at-risk populations reached with HIV prevention programmes	No Data Available	Indicator Relevant

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<b>#9 MSM</b>	<b>Most-at-risk Populations: Prevention Programmes - Men Who Have Sex with Men #9</b> Percentage of most-at-risk populations reached with HIV prevention programmes	No Data Available	Indicator Relevant
<b>#9 DU</b>	<b>Most-at-risk Populations: Prevention Programmes - Injecting Drug Users #9</b> Percentage of most-at-risk populations reached with HIV prevention programmes	No Data Available	Indicator Relevant
<b>#10</b>	<b>Support for Children Affected by HIV and AIDS #10</b> Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child	69% n=47	
<b>#11</b>	<b>Life Skills-based HIV Education in Schools #11</b> Percentage of schools that provided life skills-based HIV education in the last academic year	90.8% of all schools	have teachers who are trained but it is unknown if they are teaching the subject
<b>#12</b>	<b>Orphans: School Attendance #12</b> Current school attendance among orphans and non-orphans aged 10–14	Orphans - 100% non-orphans 56.8%	
<b>#13</b>	<b>Young People: Knowledge about HIV Prevention #13</b> Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	A range of 94% to 73% correctly answered the questions	56% of the persons answered Questions # 3,4,5 correctly
<b>#14 SW</b>	<b>Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers #14</b> Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	No Data Available	Indicator Relevant
<b>#14 MSM</b>	<b>Most-at-risk Populations: Knowledge about HIV Prevention - Men Who Have Sex with Men #14</b> Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	100% of respondents answered questions 2 and 3 correctly	Survey did not collect data to answer all questions
<b>#14 DU</b>	<b>Most-at-risk Populations: Knowledge about HIV Prevention - Injecting Drug Users #14</b> Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	85% - 43% range on the 5 questions with 13% answering all 5 correctly	
<b>#15</b>	<b>Sex Before the Age of 15 #15</b> Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	26% ALL 32% males 20% females	

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<b>#16</b>	<b>Higher-risk Sex #16</b> Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	<b>35.4% ALL 41.8% males 25.2% females</b>	
<b>#17</b>	<b>Condom Use During Higher-risk Sex #17</b> Percentage of women and men aged 15–49 who have had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse	<b>44.8% ALL 48.3% males 39.1% females</b>	
<b>#18 SW</b>	<b>Sex Workers: Condom Use #18</b> Percentage of female and male sex workers reporting the use of a condom with their most recent client	<b>No Data Available</b>	<b>Indicator Relevant</b>
<b>#19 MSM</b>	<b>Men Who Have Sex with Men: Condom Use #19</b> Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	<b>73.70%</b>	
<b>#20 DU</b>	<b>Injecting Drug Users: Condom Use #20</b> Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	<b>No Data Available</b>	<b>Indicator Relevant</b>
<b>#21 IDU</b>	<b>Injecting Drug Users: Safe Injecting Practices #21</b> Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	<b>No Data Available</b>	<b>Indicator Relevant</b>
<b>#22</b>	<b>Reduction in HIV Prevalence - Youth #22</b> Percentage of young women and men aged 15–24 who are HIV-infected	<b>0.51%</b>	
<b>#23 SW</b>	<b>Most-at-risk Populations: Reduction in HIV Prevalence - Sex Workers #23</b> Percentage of most-at-risk populations who are HIV-infected	<b>No Data Available</b>	<b>Indicator Relevant</b>
<b>#23 MSM</b>	<b>Most-at-risk Populations: Reduction in HIV Prevalence - Men Who Have Sex with Men #23</b> Percentage of most-at-risk populations who are HIV-infected	<b>No Data Available</b>	<b>Indicator Relevant</b>
<b>#23 DU</b>	<b>Most-at-risk Populations: Reduction in HIV Prevalence - Injecting Drug Users #23</b> Percentage of most-at-risk populations who are HIV-infected	<b>7.5% total, 6.8% males, 11.1% females</b>	
<b>#24</b>	<b>HIV Treatment: Survival After 12 Months on Antiretroviral Therapy #24</b> Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	<b>98% total, 100% males, 96.6% females</b>	

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## III. Overview of the AIDS Epidemic

Saint Lucia, a small island developing state is an island nation located in the Eastern Caribbean Sea (13 53 N, 60 58 W) with a population of 170,649 (July 2007 est.)<sup>4</sup>. Since attaining independence from the United Kingdom in 1979, the country has functioned as a stable parliamentary democracy, boasting a strong legal and institutional system and public service. Impressive development indicators, including a GDP per capita of US\$6,324; adult literacy of 89 percent and life expectancy of 74.2 years, have contributed to Saint Lucia being ranked 71/177 on the UNDP 2006 Human Development Index which has the country being listed as having achieved medium human development. However, this ranking masks extreme economic and social vulnerabilities, which in turn act as drivers of the country's expanding HIV epidemic.

The Caribbean has the second highest HIV prevalence rate in the world, after sub-Saharan Africa. Saint Lucia's epidemic is potentially significant, although not yet defined as generalised (i.e. HIV prevalence in the general population is not yet above 1%). While Saint Lucia is a middle income country, the 2006 CDB Assessment of Poverty study shows poverty to be on the increase, with 28.8% of the population in 2005-6 living below the poverty line as compared with 26% in 1995. By the end of the 3rd Quarter 2007, six hundred and forty eight (648) HIV cases were diagnosed, Three 341 are AIDS cases, of whom 288 have died, reflecting a cumulative mortality rate of 84 per cent as of September 2007. The first cases of HIV were registered in 1985.

During 2006, 53 new cases of HIV infection were registered (32 male and 20 female, 1 unknown), and 63 new cases during 2007 (36 male and 26 female, an almost 3:2 ratio). 19 individuals died of in 2005 with the introduction of ARV in that year 2005 the death rate has been reduced to 8 as of end of 2007.

As of the end of 2007 the adult HIV/AIDS – adult (20-49 y.) prevalence rate HIV prevalence was estimated to be 0.23% (2007) with the 15 – 24 year old rate set at .51% based pre-natal clinic data<sup>5</sup>

Table 1 New HIV Cases in

	Females	Males	Unknown	Grand Total
2006	20	32	1	53
2007	26	36		63
Total	46	68	1	116

Saint Lucia's epidemic is currently being driven by underlying social and economic factors, including increased poverty, drug trafficking, cocaine use and sex work.

<sup>4</sup> <https://www.cia.gov/library/publications/the-world-factbook/geos/st.html>

<sup>5</sup> National Aids Programme statistic

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The Caribbean has the highest homicide rate in the world<sup>6</sup>, and Saint Lucia has followed this trend with an increased incidence of violent offences in recent years both from domestic violence and drug linked “turf” battles of drug gangs. Trends in HIV transmission are linked to increased poverty and social disintegration, with significantly higher levels of HIV being found in a number of vulnerable population groups. Although population surveillance systems are weak, data suggests much higher levels of HIV infection in the prison population and among non-injecting<sup>7</sup> cocaine users. A seroprevalence survey carried out by CAREC among inmates at the Bordelais Correctional Facility in St Lucia in 2004 found a 2% prevalence rate. This study involved the voluntary participation of 347 male inmates (with approximately 150 inmates opting out). A study conducted in 2007 among 106 homeless and poor crack cocaine users, revealed an HIV prevalence rate of 7.5% and very high rates of other sexually transmitted infections.

Table 2 HIV and STI among cocaine Users

HIV and STI among cocaine Users (N=106) participating in a BSS of homeless and poor crack users in Castries 2007			
	Positive	Negative	No Results
HIV Status	8 (7.5%)	98 (92.5%)	0 (0%)
Hepatitis B	3 (2.8%)	101 (95.3%)	2 (1.9%)
HTLV1	10 (9.4%)	96 (90.6%)	0 (0%)
VDRL	62 (58.5%)	43 (40.6%)	1 (0.9%)

This sero-prevalence and behavioural survey was carried out by the Caribbean Drug Abuse Research Institute as part of a cooperation project of the Caribbean Harm Reduction Coalition’s (CHRC) outreach support programme for homeless drug users. Activities include facilitation of access to antiretroviral treatment for HIV positive clients and adherence counselling in addition to on-going harm reduction services.

There are no data available on HIV rates among sex workers or men who have sex with men in Saint Lucia and this is seen as a serious void when developing evidenced based programming. These are groups known to be at risk in the region; significantly higher rates of HIV have been found in these population groups in other Caribbean countries with similar profiles.

Surveillance (sentinel and population based) systems in Saint Lucia need strengthening. Public free HIV and STI testing is available in Castries at Victoria Hospital daily, and at Dennery Hospital one day every two weeks, Soufriere Hospital and Vieux Fort health centre once weekly. Testing is by Elisa and results are usually available in 2 – 3 weeks which necessitates a return visit to the clinic. There is no simple mechanism to determine which clients returned for their results.

6 Crime, Violence, and Development: Trends, Costs, and Policy Options in the Caribbean, A Joint Report by the United Nations Office on Drugs and Crime and the Latin America and the Caribbean Region of the World Bank, March 2007

7 There have been no reported cases of injecting drug use at the drug treatment centre, in the prison or by the police during drug raids in Saint Lucia.

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Only the patient log book or the individual patient record if a patient returns for their results, requiring extensive review to determine who has returned and who has not.

At the end of 2007 a pilot test of HIV testing in certain primary health centres was being implemented in anticipation of a general roll out of HIV testing throughout all 8 health regions.

Public HIV and STI services are only available in the morning and therefore miss clients such as sex workers and drug users who tend to be nocturnal and “sleep in”. Private labs and physicians charge between \$45 and \$75 for an HIV test. There is a monthly reporting requirement for all labs and physicians to report HIV test results to the National AIDS Programme but these reports are not always received in a timely fashion. In 2007 99+% of pregnant women were reached with HIV testing and or VCT services, and of these, only one opted out from having an HIV test. Of the 16 women in the PMTCT programme in 2007 only one was discovered at delivery. All ante-natal clinic attendees in Vieux Fort received HIV prevention education. In fact one of the reasons more young females are found to be HIV positive while asymptomatic is the early screening provided by the PMTCT programme.

The STI clinic at Victoria Hospital continues to be the leading source of clients referred to the HIV clinic (n=18) followed by cases diagnosed during hospitalisation (n=14), The VH STI clinic at present provides the most consistent source of VCT in St Lucia.

Considering Saint Lucia has a relatively small population living on an island state, with a high annual influx of tourists, the significantly higher rates of HIV infection now found (and expected to be found) in multiple sub-population groups implies a serious trend in the expansion of the epidemic. All vulnerable groups currently identified act as ‘bridging populations’, facilitating HIV transmission to the general adult population.

The availability of additional seroprevalence data during 2006-7 and increased recognition of the vulnerabilities fuelling Saint Lucia’s HIV epidemic provide a window of opportunity for evaluating the current National Strategic Plan during 2008. This will allow for developing annual action plans with budgets for implementing an expanded response over the next three years. This response should be geared towards the achievement of strategically set targets for Universal Access to priority services by 2010, and the increased sustainability of an effective national response by 2015.

### Priority Services for Saint Lucia

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Expanded coverage and availability of services HIV testing and counselling

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

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The control of sexually transmitted infections to prevent HIV transmission

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

Impact of treatment on HIV prevention

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

Strengthening and expanding health systems.

- Decentralized VCT, care and treatment of HIV and OIs

Investing in strategic information to guide a more effective response

- Strengthening of surveillance of the HIV/AIDS epidemic.

### IV. National Response to the AIDS Epidemic

#### *National Strategic Plan*

The current national response is largely funded through a World Bank loan, grant and credit agreement covering October 2004 to June 2009, worth a total of US\$6.4 million. The response also receives funds from a sub-regional grant covering six O.E.C.S. countries under an agreement with the Global Fund to fight AIDS, TB and Malaria (GFATM). In April 2007, St Lucia was one of four countries in the Eastern Caribbean to become newly eligible for a national grant from the Global Fund and plans are in place to submit a grant proposal in 2008.

With the appointment of the Line Ministry and Civil Society Coordinator in the NAPS, additional line ministries are becoming involved in the response. In 2005 the Ministry of Education established a dedicated focal point and a HFLE specialist, both paid for under the World Bank agreement, and formed an AIDS Committee chaired by the Deputy Permanent Secretary. The Ministries of Commerce, Tourism, Finance, Youth and Sports, Social Transformation, Communication and Works, and Public Service all identified HIV focal points during 2007. These ministries are represented on coordinating committee of focal points.

The national response is currently organised around four key strategies outlined in the National Strategic Plan (NSP) 2005-2009 (see below). As such, the NSP will most likely be evaluated and reviewed during 2008, to inform the development and submission of a national five-year proposal to the Fund.

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

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

Four broad strategies:

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

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

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

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

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

### Composition of the NACC

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

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The National AIDS Programme Secretariat (NAPS) acts as the executive arm of the NACC. All posts (see below) are paid under the World Bank agreement.

### Staff composition of National AIDS Programme Secretariat

- 1) Director
- 2) Line Ministry and Civil Society Coordinator
- 3) Health Education Coordinator
- 4) M & E Coordinator
- 5) Information Technology Officer
- 6) IEC Coordinator

Although the national response is not confined to the health sector, the Ministry of Health continues to be the lead ministry in the response. Staffing involved in the HIV response within the Ministry of Health (MoH) include a Director of the National AIDS Programme, a health educator, secretary, two STI nurses, a Clinical Care Co-ordinator, two STI physicians, VCT/PMTCT co-ordinator, two social workers and community health workers.

### *Key Activities 2006-7*

#### Prevention

#### IEC/BCC:

- New focus on a communications strategy and development of HIV and AIDS terminology in Kweyól. While English is the official language of Saint Lucia, Kweyól is the 'cradle language for a majority of the population.
- NAPS Committee established to organize activities linked to special events (carnival, jazz and other festivals). Four soca singers developed awareness lyrics targeting youth. The winning song for the King Crown for Calypso Competition in 2006 featured AIDS educational lyrics.

#### Care and support

- To implement decentralised access to services, more than 20 PLWHA and civil society workers were trained in home-based care in the south of the island during (2006).
- Allowances for school books, uniforms, transportation and food were provided to 62 orphans and vulnerable children affected by HIV, under an inter-ministerial (Education and Health) support programme.
- Access to free medical care (specialty care included) and medications,

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- Nutritional support for families affected by HIV and who meet the financial means test
- Access to support for PMTCT (infant formula)

### *Treatment*

National care and treatment protocols developed and disseminated in 2006.

Treatment is centralised with the main STI and only HIV clinic based at Victoria Hospital run by a part-time Clinical Care Coordinator paid under the World Bank agreement. Antiretroviral treatment is provided free of charge to all patients at the Castries STI clinic. Individuals who select to be treated by a private physician must pay for their services but are provided free ARVs.

An assessment of the health systems infrastructure was conducted as part of a WB review during 2007, including Victoria Hospital and STI clinics – The VH STI clinic was declared inadequate for major refurbishing but received a facelift until a new facility can be indentified. STI/HIV patients continue to receive care under poor physical conditions.

### Counselling and Testing for HIV

In the 4 STI sites noted above free ELISA HIV testing and counselling was provided during 2006-7. Counselling is carried out by community health nurses who have been trained in national VCT protocols/guidelines.

### PMTCT

In 2007 99+%<sup>8</sup> of pregnant women were reached with VCT services, and of these, only one opted out from having an HIV test. PMTCT has assisted in allowing us to diagnose females. They are more willing to access treatment as they care about the possibility of their unborn child contracting the disease.

The three patients who are all known to have had peri-natal transmission are female. The Clinical staff is monitoring the PMTCT programme to see if there is any disproportionate tendency for transmission in one sex over the other.

In 2007 16 women received PMTCT services. Only one case was determined at the point of delivery.

All relevant wards have protocols for the management of HIV positive mothers in hospital, but there was poor communication between the obstetric and paediatric departments during much of 2006-7. Transfer of new-borns from paediatric

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<sup>8</sup> The reason this is not registered as 100% is that a few women continue to birth at home

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departments to community paediatric services, was also assessed to be in need of improvement.

### Post Exposure Prophylaxis

Post Exposure Prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP is provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work. There were 41 incidents potentially requiring PEP that were reported to the MoH during 2007. 29 of those cases received PEP and 11 did not. One person started PEP and stopped due to side effects. All but two persons worked in the health sector. Of those two one was a tourist (child) who was injured with hollow bore needle on beach, the other a hotel guest services attendant who was also injured with hollow bore needle. Both of these cases are indicative of unsafe disposal of injecting equipment. While this could be a simple case of the unsafe disposal of a syringe used in the administration of insulin, one would assume diabetics would be more schooled in proper syringe disposal.

No one attending the MoH review of this document was aware of any protocols in place for the use of PEP in the event of rape.

### Human rights

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

### Civil Society

Civil Society received 36% of funding from the National AIDS Programmes during 2006-7, to carry out activities. NGOs also obtained funding independently from bilateral/multi-lateral donors and the private sector. But there was no central reporting mechanism to track independent donor support for civil society projects. Much work is undertaken by civil society especially in prevention of transmission with in MARP. Tender Loving Care represents CRN+ and is made up of PLWHA working with and for PLWHA, United and Strong works with MSM, CAFRA works

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<sup>9</sup> See Annex 5 for a copy of the key findings:

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with sex workers, AIDS Action Foundation works with at risk populations and PLWHA and the Caribbean Harm Reduction Coalition with crack cocaine users.

### V. Successes of Current Programming

The following HIV programmatic successes in Saint Lucia were noted in a report on Out of School Youth:<sup>10</sup>

- Widespread condom distribution
- Good anti-stigma messages
- Free anti-retroviral medication provision
- Some established, community-based condom distribution outlets (as well as spermicidal and oral contraceptives), including at bars, discos, some homes in the community, small retail shops sold at a low service charge
- Condom availability (for purchase) at grocery stores, pharmacies without age requirement
- VCT services provided and with referral/accompaniment to clinics when the counselling services are provided off-site from testing

### Collaborative Efforts<sup>11</sup>

In general there is a feeling among many of the organizations working in HIV that they worked well with at least one other group. Their collaborative efforts included:

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

### Caribbean Harm Reduction Coalition's (CHRC)

The Caribbean Harm Reduction Coalition's (CHRC) outreach work with crack cocaine users is unique in the Caribbean. A peer educator / outreach worker serves as an adherence counsellor visiting homeless PWAs, monitoring

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<sup>10</sup> Jones, D.M., Out-of School Youth & HIV A Framework for Programs 2007

<sup>11</sup> Ibid

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medication, providing nutritional support and bringing clients to the clinic for check ups in addition to general prevention outreach. In addition CHRC conducts outreach to encourage homeless crack users to be tested for HIV and collects behavioural and other data in order to develop evidenced based prevention programming.

### **AIDS Action Foundation (AAF)**

#### Public/Private sector partnership

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

- Provision of ARVs
- Development of workplace policy
- Development and airing of HIV prevention messages
- Care and support of PLWHA
- Reduction in communication cost

#### Development of training tool

AAF with funds from the Poverty Reduction Fund developed a video "By Chance by Choice". The video focuses on women as the primary audience and seeks to highlight personal risk triggers and personal responsibility. The evaluation of this video, over the last four years has proved that it is an effective teaching tool as it enables individuals to understand HIV transmission and prevention on a personal level.

#### Barber Shop program

Under this program barber shops are now institutionalized as condom distributing centres. Young persons, including young girls have admitted to being more comfortable accessing condoms from the barber shops. The above program was initiated by AAF with a grant from the Japanese government in 2003.

The private sector has been involved in the national response, AAF collaborated with Sandals Resorts (Jamaican owned tourist resort), Peter and Co, Renwick and Co and others which implemented HIV in the workplace programme. Media houses provided reduced and free placement of HIV public service announcements provided by AAF. Cimpex provided a donation of free ARVs prior to the provision of free ARVs through the World Bank Grant. DIGICEL provided US\$ 10,000 for to youth campaigns during carnival 2006.

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## VI. Major Challenges and Remedial Actions

### Prevention

- Behavioural Surveillance needs to be improved, as the trends and drivers of the epidemic are still not fully understood. However, new data on sero-prevalence levels among crack cocaine users (Day 2007) point towards the importance of expanding programmes among this highly vulnerable population. With the exception of the PSI TRaC-M survey of MSM there has been no BSS or other study on MSM or sex workers conducted in Saint Lucia. This knowledge gap needs to be filled if effective prevention programming is to be carried out.
- The national response would benefit from more strategically targeting initiatives based on an improved understanding of '*vulnerability*' as opposed to simply identifying groups perceived to be '*most at risk*' due to specific, individual behaviours. Most at risk populations in Saint Lucia include crack cocaine addicts and those engaged in activities linked to the tourist industry and exposed to opportunities to engage in high risk behaviours, such as drug taking and transactional sex.
- Radio and television should be used more often for behaviour change communication campaigns; interventions need to be tailored to the Kweyol speaking population.
- Prevention services implemented through the health sector should be further decentralized: only 4 out of 8 health districts have access to VCT in the public sector.
- The involvement of key line ministries in prevention efforts needs to commence.
- Perception of personal risk of becoming infected remains an abstract concept. Many people continue to believe "It cannot happen to me".
- Anecdotal data suggests that stigma and discrimination in the health sector remains a big challenge with health care workers still treating HIV patients differently than other patients.
- The challenge of harmonising the assessed needs of a civil society project with the criteria of the NAPS and the restrictive nature of the donor focus.

### Treatment, Care and Support

- HIV/STI services are still in the hands of very few overburdened specialists. Further integration of HIV related activities in the health system is required, especially between Sexual and Reproductive Health (SRH) services and the Primary Health Care (PHC) system.

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- HIV/STI services are concentrated at the STI Clinic at Victoria Hospital in Castries requiring all HIV patients to travel to the City for treatment and medication.
- Treatment facilities do not adequately serve the needs of the entire population. Acute care services are primarily concentrated in Castries and difficult for rural based populations to access.
- Sexual and reproductive education equipment such as dildos and pelvic models are lacking.
- The current staff has the burden of implementing in treatment, care and support while also being involved in running training workshops, clinics, and outreach activities.
- Access to treatment, care and support services is limited due to stigma and discrimination: an effective national campaign could now be designed based on recently available BSS data which help to define the causes of stigma: e.g. continuing fear of contagion through food, and prejudice in the workplace.
- Clinics devoted to VCT and HIV treatment lack space to ensure confidentiality and urgent refurbishing should be considered, even if other locations have to be identified in the medium, long-term.
- Additional community based groups, NGOs, private sector organisations and PLWH support groups should be empowered to implement service delivery at national and sub-national levels, especially if 2010 Universal Access targets are to be reached. This could be achieved through targeted capacity building among civil society groups, and increased access to funds to deliver key services including mobile VCT outreach, prevention education, as well as treatment adherence, care and support.
- Clinical management should be integrated with social and community based support systems, through the development of a minimum package of care and support which builds on existing primary health care capacity; promotes condomization as a prevention strategy; and establishes drug regimens to deal with opportunistic infections.

### VII. Support from the Country's Development Partners

In addition to loan/grant agreements with the World Bank and GFATM/OECS Secretariat, Saint Lucia received technical support and financial assistance for its HIV response from several bilateral and multilateral agencies during 2006-7. Much of this assistance has gone to support and strengthen the health sector.

### MEASURE Evaluation

Determining that information on the most-at-risk populations in Saint Lucia was needed to guide programs and policies for HIV/AIDS prevention MEASURE

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Evaluation with financing from USAID supported a rapid assessment of places where people go to look for sexual contacts. “PLACE”<sup>12</sup> as this rapid assessment methodology is called relies on collecting data at venues where people most at risk of becoming infected with or of transmitting HIV are likely to socialize. Place was implement in 3 strategically-chosen areas, based on contextual factors in the district that suggested that the incidence of HIV infection is likely to be highest in these areas. In addition to being useful in completing some of the indicators for the UNGASS report, the results of PLACE will be used as the basis for local HIV/AIDS strategic plans and to guide prevention programming decisions. This project was valued at \$175,000 USD, \$50K of which was forwarded to the MoH for local disbursement.

During small group work sessions at the PLACE workshop in Castries (September 21 2007), the following gaps in Saint Lucia organizational efforts were reported by the organizations who attended the work sessions:

- Networking among organizations is limited
- Not enough men (male figures) involved in HIV work in general, and especially, with outreach/peer work
- No standardized information, messages or trainings
- Inefficient management of funding
- Need for more, ongoing VCT training to continuously supply qualified VCT’s
- Scarcity of available peer educators
- Too many services are “Castries-based”
- Consultation sessions don’t have follow-up work done
- Overlap of services by organizations
- No records of condoms distributed—i.e., to whom, how many, etc.
- No monitoring of ensuring that trainers have the “heart” for their work
- Not much communication or work going on with churches

### Population Service International (PSI)

As part of a larger regional social marketing research Population Service International (PSI) conducted a TRaC-M survey (Tracking Results Continuously – Monitoring Survey) aimed at changing sexual behaviour that elevates the risk of HIV infection and transmission among, in the case of Saint Lucia, men who have sex with men (MSM). This was funded by the Canadian International Development Agency. This was the only data that was available on MSM in Saint Lucia and was used to partially report on the MSM indicators. This project which was funded by CIDA was valued at \$43,000 USD.

### Government of France

The Government of France provided some financial support for the initial research that led to the conduct of the BSS for homeless drug users in 2007 which was

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<sup>12</sup> <http://www.cpc.unc.edu/measure/publications/pdf/tr-07-62.pdf>

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funded by a grant from the Caribbean Health Research Council, the Caribbean Treatment Access Group and the internally by the Caribbean Drug Abuse Research Institute. Support promised in 2006 from CARICOM / PANCAP reached the stage of an approved tender and a draft contract but this contract was not executed by the close of 2007 and the funds earmarked for the project were returned to the European Union by PANCAP.

### Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau

The French Government through **ESTHER** (Ensemble pour une Solidarité Thérapeutique Hospitalière En Réseau) supported 2 training programmes during the reporting period of which Saint Lucia participated in one. Entitled "Scaling up antiretroviral Therapy in Resource-limited settings: Introduction to HIV/AIDS Management for adults and adolescents, the train was a two week attachment in at the Centre Hospitalier et Universitaire (CHU) Fort de France. 5 individuals, a physician, nurse, pharmacist, social worker, and community member spent 2 weeks in Martinique on training.

### Government of Japan

The Government of Japan sponsored a one month training course in Japan in July 2006 which was attended by the Clinical Surveillance Officer

### Caribbean Regional Network of Sero-Positives / GFATM

As part of their Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) grant CRN+ in collaboration with CCNAPC implemented a project to establish a specialized system in to receive and respond to complaints pertaining to human rights violations to PLWHA through the appropriate and relevant authorities in each country. A human rights coordinator was hired to carry out this function.

### UNAIDS World AIDS Day activities

UNAIDS – technical support provided in June 2007 on financial and institutional arrangements and related documentation for the development of a national proposal to GFATM, including concept development for mobilization of the tourist industry in HIV prevention and workplace policies. Support provided for data reporting at the global level (specifically UNGASS 2006 and 2008).

### PAHO / CAREC

PAHO / CAREC capacity building in the lab, Health Care workers training  
The main objectives of this regional programme were the:

- Training of existing staff in Laboratory Management and Quality Assurance

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- Inclusion of these principles within the curricula of training institutions
- Development of standards for laboratories and an accreditation system for monitoring of laboratory quality
- Development of information systems to support disease prevention and control initiatives
- Operational research to support policy development

### Challenges of working with development partners

#### Sharing of information

- Many organizations are involved in data collection but not data sharing. Data is collected and reports written but these are not always available to the stakeholders from whom the data was collected.
- National indicators are sometimes ignored in the data collection process.
- Even when reports are shared, data tables and SPSS (or other database) files are not. This makes doing secondary analysis of data impossible. Where indicators were populated using data from external research, disaggregating data by age and or sex was impossible without the original data sets.

#### Collecting standardised indicators

- Because of the lack of research done nationally, this report was compiled using data collected by various external agencies.
- Part of the responsibility lies with the agency initiating the research but host countries must be aware of what data is needed to report to donors and require researchers to collect that data in addition to the project data being collected.
- As was stated in our 2006 report external agencies such as UNAIDS World Bank, Global Fund, USAID, need to harmonise their indicators to remove the excessive reporting burden of the National Aids Programme Secretariat.

### VIII. Monitoring and Evaluation Environment

- More primary research is required to get evidence related to vulnerabilities in Saint Lucia.
- Improved M&E systems require stronger collaboration between the NAPS and the epidemiology and statistics units of key line ministries.
- For some new HIV cases, the mode of transmission is still unknown, which points to gaps in the surveillance system, and a lack of trust in the system on the part of the patients and buy-in for improved understanding of the trends and drivers of the epidemic.

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## Annexes

### Annex 1 Acronyms

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

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

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### Annex 2 Cumulative HIV Cases 1985 to September 2007 Percentage by sex and age

AGEGROUP	Female	Male	Unknown	Grand Total
00-01	1.70%	1.39%	1.23%	4.32%
01-04	1.85%	0.93%	0.31%	3.09%
05-09	0.62%	0.31%	0.15%	1.08%
10-14	0.46%	0.15%	0.00%	0.62%
15-19	2.78%	0.15%	0.00%	2.93%
20-24	3.24%	2.93%	0.62%	6.79%
25-29	7.72%	4.63%	0.31%	12.65%
30-34	6.02%	9.41%	0.62%	16.05%
35-39	6.02%	6.94%	0.77%	13.73%
40-44	3.86%	9.57%	0.15%	13.58%
45-49	3.70%	5.56%	0.31%	9.57%
50-54	2.31%	3.55%	0.77%	6.64%
55-59	1.08%	2.47%	0.15%	3.70%
60-64	0.77%	0.31%	0.15%	1.23%
65-69	0.62%	0.46%	0.00%	1.08%
70-74	0.00%	0.31%	0.00%	0.31%
80-84	0.00%	0.15%	0.15%	0.31%
85+	0.15%	0.00%	0.00%	0.15%
UNK	0.46%	1.23%	0.46%	2.16%

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### Annex 3 SLU National Assessment on HIV/AIDS, Law, Ethics and Human Rts

#### SUMMARY OF FINDINGS:

A legal assessment entitled St Lucia National Assessment on HIV/AIDS, Law, Ethics and Human Rights<sup>13</sup> was conducted by the NGO AIDS Action Foundation, with funds provided by PANCAP (CIDA). [Report title: Assessment of Laws and Policy related to HIV and AIDS in Saint Lucia published 2007]. . Topics reported on included Disclosure, Testing and Confidentiality, Contact Tracing, Education, Universal Safety Precautions (USP), Condom Availability (including schools and prisons, Sex Education, Homosexuality, Advocacy, Stigma and Discrimination Law Enforcement, SRH services for Minors, Insurance, Economic and Social Issues for PLWHA, Political Leadership and Medical Management. The following represents the findings from the various focus groups and informant interviews.

#### Disclosure

- There are problems with disclosure of positive HIV status.
- PLWHA gave varying views on current methods of disclosure that they have experienced. They recommend that they need time to disclose to partners and that doctors also have a responsibility to help with disclosure.
- In the experience of PLWHA, disclosure can lead to arrest under section 140 of the Criminal Code 2002 and has lead to domestic violence, isolation and discrimination.
- There is currently no safe house or protection for persons who disclose their status and face violence.
- Section 140 restricts access to legal redress by PLWHA.
- PLWHA believe that giving the doctor the power to notify will complicate matters. There was the fear that doctors may abuse that privilege.
- Teachers want to know the HIV status of students because they feel it would allow for better management of students.
- Fire Service personnel were of the view that they should have knowledge of the individual's status.
- Nurses felt it essential that they know a mother's status so as to allow for the proper management and follow up care of mother and child.

#### Testing and Confidentiality

- VCT services are currently limited and can be accessed mainly at STI clinics and in some instances at the primary health care clinic.

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<sup>13</sup> See Appendix 5 for a copy of the key findings:

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- The current STI clinic set up does not encourage confidentiality. For example the facility does not have a separate exit and entrance for patients accessing its services.
- The fact that STI clinic is held on certain days encourages stigma.
- Nurses sometimes walk around with person's medication in the open and unknowingly disclose their status.

### Contact Tracing

- Contact Tracers are community nurses and therefore well known in the community. This leads to the stigmatisation of patients when visited by the contact tracer.
- Currently contract tracers operate without any guidelines and code of conduct.
- PLWHA have accused contact tracers of breaching confidentiality.

### Education

- Although focal group participants displayed knowledge of HIV transmission and prevention, they feel that they more intensive education and training is necessary.
- The inmates at Bordelais made a plea for education on HIV as they highlighted that they have families and friends who they must return to and would like to be furnished with that education.
- Media persons feel that young persons remain far removed from the HIV situation demonstrating the need for further education.
- Generally focal group participants recommend education as the most effective way of minimising the stigma and discrimination levelled against PLWHA and suggest that it start at an early age. One PLWHA recounts her daughter being taunted by school mates who teased her about her father dying of AIDS.
- Young people are requesting that more attractive HIV messages specially developed by and targeted to youth.
- Though women understand the basics of HIV transmission they do not fully understand or appreciate their risk. This is particularly true of women in committed relationships.
- A limited amount of HIV training is ongoing in workplaces; however, some employers feel that much more can be done.
- Churches are involved in teaching abstinence as a prevention method.

### Universal Safety Precautions (USP)/Body Substance Isolation

- The practice of USP is compromised by the limited availability of medical supplies such as gloves.
- There are complaints of substandard quality of gloves necessary for the practice of USP.

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- Teachers have expressed the need to be taught Body Substance Isolation in order to better protect themselves and students from HIV transmission.

### Condom Availability

- Participants indicated that condoms are available at limited locations and that pharmacies are the main outlets for purchasing condoms. They have called for the number of distribution outlets to widen.
- There is still a general discomfort when purchasing condoms
- Distribution of Condoms in Prison - the majority of inmates interviewed stated that they did not want condoms distributed in the prison.
- Students attending secondary and tertiary institutions believe that condoms should be made available at the schools. However, there is no clear understanding as to where and to whom it should be given. Some suggest that it be:
  - The guidance counsellor
  - Vending machine, possibly placed in the washrooms
  - Members of the students' council
- Most teachers are divided as to the distribution of condoms in schools.
- Women involved in sex work have difficulty negotiating condom use with clients.

### Sex Education

- Health and Family Life Education curriculum is too limited in what it covers.
- Students in tertiary level institutions generally felt that they did not have sufficient knowledge and the institutions have a responsibility to provide such education.
- Young people feel that the burden of sex education should be on the parents.

### Homosexuality

- There is still a high level of intolerance towards homosexuals. Persons use the Bible to justify the stigma and discrimination levelled at persons who are or perceived to be homosexual. More males as opposed to females strongly oppose homosexuality, however, lesbian activity is not as severely criticised.
- It is generally felt that Saint Lucia was not ready for the decriminalisation of buggery.
- A similar view is held by the inmates of Bordelais who advocate the separation of persons practising homosexuality from the general prison population. They have appealed to the authorities to separate known homosexuals.

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- The focus groups with the MSM community revealed that the law on buggery should be repealed. The law as presently constituted basically infringes on how they live and by its mere nature promotes discrimination. They also noted that the law does not address the issues of rape among the MSM population.

### Advocacy

- Participants feel that there is a need for open discussion of sexual and reproductive health.
- Messages targeted at young persons are not innovative and does not impact on them.
- Media personnel feel that the advertisements available do not adequately target the various segments of the population. There is a need for segmentation analysis and they recommend greater involvement of young people in the development of the messages.
- Media houses are willing to commit to the fight against HIV however, there must be created a balance between the raison d'être of the company which is profit making and the social and economic importance of fighting HIV.

### Stigma and Discrimination

- There is a lack of understanding of the social issues facing PLWHA.
- PLWHA state that accessing medical treatment is not conducted in a confidential manner.
- PLWHA have been denied employment because of their status.
- The MSM feel that their lives are determined by stigma and discrimination and the following associated issues were highlighted.
  - “gay persons are afraid to speak up.”
  - Persons were of the opinion that to be gay is to be promiscuous.
  - Being gay affected their ability to gain employment
- Discriminatory attitudes towards gays are promoted by institutions such as the media, the church and the police. Among these, religion was seen as the major culprit and the attitude of the police was especially discriminatory.
- Persons experienced harassment on the job as a result of their sexual orientation.
- Generally the Blood Bank will not take blood since it is perceived that men having sex with men are high risk
- Some gay men have difficulty accessing health care. There are reports of local doctors refusing treatment.
- Sex Workers do not face the levels of discrimination targeted at MSM however, they are reluctant to openly admit involvement in sex work to health service providers.

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### Law Enforcement

- PLWHA think Section 140 of the Criminal Code 2002 is discriminatory and that it should be repealed. The section requires that you are aware of your HIV status. This is serving to drive people underground and prevents testing.
- There is a general assumption that persons who are HIV+ are intent on infecting persons in the wider community. However there is still a lack of understanding that each person has personal responsibility to protect themselves from HIV infection.
- Police officers are confused as to the ability to enforce Section 140.
- The doctors believe that public health legislation should be used to deal with wilful transmission of HIV:
  - It is impossible to prove infection based on the rules of evidence under the Criminal Code provision.
  - Some doctors feel that the law should be in the interest of the health of the person, i.e. where the patient's health and safety is at risk.
- There are currently no sanctions for those persons who breach patient confidentiality.

### Medical Attention for Minors

- There are no guidelines and protocols for the provision of sexual and reproductive health care for minors in the absence of parental consent.
- Medical professionals face a dilemma when providing health care to minors because the age of consent is 16 yet the age of majority is 18.

### Insurance

- MSM are refused insurance coverage on the basis of their sexuality.
- Insurance companies are not subject to a duty of confidentiality.
- Insurance agents collect personal medical information of clients and this leads to a breach of confidentiality.
- Health Insurance does not cover HIV.
- Life insurance is available from a limited number of companies for PLWHA up to a limit of \$50,000.00.

### Economic and Social Issues for PLWHA

The following are some of the critical issues for PLWHA as identified by the support group:

- Security
- Clean water
- Proper housing
- Electricity
- House Maintenance

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- Food – Balanced Meals
  - Insurance- Medical and life
  - Employment
  - Education of PLWHA
  - Counselling Services
  - Safe Place
  - Legal services
- 
- There is a social assistance programme operated by the National AIDS Programme Office which provides a stipend of EC\$250.00 per month for PLWHA in need. However they feel that the stipend is inadequate. Additionally, the manner in which the programme of assistance is currently managed raises questions of confidentiality.
    - PLWHA stated that they spend a large amount on transportation in order to collect the voucher. At the place of purchase one must state who the receipt or open bill is paid to and the mere mention of the National AIDS Programme sends a red flag as to one's status.
    - Assistance is restricted to food items only; no personal items can be purchased such as soap, a tank of gas. The Programme also restricts what size food items one can buy. For example, PLWHA have had instances where they are not allowed to purchase a large can of milk and are instead forced to buy several small ones.

### Political Leadership

- The fact that there is a National AIDS Programme, Global Fund and World Bank resources committed to HIV prevention and the fact that the Government is partaking in the present legal assessment demonstrates that there is a certain degree of commitment to the issue by the political directorate.

### Medical Management

- There is no holistic management of PLWHA whereby the entire health care team is informed of patient's status.
- There some instances where disclosure of status is a medical necessity however these are perceived as discrimination by PLWHA.
- Currently PLWHA are managed by a health care team that comprises a Clinical Care Coordinator, a Nurse and a Social Worker.
- Doctors have experienced verbal abuse and threats of physical abuse from PLWHA in respect to accessing the stipend provided by the National AIDS Programme.
- Currently insurance companies direct persons to laboratories for HIV testing and collect the results without the involvement of a doctor or and VCT.

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- Although there is an emphasis on confidentiality in the code of conduct for health care professionals, it is not currently practiced by all when dealing with PLWHA.
- In instances where an expectant HIV+ woman refuses treatment which places her unborn child at risk, there is no legislation to override the mother's decision and provide treatment in the interest of the unborn child.
- There is no independent access to sexual and reproductive health care for children under 16 without the consent of parents. However, medical providers believe that care should be provided at their discretion.

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### Annex 4 Occupational Exposure for 2007

MONTH	INSTITUTION	OCCUPATION	EVENT	PROPHLAXIS USED
January	SJH	Doctor	Unknown	No
	VH	Doctor	Unknown	Yes but Stopped because of side effects
February	SJH	Nurse	Unknown	No
	VH	ANCILLIARY WORKER	Unknown	Yes
March	SJH	DENTAL ASSISTANT	Unknown	Yes
	SJH	HOSPITAL ATTENDANT	Unknown	Yes
	VH	Nurse	Unknown	Unknown
	VH	Nurse	Unknown	Unknown
April	GIPC	Doctor	Blood to mucous membranes	Y
	VH	Domestic assistant	Injury with sharp object with blood stained liquid	N
	GIPC	Nurse	Hollow bore needle stick to intact skin with blood stained liquid	Y
	Castries Health Centre	Community Health Aide	Solid bore needle stick to intact skin with blood stained liquid	Y
	SJH	Office clerk During phlebotomy course	Needle stick injury to intact skin with hollow bore needle with blood stained fluid	Y
	SJH	Doctor	Injury with sharp object with blood stained liquid	Y
	SJH	Doctor	Injury with sharp object with blood stained liquid	Y
	VH	Lab Technician	Injury with hollow bore needle with blood stained liquid	Y
	VH	Student Nurse	Injury with hollow bore needle with blood stained liquid	N
	VH	Nurse	Injury with hollow bore needle with	Y

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			blood stained liquid	
	VH	Lab Technician	Injury with hollow bore needle with blood stained liquid	N
May	VH	Lab Technician	Injury with hollow bore needle with blood stained liquid	Y
June	SJH	Doctor	Injury with hollow bore needle with blood stained liquid	Y
	VH	Nurse	Solid bore needle stick to intact skin with blood stained liquid	N
	VH	Nurse	Solid bore needle stick to intact skin with blood stained liquid	N
July	SJH	Dental assistant	Injury with hollow bore needle with blood stained liquid	Y
	SJH	Nurse	Injury with hollow bore needle with blood stained liquid	Y
	VH	Guest services staff Sandals Grande	Injury with hollow bore needle with blood stained liquid	Y
August	VH	Doctor Almond Smugglers Hotel	Injury with hollow bore needle with blood stained liquid	Y
	VH	Lab technician	Injury with hollow bore needle with blood stained liquid	Y
	VH	Ancillary staff	Injury with hollow bore needle with blood stained liquid	Y
	VH	Nurse	Injury with hollow bore needle with blood stained liquid	N
	SJH	Guest(child) Coconut Bay Hotel	Injury with hollow bore needle on beach	Y

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September	VH/STI	Nurse	Splash exposure to intact skin	N
	VH	Lab technician	Splash exposure to mucous membranes	Y
	VH	Nurse	Splash exposure to mucous membranes	N
	SJH	Doctor	Injury with hollow bore needle with blood stained liquid	Y
	SJH	Nurse	Injury with hollow bore needle with blood stained liquid	Y
October	SJH	Housekeeping staff	Injury with hollow bore needle with blood stained liquid	Y
	SJH	Student nurse	Injury with hollow bore needle with blood stained liquid	Y
	VH	Nurse	Injury with hollow bore needle with blood stained liquid	Y
November	SJH	Doctor	Injury with solid bore needle with blood	N
	SJH	Doctor	Injury with hollow bore needle with blood stained liquid	Y
December				

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### Annex 5 Existing Educational /Service Resources<sup>14</sup>

The following is a short summary of some of the current HIV activities reported in select social service and HIV organizations in Saint Lucia. This list is not an exhaustive account of all services and organizations but is a representation of the information that is based on agency brochures, interviews of the 12 organizations noted in this report, and anecdotal public information.

#### **Golden Hope**

- HIV Testing and Monitoring Care
- Occasional HIV Education
- ARV through DOT
- 3-months of ARV upon discharge

#### **Bordelais Correction Facility**

- HIV Testing and Monitoring Care
- ARV through DOT
- 3-months of ARV upon release

#### **Turning Point**

- Occasional HIV Education
- Short-term (1- to 2-month rehabilitation)
- ARV through DOT

#### **Caribbean Drug Abuse Research Institute**

- Research and reporting on the Saint Lucia drug-use community.

#### **Caribbean Harm Reduction Coalition**

- Drug-user advocacy and human rights
- service provision
- adherence counselling for crack using PWA

#### **Saint Lucia Red Cross**

- HIV Public Education
- HIV Community-based Counselling
- Social Service Referrals
- Peer Education and Practical Support

#### **Saint Lucia Crisis Centre**

- Support for women experiencing domestic violence (including related to HIV)
- Social Service Referrals
- Community-based Counselling
- Emergency Hotline

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<sup>14</sup> Jones, D.M., Out-of School Youth & HIV A Framework for Programs 2007

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- Public/Company education regarding the link of HIV & domestic violence

### **United and Strong, Inc.**

- Individual HIV Education
- Peer Education/Practical Support for GLBT
- HIV Workplace Training

### **Tender Loving Care**

- Peer Education & Practical Support for People affected by HIV and AIDS

### **Caribbean Association for Feminist Research and Action (CAFRA) / National Organization of Women (NOW)**

- Support for Sex Workers and Migrant Workers
- On-site (sex venue) HIV Education and Services

### **Ministry of Health—National AIDS Program**

- Implementation of National HIV Strategic Plan
- Condom Education and Distribution
- HIV Education
- Testing Services
- HIV Information Clearinghouse/IEC Distribution
- Research/Surveys among Vulnerable Groups
- Training of Trainers
- Training of VCT Counsellors

### **Ministry of Health Bureau of Health Education and Promotion**

- Distribution of IEC Materials (at schools, health centres and in the community)
- Community-based Counselling Services
- Voluntary Counselling and Testing Services
- HIV Workshop Facilitation in Primary and Secondary Schools (Youth Choose Program), Health Clinics (with clients and Community Health Aide Workers) and the Community (among, Taxi Drivers, PTA groups, etc.)
- Primary and Secondary Teacher Training and Support

### **STI Facilities**

- Pre-and Post-Counselling Services
- HIV Testing
- STI Screening
- ARV provision (DOT and non-DOT)
- Referrals as Needed

### **Society for the Development of Youth**

- HIV Education and Referral.
- Training of Peer Educators

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### **AIDS Action Foundation**

- Research/Surveys/Focus Groups Among Vulnerable Groups
- Train-the-Trainer Workshops
- Direct HIV Education

### **Saint Lucia Blind Welfare Association**

- Group Discussion Work about living skills and HIV
- VCT Certified Staff

### **The Saint Lucia Mental Health Association**

- Training for mental health staff on mental health issues related to HIV, i.e., screening for depression, etc.
- Training of mental health staff on HIV sensitization and basic HIV knowledge
- Education of outpatient and inpatient clients on HIV and AIDS
- TOT workshops for staff and clients around being an HIV educator/peer

### **Saint Lucia Planned Parenthood Association**

- Family Life Education and Counselling
- Education on Contraception/Contraceptive Supplies
- Pregnancy Testing
- Pap Tests
- Male Clinic
- Women's Sterilization
- Vasectomy Services
- Peer Helpers/Assistants
- Parental Education
- Youth Presentations by Youth

### **National AIDS Program Secretariat**

- Development/Coordination of the National HIV/AIDS Strategic Plan
- HIV Program Funding
- NGO/Governmental Capacity Building /Training/Technical Assistance

### **Upton Gardens Girls Centre**

- Client Counselling
- Living Skills Training
- Advocacy
- On-site Medical Care
- Social Service Referrals

### **Trinity Lutheran Church**

- Health Fair
- Health Clinic
- Training/support for youth presenters in schools/other organizations regarding Family Life Skills and Sexual Education

## **UNGASS 2008 Saint Lucia**

Annex 6 Documents Consulted when preparing this report

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Monitoring the Declaration of Commitment on HIV/AIDS

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UNICEF, A Study of Child Vulnerability in Barbados, Saint Lucia, Saint Vincent & Grenadines, November 2006

World Bank, Project Appraisal Document on a proposed loan to Saint Lucia for the HIV/AIDS Prevention and Control Project, 2004

## UNGASS 2008 Saint Lucia

### Annex 7 Attendance UNGASS Report consultations

#### UNGASS Report consultations

##### Civil Society Consultation

##### Attendance sheet

16 January 2007

AIDS Action Foundation Conference Room

Name	Representing
Tamara Felicien	Caribbean harm Reduction Coalition
Petrona Clovis	Tender Loving Care
Marcia Boxhill	CARITAS Antilles
Veronica Cenac	AIDS Action Foundation
Joan Didier	AIDS Action Foundation
Catherine Spooner	AIDS Action Foundation

#### UNGASS Report consultations

##### Government Consultation

##### Attendance sheet - 18 January 2007

National AIDS Programme Secretariat Conference Room

Name	Representing
Nahum Jn Baptise Director	National AIDS Programme Secretariat
Kentry D Jn Pierre IEC	National AIDS Programme Secretariat
Natasha Lloyd CSO/LM	National AIDS Programme Secretariat
Sonia Alexander Director	National AIDS Programme MOH
Allison Jean	Central Procurement MoH
Pamela Ambrose Director	Ezra Long Laboratory VH
Cynthia Labadie Focal	Min of Consumer Affairs
Judith Crane-St Hill Focal	Min of Tourism and Civil Aviation
Rosilia Joseph Account	Project Coordination Unit
Calus Monchery	Project Coordination Unit