St. Lucia

National HIV and AIDS Strategic Plan

2011-2015

National AIDS Programme, Ministry of Health

National AIDS Programme Secretariat

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FOREWORD (TO BE WRITTEN)

Include acknowledgements in foreword: The strategic planning process was led by the National AIDS Coordinating Committee on HIV/AIDS under the guidance of the Director, National AIDS Programme Secretariat. Technical and financial support for the development of the strategy was provided by AIDS Strategy and Action Plan Service (ASAP), a service of UNAIDS hosted by the World Bank. AIDInc, a regional development consulting firm, facilitated stakeholder consultations that provided key inputs for the strategy.

EXECUTIVE SUMMARY

The prevalence of HIV in St. Lucia is estimated to be under 1% in the general population, and the number of new infections appears to be stable over the past five years. However, due to the limited availability of data, it is not possible to have an accurate picture of the prevalence rate, and more importantly the key drivers for HIV transmission. Nonetheless, a number of small studies indicate higher prevalence among some groups at high risk of exposure to the virus suggesting a concentrated epidemic.

Risk factors in St. Lucia include a range of behaviors, including anal sex between men, sex work, and drug use. Similarly, a number of cultural factors identified by stakeholders could also be helping to drive the epidemic. These include multiple sexual partners, men on the 'down low', young women involved in transactional sex for survival or for 'gains', stigma and discrimination (which keeps people from testing and getting the prevention education and care they need), continued belief in myths and misconceptions about the virus, the taboo nature of sex (which inhibits discussion that could help prevent transmission), and a changing socio-economic context. In addition, legal barriers to working openly with men who have sex with men (MSM), sex workers and drug users make it difficult to reach these populations in need of support. Lastly, poverty seems to be playing a role in increasing vulnerability to HIV infection.

The national response has made gains during the last five years due in part to coordination by the National AIDS Program Secretariat (NAPS) and contributions of health and non-health partners. Achievements have included reduced mortality and morbidity, and a wide range of prevention interventions (although these have been directed mainly at the general population). While the program has been funded largely from external sources in the past five years, both the World Bank and Global Fund projects are closing by the end of 2010.

In light of the critical need to obtain a better understanding of key drivers of the epidemic, the strategy has a two-phase approach. The first phase covering the first two years, outlined in the present document, focuses on strengthening the epidemiological and behavioral evidence base as a precursor to further prevention planning.

The strategy also prioritizes continuing critical interventions in particular, program coordination and management; treatment, care and support; and targeted prevention work. Once there is a better understanding of the epidemic, stakeholders will review the new evidence and elaborate a well-targeted prevention plan for the remaining three years of the strategic plan period.

This two-year strategy is structured around six outcome results that are to be achieved during the first phase of the five-year NSP. They include the following:

1) Evidence base strengthened to provide a solid foundation for future prevention planning

2) Targeted prevention work with MSM, sex workers and drug users based upon existing evidence scaled up
3) Support to OVC and needy people living with HIV and prevention work with youth and in the workplace maintained
4) Treatment, care and support services maintained and strengthened
5) Capacity to manage the national response strengthened
6) Institutional arrangements in place to continue program implementation and monitoring

Government commitment to sustaining the gains achieved over the past five years will be essential for the achievement of these outcomes for 2010-2011 and beyond.

1. INTRODUCTION

The purpose of the St. Lucia National HIV/AIDS Strategic Plan (NSP) 2010-2015 is to guide the management and implementation of the national AIDS response, highlighting priorities for the allocation of financial and technical resources. The plan builds upon the NSP 2005-2009. It has been developed based on an assessment of the available evidence about the epidemic, the factors that influence the transmission of HIV in the country, and lessons of past implementation experience. A series of broad-based stakeholder consultations and existing national documentation provided invaluable information, followed by further refinement of the proposed priorities and related interventions. The strategy proposes a two-phase approach due to the fact that epidemiological and behavioral data are limited and do not provide a sufficiently-strong foundation on which to design effective targeted prevention interventions. Thus the first phase, outlined in the present document, focuses on strengthening the evidence base as a precursor to further prevention planning. It also includes continuing critical interventions (in particular, program coordination and management; treatment, care and support; and targeted prevention work). Once there is a better understanding of the epidemic, stakeholders will review the new evidence and elaborate a well-targeted prevention plan for the remaining three years of the strategic plan period.

This NSP has been developed in the context of falling external financing for HIV and AIDS internationally, and in St. Lucia in particular. Funding for the national response (2005-2010) has largely been through the World Bank (IBRD loan, IDA credit, and grant) with some funding from the Global Fund. Both the World Bank-funded project and the OECS Global Fund project are closing before the end of 2010. This means that more than ever St. Lucia needs to focus squarely on priority interventions that can have a real impact on the epidemic.

The new financing picture also requires renewed Government commitment to ensure sustainability of the national AIDS response by institutionalizing the management and coordination of the response within national structures, and allocating national resources wisely. On this basis, St. Lucia can sustain the gains already achieved during the previous plan period and make further progress in halting HIV transmission and providing treatment, care and support for those living with HIV and AIDS.

2. SITUATION ANALYSIS

2.1 State of the Epidemic

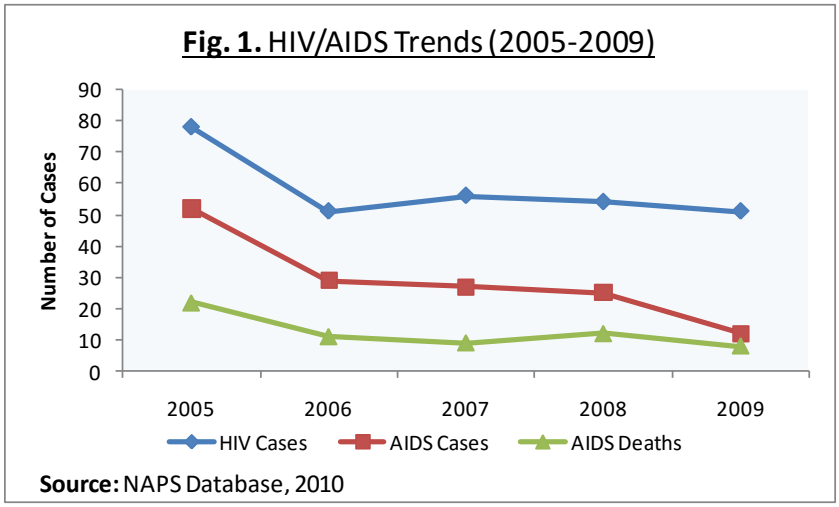
Overview: HIV prevalence in St. Lucia is estimated at below 1%. However, there is a lack of definitive prevalence data with quoted figures ranging from 0.22% to 0.93%[1]. Based on the number of people living with HIV the National AIDS Program Secretariat (NAPS) has estimated an HIV prevalence rate of 0.28%[2].

Regardless of the estimated rate, it is likely to be an underestimate as the surveillance system is based on reports from public and private laboratories on clients tested, thereby missing groups known to be at highest risk of exposure to the virus in other countries, who are reluctant to use available services and remain underground (for example, MSM and sex workers). In addition, it is believed that a number of people travel outside the country to seek HIV testing and treatment, due to perceived weaknesses with confidentiality and anonymity in their home countries, so these cases are not included in the official count. The laboratories report all HIV positive tests obtained, however not all positive cases are registered in the public system.

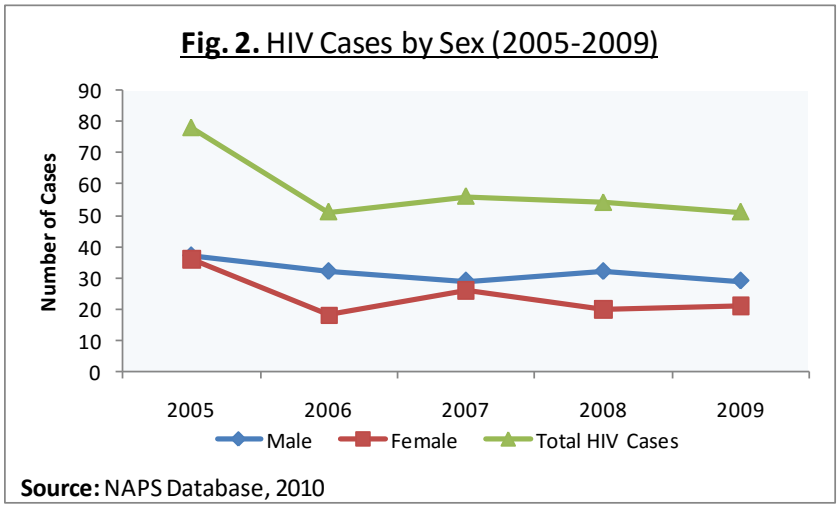
Since the first case of AIDS in St Lucia was reported in 1985, a total of 783confirmed cases of HIV have been reported and of those 314 have died.[3] At the end of June 2010, there were 443 people living with HIV of whom 239 are enrolled in care, and 146 on ART (130 on first line; 16 on second line regimens).

The number of AIDS deaths has steadily declined from 2006 to date as a result of ART (see Figure 1 on the HIV/AIDS Trends from 2005-2009). Despite a four-fold increase in VCT coverage since 2006, available data show the number of new cases has stabilized or fallen following a peak in 2005 after expansion of testing.

[1] NAPS estimates an HIV prevalence rate of 0.28%, while the estimates from AIDSProj and Spectrum indicate a prevalence of 0.93%
[2] St. Lucia, UNGASS Country Progress Report, 2009
[3] MOH and NAPS, HIV Surveillance and Program Monitoring Report, 2009



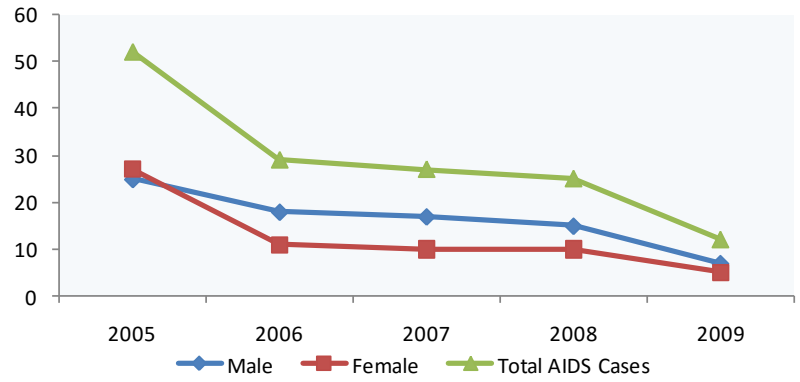
Male/Female breakdown. Overall, a larger proportion of women get tested for HIV, through opt-out testing in antenatal care (ANC) and their tendency to take greater advantage of VCT services. However, more men have tested positive for HIV and clinical AIDS, as illustrated by Figure 2 below. Approximately 55% of the HIV and 60% of AIDS cases reported to date have been in men. In 2009, this figure was 58%.



Due to the poor health-seeking behaviour demonstrated by men, more males are being diagnosed late in the clinical stage[4] (Figure 3 and 4). In addition, late testing occurs in older women who do not access the PMTCT program and also perceive themselves to be at low risk.

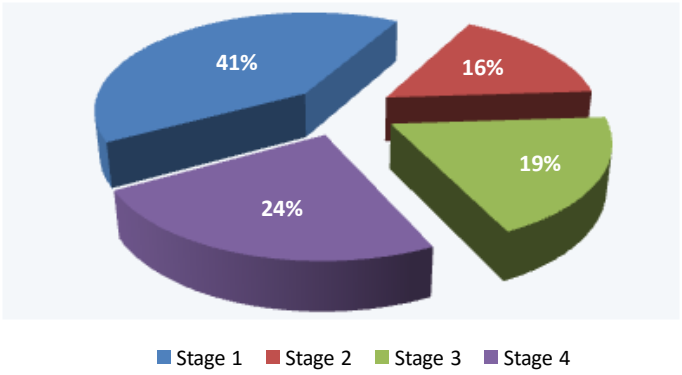
[4] Dr. d'Auvergne, St. Lucia HIV/AIDS Control and Prevention Project – Quarterly Report

Fig. 3. AIDS Cases (2005-2009)



Source: NAPS Database, 2010

Fig. 4. HIV Clinical Stage at Diagnosis, 2009



Source: Dr. d'Auvergne, 2010

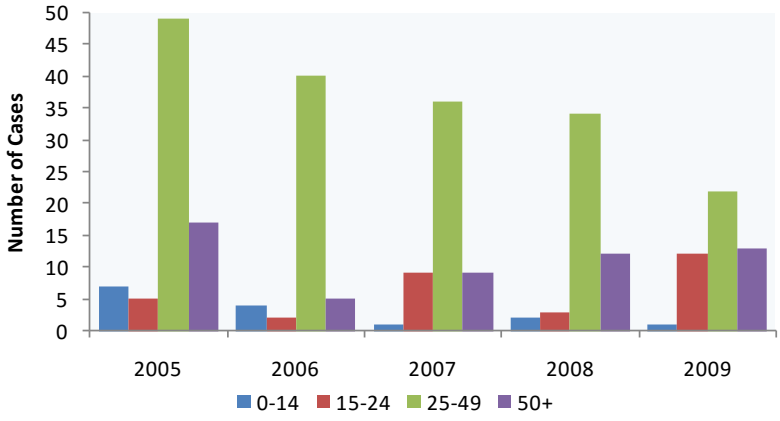
Age Breakdown: In 2009, 46% (22 out of 48) of new HIV reported cases were in the 25-49 age group. In addition, 27% and 25% of all cases were in the 15-24 and 50 plus age group, respectively. 50-59 age group with both men and women equally affected. See Table 1 below.

Table 1. New HIV Cases, by Age and Sex, 2009

Age Group	Male	Female	Total	Percent
0-14	0	1	1	2%
15-24	8	3	12[5]	25%
25-49	12	10	22	46%
50+	7	6	13	27%

Figures 5, 6 and 7 show the trends (2005-2009) in HIV cases by age group. Similar to the pattern seen in 2009, the majority of the infections during this time period occurred in the 25-49 age group. During the period, 2005-2009, on average more men than women were diagnosed with HIV, although, there has been a decline in the number new reported cases over the last five years. However, in the 0-14 and 15-24 age groups, 54% (7/13) and 53% (16/30) of new reported HIV cases were in female, respectively (See Figure 6). There has been a notable increase in the number of new HIV cases reported in the 50 plus age group since 2006 (particularly in men) as shown in Figure 7.

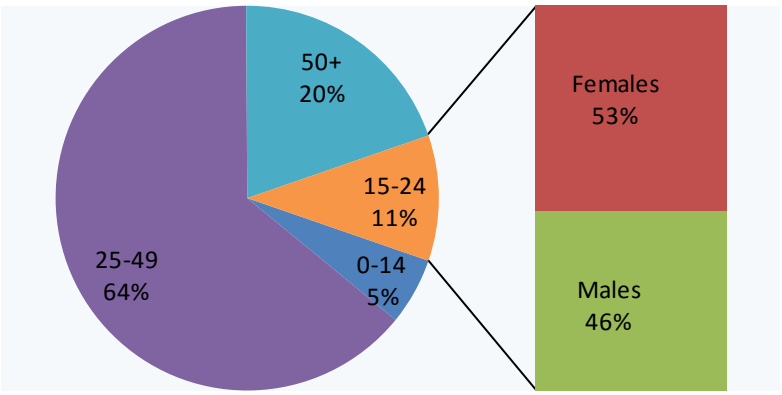
Fig.5. HIV Cases by Age Group (2005-2009)



Source: NAPS Database, 2010

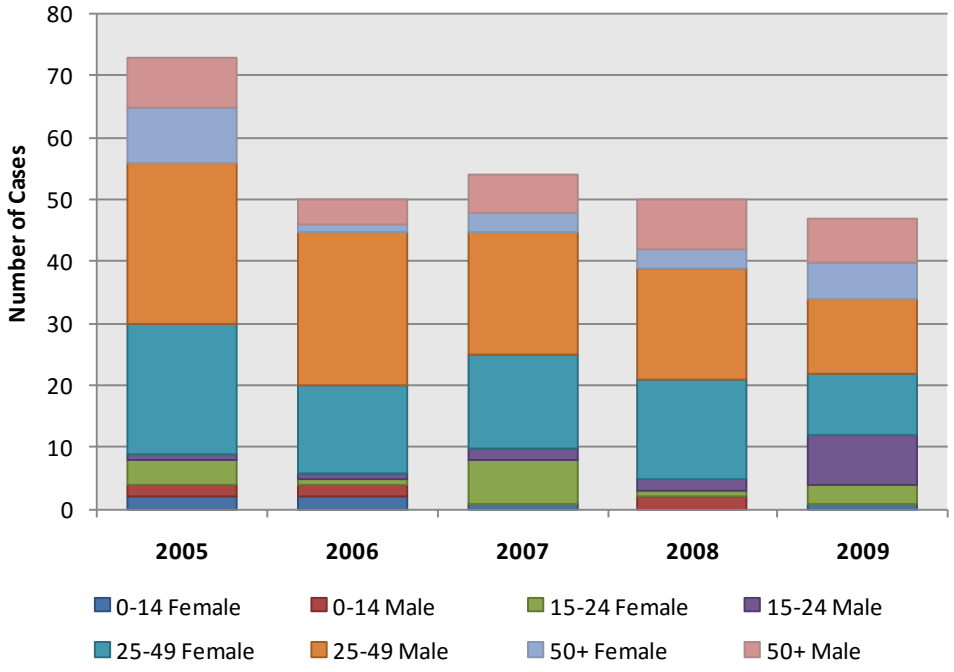
[5] Exclusion of missing data i.e. unidentified sex

Fig.6. Total HIV Cases by Age Group (2005-09)



Source: NAPS Database, 2010

Fig.7. HIV Cases by Age and Sex (2005-09)



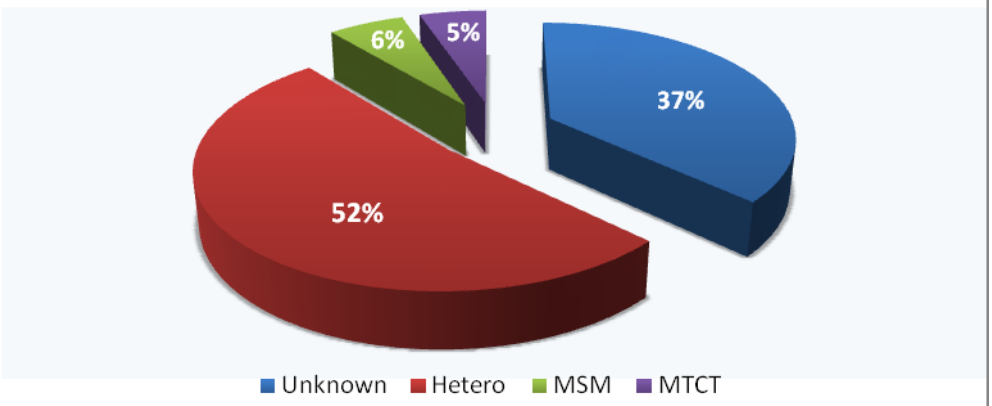
Source: NAPS Database, 2010

Modes of transmission. The critical question that needs to be answered in order to plan appropriately is 'where have the latest infections come from?" Analysis of modes of transmission in St. Lucia cannot adequately respond to this question in light of the fact that

data collection has not, until recently, included questions on behaviours that might expose people to the virus. There is also the likelihood that fear of being identified with one of the behaviours that put people at greatest risk (especially anal sex and sex work) also lead people to withhold such information. Thus, there are no data to indicate whether someone who has tested positive is bi-sexual or has sold sex, and very probably an under-estimate of those who identify themselves as MSM. The result is that the broad transmission categories of 'hetero-sexual' and 'unknown'[6] are very likely concealing the true picture of HIV in the country. [7]

With this important caveat, available data from 2009 show that 37% (19/51) of new HIV cases reported transmission via heterosexual activity, 10% (5/51) via MSM, 2% (1/51) via transmission between a pregnant mother and her unborn child (MTCT) and 51% (26/51) of cases with unknown mode of transmission. This pattern is fairly consistent with what has been observed over the years (Figure 8). The total number of infections through MSM is considered by many working on HIV and AIDS in St. Lucia to be an underestimate given the reasons noted in the paragraph above.

Fig. 8. Modes of Transmission 2005-2009



Source: NAPS Database, 2010

In terms of estimated prevalence within different populations, while HIV rates among the general population appear to have stabilized below 1%, surveys among specific populations, although few and limited in scope, indicate HIV prevalence rates that are significantly higher. Data from sentinel surveillance in prisoners (2004)[8] and homeless crack cocaine users (2007)[9]

[6] (CAREC, 2004).
[7] UNGASS Country Report 2010 (for the period January 2008 – December 2009 (pp. 4,5)
[8] Please include source for the prison study

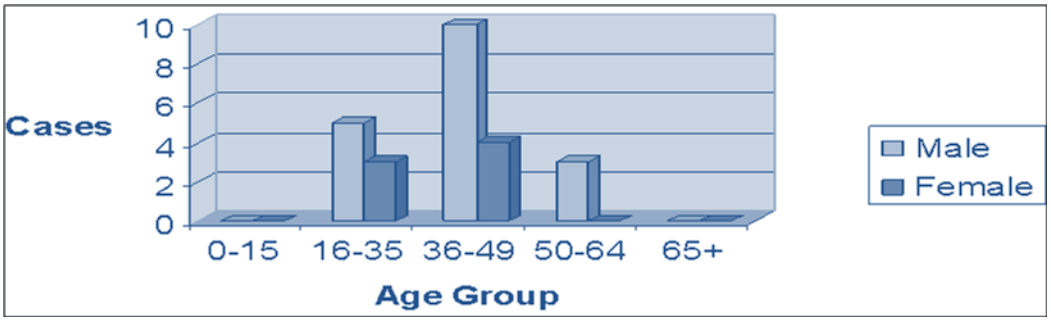
revealed a prevalence of 2% and 7% respectively, thereby indicating that the epidemic may be concentrated in some populations. There is lack of sentinel surveillance in other populations considered to be at increased risk such as MSM and sex workers.

2.2 Sexually Transmitted Infections (STIs) and other Opportunistic Infections[10]

The same factors that place people at risk of exposure to HIV also apply to STIs. The presence of STIs is an early warning indicator to the increased risk of HIV infection. In people living with HIV, STIs hasten disease progression by increasing HIV replication, while in HIV-negative individuals STIs put them at greater risk of acquiring HIV if exposed. Therefore, early detection and treatment of STIs is very important in both prevention and treatment of HIV.

Syphilis is the most prevalent STI in St. Lucia, both in the general population and among those living with HIV. Many HIV patients are identified through STI screening and often have HIV/STI co-infection at time of enrollment to care. Among patients enrolled in care, co-infection of HIV and STIs is most prevalent in men (36-49 years), and significantly more men than women in the 50-64 age group are infected with STIs (Figure 9).

Fig. 9. STIs in HIV Patients (September 2009-June 2010)



2.3 Behaviors associated with Probable but Insufficiently-substantiated Risk

There is very little evidence on the behaviors and cultural factors that can increase vulnerability to HIV infection. However, extensive discussion with key stakeholders has informed the following assessment of behaviors that are most likely to be increasing the risk of HIV transmission in the country.

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

[10] Dr. d'Auvergne, St. Lucia HIV/AIDS Control and Prevention Project – Quarterly Report

- Men having sex with men (MSM). This term refers to the range of men who have anal sex with other men, including those who identify themselves as gay (homosexual) and transgender, as well as those bi-sexual men who have sex with other men on the 'down low (see below). Engaging in anal sex puts all these men at high risk of HIV transmission. Social norms and the prevalent stigma and discrimination and buggery laws have caused these populations to remain hidden.

- Sex work. This includes both commercial sex work and transactional sex, which is reported to be on the rise (see below). Commercial sex workers are both local and foreign. Many local sex workers operate in groups from private homes, organized as their own business, while others operate from brothels or directly from the marina or the street. Women from the Dominican Republic, Colombia, Peru and Brazil (among others) entered the country on work permits as 'exotic dancers' up until 2007, and many have remained, mainly working in brothels. Sex workers, facilitated by taxi drivers and hotels are also involved in providing services associated with the cruise ship industry. Due to mistreatment by the formal health system, many sex workers self-medicate using traditional methods to treat STIs; STIs can compound the risk of both acquiring and transmitting HIV. Sex workers report that they can often charge higher rates for sex without a condom, and reports from sex workers indicate that young ones are less likely to be able to negotiate condom use with their clients.

- Drug abuse. While St. Lucia does not have an injection drug problem, a large number of male and female crack cocaine users have tested positive for HIV, most probably as a result of selling sex in order to get money to buy drugs. A survey conducted by CDARI found that 33% of drug users stated that they had sold sex to men.[11] There are also reports that poor drug users can be taken advantage of by those with power.

- Prisons. Prisoners engage in both consensual and coercive sex (without reliable access to condoms), as well as in tattooing and 'ball-bearing' (which involve cuttings of skin and sharing of cutting instruments). Both anal sex and sharing of cutting instruments such as razor blades put these people at risk of HIV.

2.4 Cultural Issues

There are a range of cultural factors that create vulnerability to HIV in St. Lucia. Chief among these are the following:

- It is socially acceptable for individuals to have multiple (and sometimes concurrent) sexual partners. Traditionally this behavior has been mainly associated with men, as

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

perceptions of manhood have been linked to the number of women with whom a man has sex. Having multiple wives or girl friends, and children sired by different women, is encouraged by other men and is not discouraged by society or the church. Among older men, there is a long-standing practice of sex with younger women. More recently, women are increasingly becoming involved with more than one sexual partner. This appears to be due to a combination of factors that include, for some, a willingness to share and compete for partners and, for others, a search for security or love when a woman's main partner also supports other women.

- The phenomenon of men on the 'down low' – i.e., men who present themselves and often see themselves as hetero-sexual, many of them married, who are involved to an extent in sex with other men. Some are homosexual but are hiding behind a heterosexual lifestyle in order to align with social norms (e.g., having a legal marriage or female live-in partner) to maintain social respectability[12]. Others do not identify even privately as 'homosexual' or 'gay', rather considering themselves as bi-sexual. Some purchase sex with male sex workers. Regardless, the behavior of engaging in anal sex with other men can put them at very high risk of HIV transmission.

- It is widely believed that there is a growing number of young women involved in transactional sex, i.e., who are trading sex either to support their families or for 'gains'. Among those at the lower end of the socio-economic ladder, sex is traded to meet basic family needs, food or transport. This includes a number of young, unmarried mothers. Among those who are financially better off, sex is traded for goods such as shoes, clothing, mobile phones, as well as payment of rent or utilities. Some employed middle-class women view the practice as a way to earn a 'second salary'.

- Stigma and discrimination are reported to be widespread in St. Lucia according to the testimony of people living with HIV and others likely to be at high risk. People living with HIV report mistreatment in the work place, within the family and, in particular, within the health care sector. They live in fear of being 'found out' and are thus reluctant to access the critical prevention education and health services that they need to protect themselves and others. It also discourages testing among those suffering from symptoms, thus explaining the late stage at which many patients present to the health services. And it can lead to 'self-stigma', which also perpetuates the challenges of reaching these individuals.

  Similarly, individuals whose behaviors are not condoned by society (e.g., men having sex with men, sex workers, or drug users) are also reluctant to access critical prevention services for fear of being mistreated within the health care system. Even young people report mistreatment on the basis of their age in health care settings.

[12] **Allen C, 2002 (Can you please get the citation).**

Stigma and discrimination also severely limits the tracing of sexual contacts of those who are HIV positive, thereby hindering the national program's ability to provide prevention information and, possibly, treatment to those who have been exposed to the virus. Without knowing that they might have been exposed, these people are also then continuing to have sex and exposing others.

- In addition, despite the long-standing national response to the HIV epidemic, St Lucians continue to perpetuate myths and misconceptions about HIV. To the extent that people perpetuate myths and have misconceptions they are unlikely to protect themselves from unsafe sex. As many continue to believe that it is possible to identify someone with HIV, and that anyone who looks healthy is not infected, they are likely to put themselves at risk. The perception that one is not at risk in fact puts people and the society more broadly at unnecessarily-high risk. Incorrect perceptions of self-risk are reported particularly among young people, including 'youth on the block'.

- Related to the widespread beliefs in myths and misperceptions about HIV is the taboo nature of sex, which inhibits open discussion of the facts that can protect people from HIV. Reluctance to speak openly about sex between parents and their children, among religious youth, or in the schools keeps young people from getting the prevention information they need to reduce their risk. Unease in dealing with sexual health matters compounds men's poor health-seeking practice as it limits their ability to seek out correct HIV prevention information.

- Related to this is the fact that St. Lucia may be undergoing a fundamental change in its socio-economic development that could increase the risk of acquiring HIV Infection. The change in the family structure from the extended model to an increasingly-mixed nuclear and single parent model has left many young people with limited guidance and social skills to facilitate their development to become productive members of the society. Ensuing pressures from urbanization and high levels of unemployment combined with the current economic down turn has left many insecure about earning a decent living. This can precipitate a moderate stress which is too often alleviated by high risk-seeking behaviors such as alcohol, drug abuse and violence. These behaviors can in turn lead to unsafe sexual practices such as unprotected sex, sexual concurrency and transactional sex, thereby increasing the risk of acquiring HIV infection.

2.5 Legal Barriers to working with Sex Workers, MSM and Drug Users

The criminal code provisions regarding sex work, buggery and drug use hinder the country's ability to fully respond to the needs of individuals practicing these behaviors. By making it difficult for populations at relatively-high risk to access prevention education and services, these legal provisions increase risk of HIV transmission both within these groups and, through them, the wider population.

2.6 Poverty

According to the 2005/6 St. Lucia social poverty assessment, approximately 29% of St. Lucians live below the poverty line and an additional 11.5% are vulnerable to shocks that could place them below the poverty line. Women are more vulnerable to the effects of poverty and face higher unemployment rates. Coping strategies cited include transactional sex with several males and/or commercial sex, which expose women to the risk of contracting STIs, including HIV.[13] There is speculation that the rapid expansion of the tourism sector coupled with the high unemployment rates lead poor women to commercial sex. Poverty is also leaving many people living with HIV (and especially those on ART) in need of food in order to survive their infection and their treatment[14], and leaving AIDS orphans and vulnerable children (OVCs) without basic support to survive and to avoid risk of HIV through transactional or commercial sex work.

2.7 The situation of Young People in St. Lucia

While data are limited, and based on small sample sizes, it is likely that young people have increased vulnerability to HIV due to early sexual initiation, forced sex at first encounter, multiple sex partners, and inter-generational sex (especially girls/young women and older men). The 2006 OECS BSS[15] indicates early sexual debut and low condom use among young people, with 26% having sex before they are 15. The PLACE study[16] (2007) also revealed that risky sexual practices were more prevalent in the 15 -24 age group. In addition, 14% of young females had a partner 10 years or older in the past year. Sixty percent and 28% of males and females respectively had more than one sexual partner in the past 12 months and 14% of females had symptoms of an STI in that same period.

A 2008 USAID assessment[17] indicated that the biggest challenge facing youth in St. Lucia is unemployment, particularly in rural areas (due to the collapse of the banana industry) leading them to engage in illegal activities including selling drugs and sex. A 2009 KAP survey[18], with a small sample size, showed 11% of surveyed youth had sex before age 10, with 61% having first sex between 11-15 years of age.

MAIN MESSAGES: Data are limited, so it is difficult to explain specific drivers of the epidemic. The number of new infections appears stable over the past five years despite increased testing, with general population prevalence estimated at less than 1%. However, small studies indicate higher prevalence among some groups at high risk, and strong and consistent reports from stakeholders indicate a wide range of factors that could put the country at risk of a growing epidemic. HIV STI rates compound this risk.

[13] St. Lucia Country Poverty Assessment 2005/06
[14] 37% of the clinic population pass the needs assessment test and require social support. Dr. D'Auvergne pg. 31
[15] OECS BSS
[16] The PLACE study
[17] USAID, Rapid Youth Assessment in the Eastern Caribbean, 2008
[18] 2009 KAP Survey

3. RESPONSE ANALYSIS

The response over the past five years has been coordinated and managed by Government, with growing support from and collaboration with civil society.

3.1. Financing for the AIDS Response

The major financiers during this period include the following:

- **The World Bank-financed HIV/AIDS project** was provided through an IDA grant, an IDA Credit and an IBRD loan, for a total of US$6.4 million for the period 2006 – 2010 (September). These funds were used primarily to support the salary and running costs of the NAPS, program management and administrative strengthening through training, prevention work undertaken by line ministries and CSOs, the expansion of VCT (through laboratory reagents and equipment, non-ARV medications), MOH bio-medical waste management, renovation of health centers and VCT centers, IEC/BCC campaigns, expansion of PMTCT and support for the Treatment and Care Program of the MOH.

- **The OECS/Global Fund for AIDS, TB and Malaria (GFATM)** Round 9 grant supported St. Lucia with anti-retroviral drugs and drugs for opportunistic infections; training for people living with HIV (adherence, treatment literacy, advocacy); training for health care professionals (on stigma and discrimination, VCT, PMTCT, mentoring). It also financed baby food supplements and, through the Clinton Foundation, pediatric ARVs. Total funding for the years 2008 and 2009 equaled C$415,012.

- A number of UN agencies supported sector-specific initiatives such as: UNAIDS for capacity assessment for development of Global Fund Round 10 country Proposal, preparation of UNGASS reports, development of new strategic plan (2011-2014); and UNESCO support to the Ministry of Education to develop a sector policy.

- The Government of St Lucia provided salary and infrastructure support, as well as covering the costs of training, supplies and materials for VCT, IEC/BCC, etc. For the years 2008 and 2009 the Government contribution to the program was US$874,500.

- In addition, PANCAP has supported a review on the legal, ethical and human rights legislative and policy barriers to the HIV response, and conducted a rapid assessment through its Regional Stigma and Discrimination Unit.

- Additional financial and technical support was received from several bilateral and multilateral agencies including AID Inc, CAREC, CDB, CDC, PAHO and USAID[19].

[19] UNGASS Country Report 2010 (for the period January 2008 – December 2009 (pp. 31)

3.2. Implementation of the AIDS Response

Implementation of the national response has been undertaken by the following main partners:

- NACC (National AIDS Coordinating Council)
    - Established by Cabinet in 2005 to oversee the national program. It is chaired by the Minister of Health, co-chaired by the MoH Permanent Secretary, with the Chief Medical Officer serving as Secretary
    - Comprised of 15 representatives from Government and civil society
    - Serves as the Country Coordinating Mechanism for 3 ones principles (?)
    - Meets when and as needed to endorse proposals put before it
    - A NACC sub-committee, chaired by a representative of the private sector, reviews and approves annual work plans from line ministries and proposals from CSOs
    - The NACC has not been seen to have authority to make significant changes in the national response

- NAPS (National AIDS Program Secretariat)
    - Mandated by a Cabinet conclusion in 2006 to manage, implement and coordinate the national response (created by the World Bank-financed project)
    - Coordination involves developing plans, ensuring implementation, monitoring and reporting, M&E, meeting of stakeholders, providing regular implementation support
    - Staffing has included a Director, M&E staff, program mgmt, IT, IEC/BCC
    - Responsible for: developing line ministry action plans in collaboration with ministry AIDS focal points and civil society proposals; training of line ministry focal points and other key stakeholders including civil society
    - Technical committee convened by the NAPS to review annual work plans and CSO proposals before submission to the NACC (to assure alignment with the NSP, internal logic, M&E, and appropriateness of cost)
    - Regular meetings of NAPS, the Project Coordination Unit (PCU) in the Ministry of Finance and MoH to discuss and facilitate program implementation

- NAP (National AIDS Program)
    - Based in MoH, responsible for the health sector response to HIV and AIDS
    - Coordinates and monitors all MoH departments involved in HIV and AIDS (e.g., lab, Bureau of Health Education, Community Nursing Service, General Hospital maternity and medical wards, and the Blood Bank)
    - Staff include: Director, Health Educator, Secretary, STI Physician and Nurse
    - It is looked to for leadership to provide technical support to other partners on specific issues (e.g., VCT)

- Ministry of Health Accounts Department
    - Provides financial management and procurement support to projects funded through PAHO, UNAIDS, bilateral and UN agencies

- Project Coordination Unit (PCU)
    - Provides financial management and procurement support to NAPS for the WB-financed and GFATM projects, including training of NAPS staff and implementing agencies
    - Located in the Ministry of Finance and Economic Affairs
    - Part of the technical committee that assesses ministry work plans and proposals from CSOs

- Civil society organizations (CSOs)

The main partners include: AIDS Action Foundation, Tender Loving Care, Planned Parenthood, St. Lucia Red Cross, United and Strong, CDARI, CAFRA, ASPIRE, and St. Lucia Medical and Dental Association. Several trainings were conducted to build the capacity of CSOs: Sub projects applicants' orientation seminar, proposal writing, leadership and management, trainer of trainers' workshop, Behavior Change Communication (BCC) workshops and HIV group education workshops. Broadly, the work of CSOs over the past five years has covered:

    - General population sensitization and awareness raising
    - Support to people living with HIV and AIDS
    - Community outreach to and mobilization of MSM, sex workers, drug users and prisoners
    - Support to young people, including in-school and out of school youth
    - Workplace policy development and awareness raising in cooperation with the private sector
    - Provision of ARVs
    - Counseling and testing

- Line ministries
    - MOE: teacher training, implementation of compulsory Health and Family Life Education (HFLE) in primary and secondary schools, integration of the book bursary program for orphans and vulnerable children (OVC), and school transport for OVC at most schools, organization of VCT with Scotia Bank on Valentine's Day, and development of an education sector policy that has recently been sent to Cabinet for approval
    - Department of Human Services: social welfare support to OVC and needy PLHIV including counseling, operating a Food Bank, publication and distribution of a booklet featuring stories of St. Lucians living with HIV and basic facts (which helps address stigma and discrimination and has been useful to people newly-diagnosed)
    - Ministry of Home Affairs: conducted psycho-social and counseling training for prison staff, peer education for officers and inmates, the Bordelais Correctional Facility provides treatment, care and support to HIV positive inmates and referral links for their children to be supported under the OVC programme.
    - Ministry of Communications and Works: provides prevention education for taxi and bus drivers, and for their own staff

- Intra-Ministerial Committee (comprised of representatives from the ministries of Education, Finance, Public Service, Community Development, Tourism, Youth and Sports, the Department of Human Services and the NAPS). Activities have included sensitization of staff, testing, IEC/BCC activities with staff, working around special events such as World AIDS Day and Valentine's Day

3.3. Major Achievements (2005-2009)

The Major Achievements in the past five years include:

- Stabilized incidence of HIV and reduction in STI rates[20]

- Reduction in the mortality rate of patients with HIV from 46.2 per 100,000 in 1999 to 14.8 per 100,000 in 2009

- Prevention of mother-to-child transmission (PMTCT) : Due to scale up of testing of pregnant women, there has not been a single case of peri-natal transmission of HIV in St. Lucia since 2006 among all those enrolled in care.

- Anti-retroviral therapy has been made widely available, and taken up by two-thirds of those medically-eligible clinic patients registered in the clinic, leading to a reduction in both mortality and morbidity. In 2009, of the 15 registered patients whose CD4 count indicated eligibility for ART, 13 are now on treatment.

- Voluntary Counseling and Testing (VCT) and Provider-Initiated Testing and Counseling (PITC): since 2006 outreach efforts have led to an increase in the number of tests from 4,852 in 2005 to 20,430 in 2009, with growing acceptance of the importance of testing.

- Strengthened health care response more broadly[21]:

    - Integration of the treatment and care program covered by the World Bank-financed project into MoH
    - More health care providers delivering care and increasing decentralization of service provision
    - Creation of clinical teams to provide guidance on clinical and programmatic management of patients with HIV and STIs
    - Strengthening the PLHIV support group and stronger collaboration with vulnerable groups (sex workers, drug abusers, men having sex with men)
    - Community involvement through education of men and youth on STI/HIV

[20] Reduction in the incidence of syphilis by 21.2% and of gonorrhea by 27% from 2007 to 2009

[21] St. Lucia HIV/AIDS Control and Prevention Project Quarterly Report January – March 2010, Cleophas d'Auvergne, MD, MPA, Clinical Care Co-ordinator (29/4/10)

- Improved access to STI treatment for vulnerable youth
- training of health care providers in clinical management of STI/HIV and expansion of service
- Continued service expansion at the Bordelais Correctional Facility
- Strengthening integration of the clinical team, increasing collaboration between in-patient and out-patient care services and the HIV and TB programs
- Strengthening management information systems
- Implementation of the pharmacy information system at Victoria Hospital
- Clinical mentoring program

- Strengthened management and coordination of the national program, with greater participation of civil society and the mainstreaming of prevention programs into a number of important line ministries

- Support to OVCs to protect them and keep them in school through provision of medical care, food, foster care, school books and transport. Provision of social support for over 199 children (what percentage of those in need does this represent?) infected and affected by HIV

- Capacity of the Ezra Long Laboratory in Victoria Hospital and St. Jude Hospital Laboratory was increased to enable confirmatory testing to be done locally and more quickly and to undertake CD4 testing

- Draft National Policy on HIV and AIDS, including a model for use in workplaces across the island

3.4. Major Challenges and Lessons Learned in the Implementation of the National Program (2005-2009)

The major challenges faced by program implementers include the following:

- The broad-based culture of not using evidence to inform programming poses a challenge to obtaining support from policy makers and implementers that is critical for appropriate program development and monitoring. Health care providers do not consistently observe the reporting requirements thus leading to insufficient data necessary to provide an understanding of the epidemic and consequently to inform programming, for example private physicians do not routinely report the number of people testing positive for HIV. These cases are picked up from lab-provided reports, since all positive tests are sent to the public sector lab for confirmation but as a consequence all the relevant basic client data including mode of transmission are missing. The national response to HIV and AIDS needs to receive greater commitment by Government, which has tended to view it as a health issue rather than as a development issue

- Stigma and discrimination continue to inhibit the program's ability to work effectively with MARPs due to the limiting legislative environment, and are likely responsible for the fact that roughly 28% of those who test positive are not registered with the national program and that 43% present late with stage 3 or stage 4 AIDS diagnoses[22]

- After having provided a comfortable and enabling environment for patients it has become increasingly clear that their social support needs are outpacing their clinical treatment. Without the social support structures, issues of treatment adherence and reducing high risk behavior is difficult

Lessons learned from implementation of the national program over the past five years include the following:

- Sustainability is critical in order to maintain service provision (most acutely, life-saving drugs and food, but also essential prevention education and health services) and staff morale. [23] Project funds do not last forever and thus Government and its partners need to plan for the future. Issues of sustainability can limit planning and organization of treatment support services.

- CSOs are key partners in the response. In order to provide increasingly-better services and be able to monitor and evaluate their work, CSO capacity needs to be strengthened.

- A strong partnership with line ministries (especially with Ministry of Education and the Ministry of the Public Service) requires that HIV/AIDS focal points be allowed to work full-time in the role, rather than having HIV/AIDS duties appended to their existing function.

- Efforts to integrate the HIV program into the health system require careful consideration and planning to ensure its significance is not reduced. Despite these constraints, integration of care is essential, as demonstrated by the recent success of integrated health teams. [24]

- A trusting clinician-patient relationship is critical to the success of the clinical team in providing treatment, care and support. Patients prefer to be consistently seen by one doctor.

MAIN MESSAGES: The response has made gains during the last five years due in part to coordination by the NAPS and contributions of health and non-health partners. Achievements have included reduced mortality and morbidity, and a wide range of prevention interventions (although these were directed mainly at the general population). While the program has been funded largely from external sources in the past five years, the

[22] D'Auvergne, ibid (p.22,23)
[23] D'Auvergne, ibid (p. 35)
[24] D'Auvergne, op cit (p. 35, 36)

both World Bank and Global Fund financing are now over. Thus prioritization is critical to ensure continued provision of treatment, care and support, gaining a solid understanding of drivers of the epidemic in St. Lucia, and careful targeting of prevention work most likely to have an impact on reducing the number of new infections.

4. NATIONAL STRATEGIC PLAN 2010-2015

As noted above, immediate future financing is highly uncertain and thus key interventions are prioritized (prioritized interventions are in boxes) to the extent that only limited funding available those top priorities will need to be funded first. When further funding becomes available the rest of the proposed program will need to be financed and implemented.

4.1 VISION FOR THE NSP 2010-2015

- The national response will be well coordinated and be managed on the basis of reliable evidence, monitoring and evaluation
- Civil society will play an increasingly important role in the response, especially with respect to provision of support to MARPs
- Those at greatest risk -- sex workers, MSM, prisoners and drug users – will have access to a package of basic prevention education and health services
- The level of treatment, care and support will be maintained and improved, in collaboration with people living with HIV and AIDS
- Implementation and financing will become sustainable

4.2 GOAL: To maintain the present low level of HIV and AIDS in the general population

4.3 OUTCOMES TO BE ACHIEVED

1. Evidence base strengthened to provide a solid foundation for future prevention planning;
2. Targeted prevention work with MSM, sex workers and drug users based upon existing evidence scaled up;
3. Prevention work with youth, the prisons and the workplace maintained;
4. VCT, PMTCT, and blood safety programs and services maintained;
5. STI services streamlined;
6. Treatment, care and support services maintained and strengthened;
7. Support to OVC and needy PLHIV maintained;
8. HIV and AIDS-related stigma and discrimination in the workplace and the community reduced;
9. Institutional arrangements in place to continue program management, coordination and monitoring at the national level;
10. Capacity to manage the national response strengthened.

4.4 INTERVENTIONS TO ACHIEVE THE OUTCOMES

01. Evidence base strengthened to provide a solid foundation for future prevention planning

The strategy aims to document and disseminate evidence that will provide reliable guidance to policy makers and planners for future prevention programming and, in the process, strengthen the national HIV surveillance program.

To establish a strong evidence base for future planning and surveillance strengthening the following priority work will be undertaken:

Priority Interventions

- Population mapping and integrated bio-behavioral surveys of MSM, sex workers, prisoners and drug users (for drug users, biological surveillance only, as behavioral surveillance has recently been conducted)
- Study of clinical management, to understand *inter alia* why most of those who test do not access their test results; why many who test positive do not register with the system and are thus 'lost' to follow up; and why so many test very late in the disease process

- Study on stigma and discrimination, based on experience of people living with HIV and AIDS and groups most at risk to explain the scale and nature of the problem
- Study on inter-generational sex to determine the extent of risk to young women, older men and wives of older men
- Study of the tourism sector to assess the scale and nature of the risk of HIV transmission through sex work
- Assessment of HFLE to determine the impact of the curriculum on behavior of young in-school youth and propose ways to strengthen it
- Improve epidemic data analysis to reflect where new cases are coming from, including presentation of trends over the past five years

The bio-behavioral studies will be undertaken through collaboration among the Ministry of Health, civil society organizations and the communities with whom they work, and an external partner with a demonstrated track record in structuring and guiding the studies, training local partners to map population size, conduct the biological and behavioral surveillance, and analyze the data.

The studies on intergenerational sex will be the responsibility of experienced civil society partners.

The studies on sex work in the tourism industry, the clinical management issues and HFLE will be conducted through collaboration between civil society and the Ministry of Tourism, the Ministry of Health, and the Ministry of Education, respectively.

02. Targeted prevention work with MSM, sex workers and their clients, prisoners and drug users based upon existing evidence scaled up

Priority Interventions

A minimum package of services will be designed and implemented by civil society partners with experience in working with the targeted communities, in collaboration with the National AIDS Programme. The objective is to increase coverage and improve the quality of services to these groups, thereby reducing the risk of transmission within the groups and between members of the groups and the general population. The minimum package of services will include:

- Behavior change prevention education to ensure that communities believed to be at highest risk have correct knowledge about HIV and STIs and have the motivation and ability to act on their knowledge
- VCT in prioritized locations where those most likely to have been exposed to the virus are likely to be found
- Condoms/lubricant for communities engaged in risky sex
- STI services for individuals at high risk of infection

In order to fully implement provision of the minimum package of services, a supportive environment to encourage behavior change will be enhanced through:

- Increased awareness among decision-makers of the risks confronting these groups and the factors that impede efforts to reduce these risks
- Improved collaborative relations with the police and local authorities/communities to support prevention interventions with the groups at greatest risk
- Respectful, client-friendly, confidential STI clinical services

03. Prevention work with youth, the prisons and the workplace maintained

The strategy aims to implement prevention programs for youth, the prisons and in the workplace.

The strategy will focus on young people, both in school and out of school, in light of the apparent low level of understanding of the epidemic, how to protect themselves, and the high level of sexual activity:

- For in-school youth: While the assessment of the current HFLE program is going on, the Ministry of Education will continue its ongoing work program, with the expectation that it will be refined on the basis of results from the HFLE assessment.
- For out-of-school youth: Outreach by CSOs to youth on the block will be scaled-up.

The strategy will maintain prevention work for staff and inmates at the prisons. Interventions will include:

- TB screening for inmates only
- HIV 101 training for staff and inmates
- Distribution of IEC/BCC materials
- HIV testing (VCT/PITC)

The strategy will also support scaling-up of workplace HIV/AIDS programming through collaboration between the private sector, CSOs and the government; the Ministry of Labour will coordinate the implementation of the National HIV/AIDS workplace program. The purpose of these efforts is to enhance basic knowledge of HIV prevention and reduce HIV and AIDS-related stigma and discrimination in the workplace. Interventions will include:

- Workplace education programs
- Workplace testing campaigns
- Expanded coverage of HIV workplace policies to prevent stigma and discrimination with respect to employment

04. VCT, PMTCT and blood safety programs and services maintained

The strategy will support HIV testing among the general population, MARPs, pregnant women and infants of HIV-positive pregnant women, blood donors and other sub-populations, delivered via the VCT, PMTCT and Blood Safety programs.

The VCT program will cover the general population, MARPS and other sub-populations. Interventions will include:

- Scaling-up of rapid testing;
- Outreach VCT to workplaces and MARPS;
- Review of National VCT strategy and program, based on results of clinical management study;
- Continued training of health care providers and other stakeholders

All pregnant women and all children of HIV-positive pregnant women will be tested for HIV. The strategy will also seek to increase coverage of male partners of pregnant women through strong community education and testing. Interventions will include:

- Testing of pregnant women at antenatal clinics and delivery rooms;
- Provision of feeding formula to HIV+ mothers;

- Provision of ARVs for HIV-positive mothers and their infants;
- IEC/BCC at antenatal clinics and delivery rooms;
- Provision of feeding formula to HIV+ mothers;
- IEC/BCC and testing of male partners;

The strategy also supports HIV testing and screening for other STDs/STI among all blood donors. *National Blood Bank Service staff will be trained on program maintenance and updates, first aid, donor marketing, customer service;*

05. STI program services streamlined

The national STI program and strategy will be reviewed and strengthened such that respectful, client-friendly, and confidential STI services are available to clients. The following initiatives will be supported:

- Incorporation of the STI services review into the STI program;
- More flexible opening hours for STI clinics;
- Scale-up of professional and specialist services available to STI cinics;
- Recruitment/ increased participation of doctors from private practice through training and other incentives;
- Implementation of a program of referrals – including primary care centres, peer educators and other implementing agencies.

06. Treatment, care and support services maintained and strengthened

Based upon assessment of the clinical care program over the past several years, the following interventions are included in the strategy in order to further strengthen the provision of services to those living with HIV and AIDS. Implementation will be led by the Ministry of Health:

Priority Interventions

- Make available human resources to maintain quality of care delivered by Government (including nutritional support, surveillance officer, data entry, pediatrician, phlebotomist)
- Implement and monitor the contact tracing program
- Strengthen adherence programs
- Increase enrollment of people living with HIV into the treatment and care program.

Services for MARPS (part of package of services)

- Treatment for all those who test positive for HIV
- Ongoing psychosocial counseling for all those who test positive for HIV
- Legal services

- Enhance integration of components supported through the World Bank-financed project into the Ministry of Health
- Increase the number of private and community clinicians treating patients with HIV through provision of incentives for the private sector, such as training of physicians in HIV-STI management
- Increase co-operation and planning with support groups of people living with HIV
- Integrate HIV and AIDS in the public health system. This will require training for health care providers on provision of HIV services and respectful and confidential treatment of HIV patients
- Strengthen leadership and training for health care providers
- Increase collaboration between the TB and HIV programs
- Scale up rapid testing
- Maintain and strengthen PMTCT program by encouraging testing of male partners including strong community education and testing to ensure greater coverage.

07. Support to OVC and needy PLHIV maintained

The strategy aims to provide care services likely to mitigate the impact of the epidemic on OVC and needy people living with HIV.

Work to support OVC will continue to be undertaken through collaboration between the Department of Human Services and the Ministry of Education. The response is intended to help keep them in school, as well as to keep them safe and help them to avoid risk for HIV, either through sexual abuse or through selling of sex to meet their basic needs. Thus, the range of ongoing services for these children, including those mainstreamed into government programs, will be maintained and expanded, including:

- Foster care
- Trained school counselors
- Transportation assistance
- Book bursary program
- Food Bank services

Support to needy people living with HIV will continue to be the responsibility of the Department of Human Services. For people living with HIV there is a special need to provide services that address the financial hardship that many of them face. Thus, in addition to the clinical support required to manage their infection, the strategy will continue and strengthen the social support services already in place, including

- Psycho-social counseling
- Food Bank (it is estimated that over 90% of those taking advantage of this service are unemployed). Ongoing efforts by the Ministry of Health to mobilize support from

the private sector can play an important role to sustain this service in collaboration with Government.

- The Ministry of Health will continue to strengthen linkages with government programs that provide welfare payments, skills training, employment and housing

08. HIV and AIDS-related stigma and discrimination in the workplace and the community reduced

The strategy to reduce HIV and AIDS related stigma and discrimination will be directed in the workplace and in the community.

The Ministry of Labour, in collaboration with focal points in implementing businesses/workplaces, will assume responsibility for coordinating and monitoring workplace programs. The reduction or elimination of stigma and discrimination in the workplace will be an integral part of workplace policies, which will be developed, implemented and monitored during implementation of workplace programs.

The Human Rights Desk (operated by AIDS Action Foundation) will be reviewed and strengthened – based on the results of the anti-stigma and discrimination study in Outcome 1 – to continue to receive and record complaints and to provide appropriate legal advice/services for redress if and when required.

Anti stigma and discrimination campaigns, including the development and dissemination of IEC/BCC materials to the general population and other sub-populations (including workplaces) is also included under this outcome.

09. Institutional arrangements in place to continue program management, coordination and monitoring at the national level

The end of the World Bank-financed project and the closure of the NAPS means that the responsibility for management and coordination of the national response – comprising responses from heath and non-health sectors - will ideally be transferred to the NAP of the Ministry of Health. Until funds are made available to institute this arrangement, the NAP will be strengthened by hiring/absorbing key technical staff of the NAPS to coordinate the key functions of M&E, non-health sector response, and IEC/BCC. A focal point or coordinator will be appointed to coordinate the health sector response.

- The NACC will continue to have oversight of the National Response and serve as the Country Coordinating Mechanism in accordance with the "3 Ones" principles;
- The NAP will implement the decisions of the NACC, report to the NACC through the Permanent Secretary of the MOH, and ensure that sectoral plans, projects and programs are aligned to the NSP for 2011-2015;
- Focal points will coordinate (sectoral) responses by implementing agencies (MOH, line ministries.

10. Capacity to manage the national response strengthened

In order to strengthen the national response to HIV and AIDS, the strategy recognizes the critical importance of strengthening the capacity to understand the epidemic, develop and implement appropriate interventions, and monitor progress. To these ends, it includes the strengthening of capacity in the following areas:

Priority Intervention

- Surveillance and epidemic analysis: TA expected through CDC under the upcoming regional PEPFAR program

- Civil society working with MARPs and PLHIV: TA expected through CDC under the upcoming regional PEPFAR program
- M&E: TA expected through CDC under the upcoming regional PEPFAR program
- Health care workers: Technical support to nurses and doctors from the main hospitals provided through potential partners such as Caribbean HIV AIDS Regional Training Network.
- Lab: Technical support on testing, diagnosis, and patient monitoring (including drug resistance monitoring) in both the public and private sectors with support from potential partners such as CCAS
- Ministry of Labor (for workplace programs)

4.5 FUTURE PLANNING

Under PEPFAR, the Government of Saint Lucia will collaborate with the Centers for Disease Control (CDC) to implement a three-year cooperative agreement commencing October 2010 to strengthen laboratory services and HIV/AIDS strategic information. The specific objectives of the support are to:

- Build capacity to implement surveillance and surveys to accurately characterize the dynamics driving the epidemic in the country (including an expanded focus on those at greatest risk), inform policy implementation, and support the implementation of evidence-based HIV programming at national and sub-national levels;

- Support the implementation of monitoring and evaluation (M&E) strategies to increase the use of strategic information for monitoring, evaluation and improvement of HIV program quality, performance and accountability;
- Strengthen capacity of the MOH to strategically generate, collect, interpret, disseminate, and use quality strategic information, as well as provide salary support for two technical staff position;
- Improve the scope and quality of HIV diagnostic and laboratory services and systems.

A total of US$ 460,000 has been budgeted comprising US$ 400,000 for Strategic Information and US$ 60,000 for Laboratory strengthening

4.6 NEXT STEPS IN PREPARATION FOR DESIGN PHASE (2013-2015)

Formal review of data provided through studies to be undertaken during the first phase will be organized by the National AIDS Programme. Findings from the studies will be disseminated to stakeholders and the formal review will provide a forum to discuss how to use their findings in careful design of the interventions to be provided during the second phase of the strategy.

The expectation is that with better data St. Lucia will be in a position to develop more targeted prevention planning and refinements in the provision of treatment, care and support. The MARP mapping work will provide population size estimates (and geographical 'hot spot' locations), and these estimates will provide the baselines against which coverage targets can be developed.

5 Results Framework

Outcome Results	Related Output Results
1. Evidence base strengthened to provide a solid foundation for future prevention planning	• Population mapping and integrated bio-behavioral surveys of MSM, sex workers, prisoners and drug users (for drug users, biological surveillance only, as behavioral surveillance has recently been conducted) • Study on stigma and discrimination, based on experience of people living with HIV and AIDS and groups most at risk to explain the scale and nature of the problem • Study on inter-generational sex to determine the extent of risk to young women, older men and wives of older men • Study of the tourism sector to assess the scale and nature of the risk of HIV transmission through sex work • Study of clinical management, to understand *inter alia* why most of those who test do not access their test results; why many who test positive do not register with the system and are thus 'lost' to follow up; and why so many test very late in the disease process • Assessment of HFLE to determine the impact of the curriculum on behavior of young in-school youth and propose ways to strengthen it • Improved epidemic data analysis to reflect where new cases are coming from, including presentation of five-year trend data

Outcome Results	Related Output Results
2. Targeted prevention work with MSM, sex workers and their clients, and drug users based upon existing evidence scaled up	*Minimum Package of Services* • Behavior change prevention education for communities believed to be at highest risk provided • VCT in prioritized locations where those most likely to have been exposed to the virus are likely to be found expanded • Condoms/lubricants for communities engaged in risky sex provided • Respectful, client-friendly, confidential STI clinical services available • Treatment for all those who test positive for HIV available • Ongoing psychosocial counseling for all those who test positive for HIV available • Legal services provided *In order to fully implement provision of the minimum package of services, a supportive environment to encourage behavior change will be enhanced through:* • Increased awareness among decision-makers of the risks confronting these groups and the factors that impede efforts to reduce these risks • Improved collaborative relations with the police and local authorities/communities to support prevention interventions with the groups at greatest risk
3. Prevention work with youth, the prisons and the workplace maintained	• Work program of the Ministry of Education refined, on basis Assessment of HFLE, and continued; • Outreach prevention work by CSOs to youth on the block scaled-up; • Workplace education campaigns scaled-up; • Workplace testing campaigns scaled-up; • Prevention work with the prisons maintained;

Outcome Results	Related Output Results
4. VCT, PMTCT, and Blood Safety programs and services maintained	• VCT program strengthened by scaling-up rapid testing; • Existing PMTCT program maintained; • Coverage of male partners of pregnant women increased through strong community education and testing; • National Blood Bank service maintained;
5. STI program and services streamlined	• Existing STI program and services reviewed; • New strategy to strengthen existing STI program developed on basis of STI program and services review; • Respectful, client-friendly, confidential STI services made available;
6. Treatment, care and support services maintained and strengthened	• Integration of components supported through the World Bank-financed project into the Ministry of Health enhanced; • Human resources to maintain quality of care delivered by Government (including nutritional support, surveillance officer, data entry, pediatrician, phlebotomist) made available; • Number of private and community clinicians treating patients with HIV increased through provision of incentives for the private sector, such as training of physicians in HIV-STI management; • Co-operation and planning with support groups of people living with HIV increased; • HIV and AIDS integrated in the public health system (training for health care providers on provision of HIV services and respectful and confidential treatment of HIV patients); • Leadership and training for health care providers strengthened; • Contact tracing program implemented and monitored; • Adherence programs strengthened; • Collaboration between the TB and HIV programs increased;

Outcome Results	Related Output Results
7. Support to OVC and needy PLHIV maintained	*For OVC: The following services will be available to [all] those in need:* • Foster care • Trained school counselors • Transportation assistance • Book bursary program • Food Bank services *For Needy People Living with HIV: available to [all] those in need:* • Psycho-social counseling provided • Food Bank established and food provided • The Ministry of Health linkages with government programs that provide welfare payments, skills training, employment and housing strengthened
8. HIV and AIDS-related stigma and discrimination in the workplace and the community reduced	• Coverage of HIV workplace policies to prevent stigma and discrimination with respect to employment expanded; • Interventions to prevent stigma and discrimination in the community developed and implemented;
9. Institutional arrangements in place to continue program implementation and monitoring	• Key technical staff of the NAPS hired to coordinate the following key functions (M&E, coordination of non-health sector response, IEC/BCC) • Focal points coordinate (sectoral) responses by implementing agencies (MOH, line ministries.

Outcome Results	Related Output Results
11. Capacity to manage the national response strengthened	• Surveillance and epidemic analysis • Civil society working with MARPs and PLHIV • M&E • Lab, health care workers • Ministry of Public Service (for workplace programs)