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DRAFT

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral therapy
ASAP	AIDS Strategy and Action Plan
BCC	Behaviour Change Communication
BHC	Basseterre Health Centre
CARICOM	Caribbean Community
CBO	Community-based Organization
CCL	Caribbean Congress of Labour
CHC	Cayon Health Centre
CHS	Community Health Services
CMO	Chief Medical Officer
CSW	Commercial sex worker
CTHC	Charlestown Health Centre
FACTTS	Facilitating Access to Confidential Care and Testing
FBO	Faith-based Organization
GHC	Gingerland Health Centre
HCP	Health care provider
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
ILO	International Labour Organization
IPPF	International Planned Parenthood Federation
IT	Information technology
KAPB	Knowledge, Attitude, Belief and Practices
LEHR	Law, ethics and human rights
MOH	Ministry of Health
MSM	Men who have sex with men
NACHA	National Advisory Council on HIV/AIDS

NAS	National AIDS Secretariat
NEHAC	Nevis HIV/AIDS Committee
NGO	Non-governmental Organizations
NTHC	Newtown health Centre
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PITC	Provider initiated testing and counselling
PLWHA	People living with HIV/AIDS
PMTCT	Preventing Mother to Child Transmission
PPMTCT	
PNC	Postnatal Clinic
PSI	Population Services International
RPR	
SDD	Stigma, Denial and Discrimination
SPHC	Sandy Point Health Centre
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex Worker
UNAIDS	
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Testing and Counselling
VDRL	
YFS	Youth-friendly services

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EXECUTIVE SUMMARY

Introduction

The interactions between HIV/AIDS and SRH are acknowledged at varying levels. Their commonalities include similar root causes, transmission and management techniques. Therefore linkages between core HIV and SRH services have been shown not only to be economically feasible, but also associated with numerous public health benefits. Recommendations are therefore postulated for each health level: policy, systems and service provider levels.

Aim

This study was designed to assess the linkages between SRH and HIV/AIDS from the policy, systems, service provider and client's levels with the assistance of group and individual sessions and self-and individual-administered questionnaires.

Method

Desk reviews were conducted on HIV, SRH and general policies identifying possible linkages. The linkages were extracted from 'Rapid Assessment tool for SRH and HIV linkages: a generic guide'¹ and categorized utilizing categories adapted from the 'Linking SRH and HIV/AIDS'² as outlined below:

1. Learn HIV status and access services: *accessibility and affordability, dual protection, referrals, integration of services, confidentiality, stigma and discrimination, VCT services, home-based care.*
2. Promote safer and healthier sex: *dual protection, attitudes towards key populations, attitudes towards PLWHA, gender equality, gender-based violence, engagement of men in responses, decentralization strategies.*

3. Optimize the connection between HIV/AIDS and STI services: *integration of services, stigma and discrimination, funding, logistics and supplies, contact tracing, VCT services.*
4. Integrate HIV/AIDS with maternal and infant health: *PMTCT programme, attitudes towards PLWHA.*
5. Creating an enabling environment: *human rights, workplace policy, gender equality, elimination of gender-based violence.*

Semi-structured and in-depth interviews from the rapid assessment were adapted at the policy, systems and service provider levels and interview- and self-administered questionnaires were conducted at the clients' level to identify these gaps. Informant interviews were then conducted for clarification and explanatory purposes.

A rating scale of 1-10 was utilized when participants were asked to quantify extents with 1 being assigned the lowest score and 10 the highest possible score.

Limitation

The rapid assessment was conducted after new policies were formulated, but not yet activated.

Analysis

The policymakers, in their interviews, referred to the new policies which were formulated but not yet activated. This affected the method of analysis which had to be adapted to include a separation between the desk review and the policymakers' interviews, and the system managers, service providers and clients' interviews.

Gaps were identified within each linkage by the following methods of analysis:

- I. Gaps within each level.
- II. Gaps between the policy document and the policymakers.
- III. Gaps between the system managers, service providers and clients level.

Results

1. Desk review

The desk review was conducted on 3 HIV, 2 SRH and 1 general policy documents.

- Almost all of the identified linkages were addressed in HIV policies, whilst the SRH policies were noted to be inadequate as it relates to SRH and HIV linkages.
- The linkages not addressed by any of the policies include:
 - I. Workplace policy with HIV and SRH components
 - II. Criminalizing HIV transmission.
- Although PMTCT was instituted in clinics, little emphasis was placed on family planning and fertility and reproductive choices within the PMTCT programme.
- The 2009-2010 National HIV Operational Plan, developed to guide the management and implementation of the national response, did not focus on gender issues and legal ages.

2. Results from Interviews and Questionnaires (see table 1)

Table 1: Summary of identified gaps and proposed recommendations for each linkage

Linkage	Identified gaps	Recommendations
Accessibility and affordability	There are inconsistencies with the requirement for parental consent for persons less than 16 years	<ul style="list-style-type: none"> • Measures should be put in place to increase accessibility of healthcare in the youths
Referrals	The adequacy of the referral system for PLWHA was not explored in the rapid assessment as the interviews were conducted at the Community Health Services and not through the Clinical Care team who is responsible for the medical management of PLWHA.	<ul style="list-style-type: none"> • The referral system should remain as is. • Screening of tuberculosis should become standard in PLWHA. • Efforts should be made to ensure that PLWHA have access to specialized medical care.
Confidentiality	The adequacy of the referral system for PLWHA was not explored in the rapid assessment as the interviews were conducted at the Community Health Services and not through the Clinical Care team who is responsible for the medical management of	<ul style="list-style-type: none"> • Present laws be amended to include recommendations made by the LEHR. • Further exploration of the confidential nature of HIV and SRH services, privacy and security of information is required.

Linkage	Identified gaps	Recommendations
	PLWHA.	
VCT services	On the day of the interview, none of the clients received VCT services.	<ul style="list-style-type: none"> Develop the HMIS More emphasis placed on PITC. Disaggregation of data for VCT to include first time and repeat clients.
Stigma and discrimination	<ul style="list-style-type: none"> Stigma and discrimination, although adequately addressed in the HIV policies, was not adequately addressed in the SRH policies. Clients' perception of stigma and discrimination was not adequately explored. 	<ul style="list-style-type: none"> Develop General Health Policy for stigma and discrimination with clearly articulated penalties for breach. Present laws be amended to include recommendations made by LEHR. Liaison with LEHR consultant working in the Ministry of Labour. Increase public sensitization on human rights and facilitate easier access to human rights desk. A focal point identified to address stigma and discrimination.
Home-based care	<ul style="list-style-type: none"> The CHS provide home-based care, but CHS are not usually required to give home-based care. The role of the CHS, FBOs, CBO in providing home-based care needs to be firmly established. 	<ul style="list-style-type: none"> Identification of resources, build a multi-sectoral team, develop and implement a strategy/policy/plan. Establish a general home-based care plan that will incorporate PLWHA. Identify all persons/organizations providing home-based care and coordinate services.
Dual protection	<ul style="list-style-type: none"> <1/3 of clients who sought SRH services were advised on condom usage. Approximately equal advice on the usage of condoms to prevent pregnancy and to prevent HIV/STIs. No local policies supporting condom access. 	<ul style="list-style-type: none"> Formulation and distribution of a condom access policy by the Ministry of Health. Formulation of a Monitoring and Evaluation Plan by the Ministry of Health. Inter-sectoral coordination organized by the Ministry of Health. Training for service providers. Involvement of clients in their care plan.
Attitudes towards key populations	<ul style="list-style-type: none"> There is a need to increase capacity building on HIV and SRH services which addresses attitudes towards key populations and improve specific HIV information and services for these populations at the health centres. 	<ul style="list-style-type: none"> Increase capacity building on HIV and SRH services which addresses attitudes towards key populations particularly the youth. Improve specific HIV services and information for MSM, CSW and the youth at health centres. Encourage and commence public debate relating to decriminalizing MSM and CSW.
Engagement of men in responses	<ul style="list-style-type: none"> Clients attending the antenatal clinics were not generally engaged in a discussion on men's health. 	<ul style="list-style-type: none"> Encourage male involvement at the Antenatal Clinics – PPMTCT. Formulation of a men's policy to guide the General Operational Plan.
Decentralization strategies	<ul style="list-style-type: none"> There is a need for more development partners for the SRH programme, greater staff motivation, equipment, supplies and drugs at the SRH facilities. 	<ul style="list-style-type: none"> Build a network of national development partners primarily for funding, support, advocacy and technical assistance. Further intervention by Maternal and Child Health Services, Child Probation and legal departments to address the early sexual debut in the Federation.
Integration of services	<ul style="list-style-type: none"> The SRH policies minimally addressed HIV-related issues and 1/5 of the services received by clients accessing SRH services were HIV-related. This may partially explain why <20% of the services received by clients accessing SRH services were HIV-related. 	<ul style="list-style-type: none"> It is envisioned that there will be a review of the SRH policy.
Funding	<ul style="list-style-type: none"> With an anticipated decrease in overseas funding, the service providers indicated there is a need for equipment, supplies and drugs which is being addressed with the mainstreaming of AIDS/STI interventions into local resource allocation programmes. 	<ul style="list-style-type: none"> Attempts should be made to either secure additional overseas funding and/or increase the economic contribution from local governments.

Linkage	Identified gaps	Recommendations
Logistics and supplies	<ul style="list-style-type: none"> There is a requirement for equipment, supplies and a single supply system. 	<ul style="list-style-type: none"> Decentralize health education. Training of health care workers. Upgrade of existing facilities.
Contact tracing	<ul style="list-style-type: none"> Contact tracing is a conflicting and contentious topic. 	<ul style="list-style-type: none"> NACHA will facilitate a contact tracing workshop in the near future
PMTCT programme	<ul style="list-style-type: none"> No identifiable gap could be ascertained as there were insufficient clients receiving PMTCT to establish a trend. 	<ul style="list-style-type: none"> Emphasis should be placed on strategies to improve male attendance and participation in PMTCT programmes.
Attitudes towards PLWHA	<ul style="list-style-type: none"> Linking HIV/AIDS and SRH services may prove useful in addressing attitudes towards PLWHA, but anti-discrimination laws protecting PLWHA should be put in place. 	<ul style="list-style-type: none"> Amend the present laws to protect PLWHA as proposed by the LEHR. Further exploration of the rights of PLWHA to be sexually active and bear children.
Human rights	<ul style="list-style-type: none"> There is a lack of reporting to the human rights desk. The rights of PLWHA to be sexually active and bear children is a conflicting topic 	<ul style="list-style-type: none"> Establish a general human rights desk instead of a human rights desk for PLWHA. Continue with educational strategies addressing human rights. Providing a legal and supportive framework as suggested by the LEHR.
Workplace policy	<ul style="list-style-type: none"> The policies promoted the presence of workplace policies and the Ministry of Labour is working to implement these workplace policies. 	<ul style="list-style-type: none"> Similar strategies that have begun in Nevis to facilitate workplace policies and programmes, be adapted for St Kitts.
Gender equality	<ul style="list-style-type: none"> Only 1 out of 21 clients attending the ANC indicated that a discussion was held regarding women's rights although the system managers indicated that capacity building on SRH and HIV integrated gender sensitivity. 	
Elimination of gender-based violence	<ul style="list-style-type: none"> 2 out of 5 service providers indicated that prevention and management of gender-based violence are offered at the health centres and 1 out of 21 clients attending the ANC indicated that a discussion was held during their visit regarding domestic violence 	<ul style="list-style-type: none"> Meetings with relevant stakeholders during the formulation of the General Operational Plan. Strategies geared at improving community involvement and active participation. Establish a Monitoring and Evaluation Plan.

1 INTRODUCTION

The rapid assessment process is described as a means of investigating complicated situations in which issues are not yet well defined and where there is insufficient time or other resources for a long-term, traditional qualitative research.¹ The United Nations Population Fund (UNFPA) has collaborated with the National Advisory Council on HIV/AIDS (NACHA) in the Ministry of Health, St Kitts to conduct a rapid assessment survey to investigate the intricate linkages for sexual and reproductive health (SRH) and HIV/AIDS. It is envisioned that the data gathered will provide a preliminary understanding and identify trends in the existing linkages between SRH and HIV/AIDS, in St Kitts and Nevis.

The interactions between SRH and HIV/AIDS are acknowledged at varying levels and it is recommended by the “Glion Call to Action” that in order to achieve internationally agreed development goals, it is vital that the linkages between reproductive health and HIV/AIDS prevention and care be addressed.³ Their commonalities extend to similar roots such as gender inequality, poverty and social marginalization of the most vulnerable population.⁴ Management of both entities simultaneously can maximize limited resources. Evidence confirms that effective large scale programmes to prevent mother-to-child transmission (PMTCT) of HIV can be implemented in settings with limited resources.⁵ Addressing HIV prevention may also have a major impact on controlling the spread of Sexually Transmitted Diseases.⁴

This rapid assessment survey adopts a ‘bird’s eye view’ to explore SRH and HIV linkages in St Kitts and Nevis. There is no single model which reflects how this integration should take place, rather adaptability and tailoring of policies and services is required taking into account the specific context and needs of clients and possible referrals options.⁶ It is recommended that the assessment should be used as a source of identifying possible gaps and enlighten policymakers to the current status of existing linkages ultimately contributing to the development of country-specific plans to forge and

strengthen these linkages.¹ Grol et al identified four broad groups of factors which are often utilized in determining the uptake and continued use of clinical guidelines. These include (i) features of the guidelines, (ii) features of the target group, (iii) features of the social context/setting and (iv) features of the organizational context.⁷ Such features were addressed by investigating the linkages at the policy, systems, service provider and client levels.

Qualitative and observational studies are valuable in identifying problems in creating change and generating hypothesis about the determinants of and the conditions for change.⁷ Therefore, interview-based qualitative research methods were utilized in this survey. The policy and systems interviews utilized a mixture of semi-structured and in-depth interviewing methods. The service provider interviews focused primarily on a semi-structured method, whilst the client interviews were conducted mainly with the dissemination of structured questionnaires. Informant interviews were then conducted at each of these levels.

Formulation of policies and protocols are often viewed as the answer and their implementation often necessitates change. However, be cognizant that a bad solution a good one which is not implemented and change has been identified as the weakest link in the healthcare quality improvement chain.⁸

1.1 MODIFICATION OF THE RAPID ASSESSMENT

The Rapid Assessment Tool for SRH and HIV linkages aims to provide a guide for assessing linkages that can be adapted to national contexts.¹ St Kitts and Nevis has identified potential linkage gaps and attempted to address them with the formulation of new policies. Such policies include the 2009-2010 HIV Operational Plan, the 2009-2013 HIV Strategic Plan and the General Operational Plan for CHS (which is still in the draft stage). The aforementioned policies are yet to be implemented or activated. The desk review of SRH and HIV policies identified these linkages and analyzed the attempts made to address them. The desk review of the policy document encompasses a detailed account of its contents that addresses each linkage and an informal assessment of the adequacy of these linkages.

Analysis of the linkages in SRH and HIV/AIDS was quite challenging due to the timing with which the survey was undertaken. The policymakers assessed policies that were both activated and inactivated during the consultation, whilst the system managers and service providers interviews were based on policies that were activated and implemented. Comparing all four levels, policymakers, system managers, service providers and clients, to identify gaps would have resulted in inconsistencies. This necessitated that the comparison, to establish gaps, occurred in two different ways: (1) between the desk review and policymakers and (2) between the system managers, service providers and clients.

1.2 LIMITATIONS IN CONDUCTING ASSESSMENT

Whilst conducting the survey, numerous difficulties were encountered and adaptation measures were instituted.

1. There were no available field researchers to assist in the distribution of the interview-administered questionnaires. Therefore the client interviews had to be adapted to include both interview- and self-administered questionnaires. This limited the quality of data usually garnered from self-administered interviews.
2. Due to a range of problems including availability of staff, and other difficulties encountered in facilitating focus group sessions including insufficient funds; the recommended focus group sessions suggested had to be amended to group interviews consisting of two or three participants. Often individual interviews had to be facilitated. This may have limited consensus views and responses garnered from challenging views. The advantage was that specific ideas were garnered to facilitate other discussions and participants in the other groups were often challenged by the interviewer.
3. Some of the policy documents were either still in the draft stage or have not yet been activated. These included the Operational Plan for the Community Health Services and the recent Poverty Assessment document which are still in the drafting phase, and the HIV/AIDS strategic and operational plans have not been activated. During the interviews with the policymakers they often referred to this documents not yet activated. This provided great difficulty during analysis of the data, which had to be adapted to include comparison of data between the desk review of the policy documents and the policymakers' interviews and comparison of data from interviews with system managers, service provider and clients. This eliminated a very important gap – comparison of policymakers with the system managers, service providers and clients. This would have been avoided if the rapid assessment was conducted after the activation of the policies and a sufficient

time period being allotted for its implementation or prior to the formulation of new policies.

4. Some staff members were interviewed at the system manager and service provider levels as these staff often performed multiple tasks, thus limiting the quantity of participants and the variety of opinions.
5. A number of key persons, who were an integral part of the interview section of the rapid assessment survey, were unavailable or on vacation for the follow-up meeting convened to address future recommendations and next steps.
6. Due to limitation in allocated time for exploration of the recommendations and next steps deduced from the linkage gaps, all of the linkages could not be explored in the follow-up meeting.
7. The self-administered questionnaires were not piloted prior to distribution.

1:3 POTENTIAL BIASES

1. There was limited participation from PLWHA as there is no specific public clinic that they attend and most prefer to remain anonymous. This affected the quality of data derived from the service provider and client interviews.
2. The recommended client interview-administered questionnaires had to be adjusted and the self-administered questionnaires then distributed by the service providers. This may produce a provider bias for the service provider.
3. Due to the limited time period allocated for the conduction of the survey (6weeks), it was difficult to include a variety of clients therefore most of the clients who participated were females attending the Antenatal Clinic (ANC).

1.4 OBJECTIVES AND OVERVIEW OF THE METHODS USED

The generic guide of the rapid assessment tool for sexual and reproductive health and HIV linkages covered a broad range of linkages issues. Countries were encouraged to review the questionnaire; modifying the questionnaire and extract requisite linkages. Modification was necessary due to the previously outlined limitations. Linkages pertaining to monitoring and evaluation and laboratory support were extracted primarily due to inadequate personnel and time available for the conduction of interviews.

The main objective of the rapid assessment in St Kitts and Nevis was to explore the linkages between SRH and HIV/AIDS from the policy, systems, service provider and client levels with the assistance of group and individual interviews and self- and interview- administered questionnaires, and provide recommendations and action plans.

The purpose of the rapid assessment was to assess the present status of SRH and HIV linkages at the policy, systems and service provider levels, identify any potential gaps amongst these levels and provide information that will be useful in planning and policymaking measures thus promoting a greater coordinated and coherent response. The timing of the survey in St Kitts elicited great difficulty during its analysis, as measures had already been taken in the inactivated HIV plans to strengthen linkages in St Kitts and Nevis. Therefore the purpose of the rapid assessment in St Kitts and Nevis was to identify any potential gaps between (1) policymakers and the policies and (2) system managers, service providers and clients.

Specific aims include:

- I. Collect and analyze data on SRH and HIV linkages from policy documents, policymakers, system managers, service providers and clients to identify the presence of linkages at each level. This involves identifying potential gaps between the policy documents and the policy level, between the system managers, service providers and clients and within each level.
- II. To identify any linkages that are emphasis is presently being placed on.

- III. To analyse the presence of an enabling environment to facilitate linkages between SRH and HIV.
- IV. The perceived impact on instituting HIV and SRH linkages at the service provider and client levels.
- V. To identify recommendations and next steps in strengthening linkages between SRH and HIV in St Kitts and Nevis.

DRAFT

2 METHODOLOGY

The rapid assessment which is geared towards identifying and strengthening linkages between SRH and HIV was conducted in June- September 2009 and involved the following:

- I. Conduction of a desk review of policies and plans utilized by the HIV and SRH departments.
- II. Conduction of interviews with policymakers, system managers, service providers and clients.
- III. Follow-up meeting to provide recommendations and determine the next step in strengthening these linkages.

Linkages were identified and reclassified under the IPPF/UNFPA established categories of required advocacy and policy dialogue, and services in strengthening linkages between SRH and HIV/AIDS.² (see tables 2 and 3)

Strengthening linkages

- 1) Learn HIV status and access services.
 - a) Confidentiality
 - b) Referrals
 - c) Stigma and discrimination
 - d) Accessibility and affordability
 - e) Home-based care
 - f) Dual protection
 - g) Integration of services
 - h) VCT services

- 2) Promote safe and healthier sex
 - a) Attitudes towards key populations
 - b) Dual protection
 - c) Engagement of men in responses

- d) Attitudes towards PLWHA
 - e) Gender equality
 - f) Elimination of gender-based violence
 - g) Decentralization strategies
- 3) Optimize the connection between the HIV/AIDS and STI services
- a) Decentralization strategies
 - b) Funding
 - c) Logistics and supplies
 - d) Contact tracing
 - e) Integration of services
 - f) VCT
 - g) Stigma and discrimination
- 4) Integrate HIV/AIDS with maternal and infant health
- a) PMTCT
 - b) Attitudes towards PLWHA

Promoting an enabling environment

- 1) Human rights
- 2) Community involvement and participation
 - a) Workplace policy
 - b) Attitudes towards key populations
- 3) Structural determinants
 - a) Gender inequality
 - b) Elimination of gender-based violence

Table 2:

Adapted from
unfpa.org/upload/lib_pub_file/501_filename_framework_priority_linkages.pdf.

	<i>Learn HIV status and access services</i>	<i>Promote safer and healthier sex services</i>
<i>Advocacy and policy dialogue</i>	Support legal and policy reform to remove barriers for young people's access to all forms of HIV testing and counselling.	Develop policies that support dual protection and advocate for more adequate resource allocation
		Support policy development on comprehensive safe sex services for young women and men, PLWHA and other key population
<i>Services</i>	Reorientate VCT services to better meet the needs of young people, as well as of key populations.	Broaden SRH services to reach key populations.
	Provide basic SRH services (information on dual protection, counselling and access to condoms) in VCT programmes.	Promote condoms use for dual protection within all family planning and HIV prevention programmes.
	Routinely offer HIV testing and counselling in STI services and establish access to comprehensive HIV services.	Provide a full range of SRH services, including prevention for and with PLWHA.
	Routinely offer HIV testing and counselling in family planning and antenatal care services in high prevalence settings	Empower women and girls to negotiate safer sex and to access SRH and HIV/AIDS services.
	Provide effective referrals for HIV treatment within VCT programmes in SRH settings	Include services that address gender-based violence and offer counselling, emergency contraception and HIV post-exposure prophylaxis to survivors of sexual assault.

Desk review of policy documents

The desk review was conducted on the main policies and plans utilized in the HIV and SRH departments and were discussed during the interviews. These included documents that were implemented, some that were inactivated and others in the draft stage.

Table 3: Adapted from unfpa.org/upload/lib_pub_file/501_filename_framework_priority_linkages.pdf.

	Optimize the connection between HIV/AIDS and STI services	Integrate HIV/AIDS with maternal and infant health
Advocacy and policy dialogue	Advocate for investment in STI management as a key strategy to reduce HIV transmission	Develop policies to provide appropriate HIV/AIDS care and treatment options for pregnant women, mothers, their infants and families.
		Ensure and monitor that all four prongs of a comprehensive strategy for preventing HIV infections in women and infants are in place and funded.
Services	Implement in STI programmes a package of HIV/AIDS services including safer sex information and counselling, routine offers of HIV testing and counselling and condoms	Provide a basic package of HIV/AIDS services/information on safer sex, counselling and access to condoms) in antenatal care settings.
	Provide STI management to PLWHA in all HIV/AIDS care and treatment services.	Integrate antenatal syphilis screening and treatment with PMTCT services.
		Strengthen maternal health services for women living with HIV/AIDS (including infant feeding counselling, family planning and access to HIV care, treatment and support).
		Provide counselling on reproductive choices for PLWHA and their partners.

Interviews with policymakers, system managers, service providers and clients

Interview-based qualitative research methods were utilized at all levels. The policy interviews utilized a mixture of in-depth and semi-structured questionnaires conducted primarily as small group interviews. The systems interviews were conducted as a mixture of in-depth and semi-structured individual interview-administered questionnaires. The service provider interviews utilized semi-structured questionnaires in both group and individual sessions. 46 client interviews were conducted with a mixture of individual interview-based and mainly self-administered questionnaires.

The interviews were conducted over a six-week period extending from June-July 2009. Key informants were identified for clarification and explanatory purposes, particularly on controversial issues. At least two informants were identified for each of the policy, systems and service provider interviews. The organization, groups and individuals who participated included the following:

Interviews:

- FACTTS
- NEHAC
- Community Health Nurses
- St Kitts National Youth Parliament Association
- NACHA
- Caribbean HIV/AIDS Alliance
- Human Rights Desk
- Mrs Gardenia Destang-Richardson – Director of NACHA
- Mrs Ingrid Charles-Gumbs – Director of Gender Affairs
- Dr Kathleen Allen- Ferdinand – Clinical Care Coordinator, St Kitts
- Dr Judy Nisbett – Clinical Care Coordinator, Nevis
- Mrs Gloria Mars – Family Planning Nurse, St Kitts
- Dr Patrick Martin – CMO
- Dr Hazel Williams-Roberts – Director of Primary Care
- Mrs Marguerite France – Coordinator of Community Health Nursing

Key informants

- Mr Elvis Newton – Permanent Secretary of Health, St Kitts
- Dr Hazel Williams-Roberts – Director of Primary Care
- Mrs Nadine Carty-Caines – Director of NECHA
- Archdeacon Valentine Hodge – St Kitts Christian Council
- Mr Kevin Ferrara – Director of Caribbean HIV/AIDS Alliance
- Mr Arudranauth Gossai – Legal Officer in the Attorney General’s Office

Follow-up meeting

- Mrs Gardenia Destang-Richardson
- Mr Patrick Martin
- Dr Kathleen Allen-Ferdinand
- Archdeacon Valentine Hodge
- Mr Arudranauth Gossai
- Mrs Nadine Carty-Caines
- National epidemiologist
- Ms Celia Christopher – Department of Gender Affairs
- Community Health Nurses from St Kitts and Nevis
- Representatives from NACHA
- Representatives from NEHAC

The interviews comprised of questionnaires that were adapted from ‘Rapid Assessment Tool for SRH and HIV linkages; a generic guide.’¹ The rapid assessment tool is designed to be utilized as a generic guide; therefore some linkages were extracted, whilst other relevant issues were inserted. Linkages extracted were those relating to monitoring and

evaluation, laboratory support and HIV testing and disclosure for minors. Linkages inserted were issues relating to human rights and confidentiality.

DRAFT

3 METHOD OF ANALYSIS

Method of analysis involves not only the identification of gaps within each level, but also involves the comparison of linkages at each level to identify gaps.

As previously discussed, St Kitts have already identified a lack of linkages of SRH and HIV/AIDS at both the policy and service provider levels and have implemented numerous strategies to strengthen these linkages at the policy level during the formulation of the National HIV/AIDS Strategic Plan 2009-2013 and the National HIV/AIDS Operational Plan 2009-2010. These policies that are not yet activated were discussed by the policymakers along with those policies already implemented. This resulted in great difficulty when identifying gaps as comparisons could only be made between:

- I. Desk review of policy documents and policymakers interview.
- II. System, service provider and client interviews.

Gaps identified for some of the linkages were discussed at the follow-up meeting to identify appropriate recommendations. Recommendations were also formulated for the other linkages not discussed at the follow-up meetings.

The next steps were then categorized according to the expected time span action:

- Immediate action
- Intermediate action
- Long-term action

Further measures of analysis that were specific for each level were utilized and these will be discussed in the next chapter.

4 SUMMARY OF EACH LEVEL

In this chapter a summary of each level interviewed is provided.

These levels include:

1. Desk review of policy documents
2. Policymaker interviews
3. System managers interviews
4. Service providers interviews
5. Client interviews

4.1 DESK REVIEW OF POLICY DOCUMENTS

Introduction

The purpose of the desk review of the policy documents is to identify SRH and HIV-related linkages in these documents and to provide a general idea of the priority these linkages are given. All the documents that govern policy relating to HIV and SRH were identified. Some of these documents were in the draft or inactivated phase.

Method

A desk review of six policy documents (*see table 4*), with assigned policy numbers, representing HIV, SRH and general policies were conducted. These documents were then subdivided into the type of document (HIV, SRH or general) and the phase of implementation (implemented, inactivated or draft) (*table 5*).

The documents were closely scrutinized to identify possible linkages and the presence or absence of the previously identified linkages was charted.

Data analysis

The data garnered from the desk review was then compared with the data garnered from the policymakers to identify any potential gaps.

Comparison of the 5 yr National HIV/AIDS Strategic Plan and the 2 yr National HIV/AIDS Operational Plan was done to identify the linkages that were given priority.

Results

The table outlines the results of the presence of the linkages observed. (*See Appendix 1*)

Table 4: Outline of policy manuals utilized

<p><i>HIV Policy and Procedure manual</i> The manual was created in 2008 by the Department of Community Health Services. It is meant to serve as a guide to health care professionals in both private and public sectors in order to provide a standard of treatment and care expected for the life of PLWHA.</p>
<p><i>Family Health Strategic Plan 2006-2010</i> This was created in 2006 to be reviewed in 2010. Although not specifically designed for SRH services, it includes Family Planning practices and is utilized by family planning nurses.</p>
<p><i>National HIV/AIDS Operational Plan 2009-2010</i> The operational plan was recently formulated by the United Nations Joint programme on HIV/AIDS (UNAIDS)- AIDS Strategy and Action Plan (ASAP) under the leadership of the National Advisory council on HIV/AIDS (NACHA). Although there are partially identifiable funds available for its implementation, there is a sizable gap of 41% for 2009 and 71% for 2010.</p>
<p><i>National HIV/AIDS Strategic Plan 2009-2013</i> The National HIV/AIDS Strategic Plan was created in 2009 by the Ministry of Health through the National AIDS Secretariat (NAS). A national stakeholder consultation was held and although there are plans for its implementation, there is a recognized need for resource mobilization activities due to scarcity of resources.</p>
<p><i>Family Planning Medical Protocols, Eastern Caribbean Region</i> Created in 20 years ago in 1989 under the auspices of USAID, it was designed to be utilized in the Caribbean Region as a guide to family planning services. It was to be reviewed in 1991 and is presently still being used as a guide to health workers.</p>
<p><i>Draft Operational Manual for Community Health Services</i> This is being presently formulated by the Department of Community Health Services and is still in the drafting process.</p>

Table 5: Identification of type and phase of documents implemented

Policy # assigned	Name of document	Type of document	Phase
P1	HIV policy and Procedure manual	HIV	implemented
P2	Family Health Strategic Plan 2006-2010	SRH	implemented
P3	National HIV/AIDS Operational Plan 2009-2010	HIV	inactivated
P4	National HIV/AIDS Strategic Plan 2009-2013	HIV	inactivated
P5	Family Planning Medical Protocols, Eastern Caribbean Region	SRH	implemented
P6	Draft Operational Manual	General	draft

Comparison of the National HIV Strategic Plan and the HIV operational plan

The National HIV Strategic Plan 2009-2013 was designed as a general five year plan, with the HIV Operational Plan 2009-2010 designed as a specific two year plan based on the National HIV Strategic Plan, thus providing a representation of the priorities for the first 2 years. Appendix 2 illustrates a comparison of the National HIV Strategic Plan and the HIV operational plan identifying priorities given to establishing and maintaining linkages in the next two years.

Most of the linkages will be focused on during the next two years. Notably absent in the operational plan is the focus on gender issues such as gender equality, engagement of men in responses and laws against gender-based violence. Attention has also not been placed on the PMTCT programme.

Summary of results

1. The following linkages were not addressed (*see table 6*)
2. There was no formal SRH strategic plan or operational plan.
3. Although PMTCT are found in the clinics, little emphasis is placed on family planning and fertility and reproductive choices within the PMTCT programme.
4. The HIV Operational Plan did not focus on gender issues and legal ages.

Table 6: Results of linkages not addressed in policy documents

The following linkages were not addressed in any of the policies (HIV, SRH or general):

- I. Develop and adopt workplace policy with HIV and SRH components.
- II. Geographic accessibility of SRH services.
- III. Affordability of SRH services.
- IV. Criminalizing HIV transmission.

The following linkages were not addressed in the SRH-related policies.

- V. Contact tracing system for SRH.
- VI. Family planning within PMTCT programme.
- VII. Fertility and reproductive choices for PMTCT.
- VIII. Within the broader SRH operational plan, formulize activities to improve access, coverage and quality of care, including for HIV, for the general population, key populations, PLWHA, men and women.
- IX. HIV treatment issues such as HIV treatment for PLWHA.
- X. HIV care and support issues such as BCC on HIV within SRH services.
- XI. HIV issues in the national SRH policy are priorities through monitoring.
- XII. HIV issues in the national SRH policies are priorities through funding/cost.

4.2 POLICYMAKER INTERVIEW

Introduction

The policy interviews were conducted with policymakers, representing SRH and HIV components equally. These interviews explored linkages between HIV and SRH at the policy level provided a subjective assessment of the adequacy of these linkages, along with addressing planning techniques and administrative concerns.

Method

Semi-structured interviews were conducted amongst five policy makers in three interview sessions. The policymakers were divided into three categories: general policymakers (representing both SRH and HIV), SRH and HIV policymakers. The first interview was conducted with two general policymakers, the second interview comprised one SRH policymaker and one HIV/AIDS policymaker, and the final interview was conducted with an HIV policymaker.

Two informant interviews were later conducted with general policymakers.

Scale ratings were utilized to provide a quantitative response. A scale rating of 1-10 was used with 1 being assigned the lowest value and 10 being assigned the highest value.

Results

A detailed account of the results will be discussed in the upcoming chapters.

4.3 SYSTEMS INTERVIEW

Introduction

The systems interview was designed to provide a perspective on HIV and SRH linkages from the management level and identify the extent to which the systems support effective linkages of SRH and HIV. The objective of the questionnaires was to identify any potential gaps between the policy and management levels prohibiting a cohesive and coordinated response.

Method

The systems interview was conducted as individual interviews. Participating were 6 system managers consisting of family planning nurses, the CMO, president of FACTTS, representative of the St Kitts Christian Council and the clinical care coordinator in Nevis. A family planning nurse and HIV fulfilled the role of key informant.

Scale ratings were utilized to provide a quantitative response. A rating of 1 to 10 was utilized with 1 being assigned the lowest value and 10 the highest value.

Results

A detailed account of the results will be discussed in the upcoming chapters.

4.4 SERVICE PROVIDER INTERVIEWS

Introduction

The extent to which HIV services are integrated into SRH services and SRH services are integrated into HIV services are assessed at the clinical service delivery level. Several limitations include lack of service providers providing care to PLWHA and male responses.

Method

9 groups of service providers were interviewed; 4 groups represented HIV and 5 groups represented SRH. Representation occurred from NACHA, NEHAC, Caribbean HIV/AIDS Alliance, Community Health nurses, gynaecologist, FACTTS and Human Rights Desk. With the exception of NACHA and Caribbean HIV/AIDS Alliance, all the other service providers represented services mainly accessed by women, with little male involvement. Gender-based violence, post abortion care and management of PLWHA were generally not offered at the services interviewed; therefore providing a limitation in the interpretation of the results.

Summary of results

- 1) Psychosocial support was identified as the most common essential HIV services offered at the HIV services facility.
- 2) Prevention and management of STIs are the most common SRH services which are integrated with HIV services at HIV facilities.
- 3) PITC, VCT and HIV counselling and testing are the most common HIV services which are integrated with SRH services at the SRH facility.
- 4) Everyone indicated that SRH services within HIV services and HIV services within SRH services are located in the same service site within the same provider.
- 5) The largest constraint identified for linking SRH and HIV services was low staff motivation (*see figure 1*).
- 6) The greatest impact of linking SRH and HIV services is the need for equipment, supplies and drugs (*see figure 2*).

Figure 1: A graphic representation of the identified constraints to offering linked SRH and HIV services as identified by the service providers

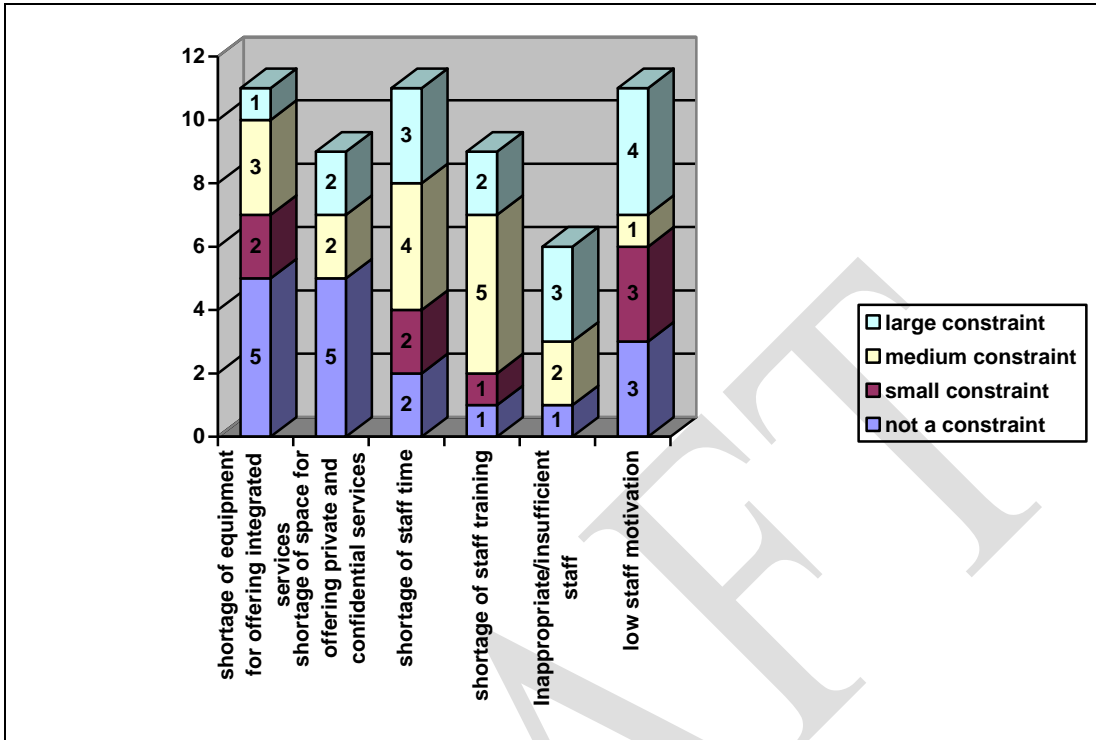
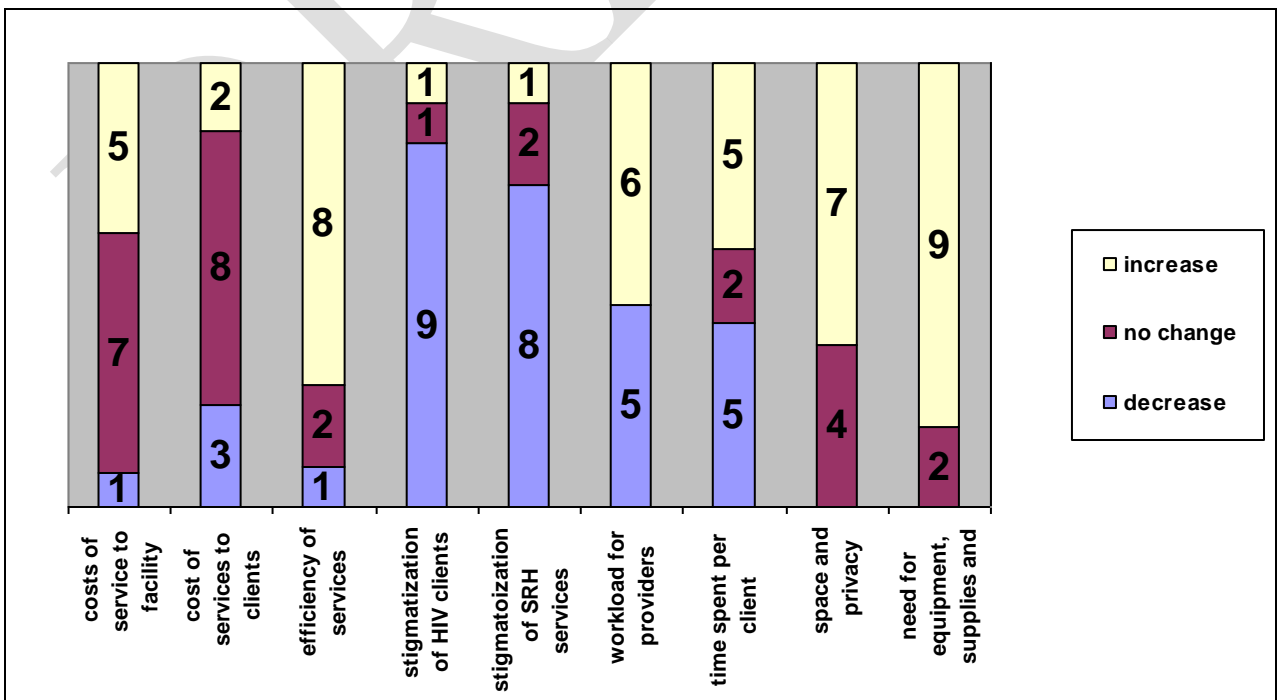


Figure 2: Likely impact of linking SRH and HIV services on the service dimensions



4.5 CLIENT INTERVIEWS

Introduction

The client exit interview was based on the clients' perception of the benefits or disadvantages in integrating HIV and SRH, an assessment of integration of services and satisfaction of services received. All the results were garnered from SRH-related services thus creating a bias in the results.

Method

55 questionnaires were prepared (*see appendix 4*). 6 questionnaires were not returned, and 3 were not completed, the completion rate was calculated at 88%. The questionnaires, adapted from the rapid assessment guide,¹ were a mixture of self- and interviewed-administered questionnaires which were disseminated to the following health centres: Basseterre Health Centre (BHC), Newtown Health Centre (NTHC), Cayon Health Centre (CHC), Sandy Point Health Centre (SPHC), Charlestown Health Centre (CTHC) and Gingerland Health Centre (GHC).

Data analysis

The data was analyzed utilizing Epi Info version 3.5.1.

Summary of results

Sample size

Based on the St Kitts and Nevis Community-based health services 2008⁹ annual report the estimated sample size attending the Pap Smear, ANC, Family Planning on an annual basis was 2362. There was no estimate of the attendance at the PNC, but in 2002 it was estimated of the 599 registered antenatals that <50% return to access postpartum services.¹⁰ Interviews were conducted in 12 working days, therefore the estimated population attending on these days utilizing an annual population value of 2500 was calculated at 114. The confidence interval utilizing a sample size of 46 was +/- 10%.

Demographics (see Appendix 5)

1) **Gender**

45(97.9%) of the participants indicated their gender and they were all female.

2) **Age**

The mean age of the participants was 29.1, the mode was 26 and the standard deviation was 10.1.

3) **Which section of the health centre did the client attend?**

Antenatal Clinic – 23

Family Planning – 12

General – 5

Postnatal Clinic -3

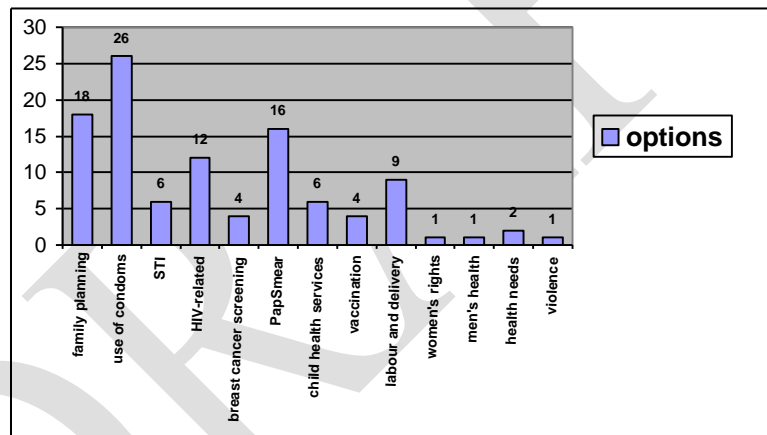
Management of STI and HIV– 0

Table 7: Comparison of services sought and rendered

Services sought	Services rendered	Options discussed
Family Planning (n=11)	<ul style="list-style-type: none"> Family Planning services – 10 Condom services – 1 Physical examination- 1 Postnatal services - 1 	<ul style="list-style-type: none"> Family planning – 7 Pap Smear – 5 Use of condoms to prevent STI-3 Use of condoms to prevent pregnancy, HIV prevention – 2 STI, child health services, vaccination -1
Antenatal Clinic (n=21)	<ul style="list-style-type: none"> ANC services - 13 Social support – 4 Prevention of HIV- 2 Nutritional support – 2 Prevention and management of STIs - 2 PMTCT – 1 Family Planning – 1 Condom services – 1 Advice - 1 	<ul style="list-style-type: none"> Labour and delivery – 7 Use of condoms to prevent STIs – 6 Family Planning, HIV prevention, counselling and testing for HIV, Pap Smear – 4 Use of condoms to prevent pregnancies, child health services, STI– 3 Vaccination - 2 Use of female condoms, breast cancer screening, health needs of young people, men’s health, HIV treatable with medication, women’s right, domestic violence – 1
Pap Smear (n=3)	<ul style="list-style-type: none"> Pap smear – 2 Family Planning – 2 Condom services – 1 Physical examination - 1 	<ul style="list-style-type: none"> Pap Smear – 3 Family Planning – 2 Use of condoms to prevent pregnancy – 1 Use of condoms to prevent STI’s – 1 HIV prevention, child health services, vaccination -1
Postnatal Clinic (n=3)	<ul style="list-style-type: none"> Family Planning- 1 Postnatal services- 3 	<ul style="list-style-type: none"> Family Planning – 3 Use of condoms to prevent pregnancy – 2 Use of condom to prevent STI – 2 Pap Smear - 2 Use of female condoms, STI, Counselling and testing for HIV, Breast cancer screening, child health services, labour and delivery– 1

- 4) 6 out of 38 (15.8%) of the clients received HIV-related services (*see table 7*).
- 5) 12 out of 89 (13.5%) of the options discussed were HIV-related (*see figure 3*).
- 6) 85% of the participants preferred having SRH and HIV services at the same health centre.
- 7) 72% of participants prefer to have HIV and SRH services from the same provider.
- 8) 61.7% of the participants indicated that they were not embarrassed to talk about HIV with a doctor/nurse from the same village or neighbourhood.
- 9) 55.3% of participants indicated that they would feel comfortable if they were seen immediately by a service provider after an HIV-positive patient when visiting the clinic.

Figure:3 Options that service provider spoke about that day



5 LEARN HIV STATUS AND ACCESS SERVICES

This category focuses primarily on legal and policy reforms to remove barriers relating to HIV testing and the reorientation of VCT services to strengthen linkages between SRH and HIV (*see table 2*). The following linkages were assigned to this category:

- accessibility and affordability
- dual protection (*discussed in chapter 7.1*)
- referrals
- integration of services (*discussed in chapter 8.1*)
- confidentiality
- stigma and discrimination
- VCT services
- Home-based care

There was a noted overlap in some of these linkages and as such dual protection and integration of services will be discussed in another chapter.

5.1 ACCESSIBILITY AND AFFORDABILITY

Accessibility and affordability explores the removal of barriers for the youth and other key populations, access to all forms of HIV testing and counselling and establishing access to comprehensive HIV services.

Desk review

1. NGOs are expected to work with ensuring accessibility to health care.
 2. It is understood that patients should have universal access to quality clinical HIV/AIDS care and treatment services, including home-based care.
 3. The MOH will improve STI surveillance.
 4. The draft General Operational Plan suggests that potential clients under the age of 16 should be encouraged to attend with a parent, however they should not be denied services if this is not possible and they can understand and give informed consent.
 5. The SRH protocol states that parental consent is required for those persons under 16 years.
 6. ART and HIV testing is made available and affordable to everyone.
-

Interview with policymakers

1. The policymakers all indicated that the HIV operational plan identified explicit activities to improve access, coverage and quality of care, in the general population, key populations (SW, MSM and youth) and PLWHA.
 2. The majority of policymakers thought that the legal ages were not respected or monitored as caregivers do not turn away individuals because of their ages.
-

Interview with service providers

All the service providers stated that their facility offered SRH within HIV services and HIV services within SRH services at the same service site with the same provider.

Gaps within each level

There are inconsistencies with the draft General Operational Plan and the SRH protocol. The general operational plan to be implemented states that ‘potential clients under the age of 16 years is encouraged to attend with a parent and should not be denied services if this is not possible’, the SRH protocol in contrast states that ‘parental consent is required for those persons under 16 years’.

Gaps between policy documents and policymakers

The SRH protocol states that parental consent is required for those persons under 16 years but the majority of policymakers thought that legal ages were not respected or monitored as caregivers do not turn away individuals because of their ages.

Conclusion

There are inconsistencies with the requirement for parental consent for those persons less than 16 years of age.

Discussion

A system manager noted that in St Kitts and Nevis the mandate is “Universal Access to Health Care”. The policies also noted that everyone should have access to health care and the NGOs will play its part in ensuring accessibility to health care. This may be achieved through the formulation of workplace policies and implementation of workplace programmes.

Measures must be put in place to improve access of health services to the most vulnerable population. This population consisting primarily of CSW, MSM, youth and men should be targeted, as often this population is the least likely to seek health care services. The accessibility of the health services to men will be discussed in another chapter, whilst discussion in this chapter revolves primarily around the CSW, MSM and particularly the young women. The Caribbean HIV/AIDS Alliance has targeted the CSW and the MSM through educational strategies and encouragement to access health care services.

Emphasis should now be placed on the vulnerable young women especially those engaging in transactional sexual activities.

The findings in the rapid assessment supported the findings in the LEHR that legal ages were not being respected and there are legal ramifications for providing care to minors without the presence of the legal guardian. The LEHR proposed amendments to the law to protect service providers and made the following recommendations:

- Amend the Probation and Child Welfare Board Act allowing a HCP to apply discretion in determining whether to treat a person less than 16 years without the consent of their parents or guardian.
- Provide condom vending machines in secondary and tertiary institutions.

The most recent behavioural survey conducted indicated that school children are selling their bodies for the purpose of a ‘top up’¹¹ and a participant at the follow-up meeting noted that *‘parents are pimping their children’*. This vulnerable group must be assured access to health care services if we are to effectively link HIV and SRH services. Yet the impact in increasing the legal age for accessing health care without parental consent may prove to be a further deterrent unless amendments are made to the law.

Recommendation

1. Measures should be put in place to increase accessibility of healthcare in the youths; this can begin with the implementation of legal protection of service providers as suggested by the LEHR.

5.2 REFERRALS

This linkage not only explores providing effective referral for ARV treatment within VCT programmes in SRH, but also encompasses other avenues of care for PLWHA.

Desk review of policy documents

1. Through the National Continuum of HIV/AIDS care strategy, address referrals to other services. The SRH needs of PLWHA will be addressed through this care strategy.
 2. Refer PLWHA into support groups such as FACTTS and other care services.
 3. All positive patients should be referred for formal medical/social/lab evaluation when they are diagnosed and the clinician and patient identify the best referral option.
-

Interviews with policymakers

1. Referrals occur within the clinical care team primarily to address the issue of confidentiality.
-

Interviews with service providers

1. The service providers at the Community Health Services (CHS) indicated that they did not receive referrals for PLWHA.
 2. In this facility, is there any follow-up to see whether clients act on referrals?
5 of the 9 groups indicated that there were follow-up. Some of these follow-ups include calling patients and home visits.
-

Interviews with clients

- 10) Were you referred elsewhere?
5 (11.4%) indicated yes they were referred elsewhere.
-

Gaps within each level

It was not known if the clients interviewed were PLWHA and the clinics surveyed did not knowingly manage PLWHAs, so the adequacy of the referral system was not explored.

Gaps between policy documents and policymakers

The policymakers acknowledged that referrals occur within the clinical care team to address the issue of confidentiality; however the policy documents states that the care strategy addresses referrals to other services through the clinical care team suggesting that referrals may occur outside the clinical care team eg FACCTS and other care services.

Conclusion

The adequacy of the referral system for PLWHA was not explored in the rapid assessment as the interviews were conducted at the Community Health Services and not through the Clinical Care team who is responsible for the medical management of PLWHA.

Discussion (from follow-up meeting)

A discussion regarding the '*referral system*' took place during the follow-up meeting. Some participants thought that CHS providers should be informed of the HIV status of their clients. However, it was pointed out that disclosure of the HIV status of patients is not necessary before you provide health care. Care should be administered on the premise of 'Universal Care' where everyone is treated the same. It was noted that the present referral system is designed to improve confidentiality and until there is a system in the CHS which protects patients, relaying the status of clients to CHS providers were not necessary.

It was pointed out during the discussion that clients who are HIV+ve should also be screened for tuberculosis and this should be standard.

The top five referral needs of PLWHA in St Kitts and Nevis were identified by the group as:

- I. Specialized medical care
- II. ARV drugs
- III. Nutritional supplements
- IV. Individual and family psychotherapy
- V. Laboratory studies

After reviewing the data adapted from “Saint Kitts and Nevis: Caribbean Region HIV and AIDS Service Provision Assessment Survey 2006,”¹² the group identified the gap in the basic-level of services for HIV and AIDS in St Kitts as facilities offering palliative care. It was suggested that there will come a time when there may be an increased need for palliative or home-based care as the availability of funding decreases, but it is not identified as a present priority as PLWHA are living healthier productive lives as a result of the advent of ART.

Recommendations (from follow-up meeting)

1. The referral system should remain as is, with disclosure of client status only occurring if necessary. Efforts should be made to address the confidential nature of CHS.
2. Screening of tuberculosis should become standard in PLWHA.
3. Efforts should be made to ensure that PLWHA have access to specialized medical care including home-based care/palliative care should the need arise.

5.3 CONFIDENTIALITY

One of the major barriers identified for access to HIV testing and counselling, and access to VCT and ARV services is the issue of confidentiality. In a small country (population of approximately 40,000), it is often perceived that nobody business is confidential.

Desk review of policy documents

1. Every patient has the right to privacy and the confidentiality of their individually-identifiable health care information protected.
 2. The provision of an HIV/AIDS clinical team to improve confidentiality.
 3. VCT will be conducted with strict attention to privacy and confidentiality.
 4. Identify sources of support and negotiate disclosure.
 5. Negotiate patient referral
-

Interview with policymakers

1. What specific policies are there on confidentiality and disclosure for HIV-related services?

All agreed that there were policy statements on the consequence of confidentiality. The issue of confidentiality was addressed by setting up a system through which all clinical matters concerning PLWHA is handled by the clinical care team. The results are coded and referrals occur within this team. Persons were encouraged to disclose their status to their spouses.

Interview with system managers

1. All the system managers agreed that capacity building on SRH and HIV integrated guiding principles such as confidentiality.
-

Gaps within each level

Significant measures put in place to improve confidentiality were acknowledged by the policymakers and system managers, but an adequate assessment of confidentiality from both a client and PLWHA's perspective was not addressed in the rapid assessment.

Gaps between policy documents and policymakers

The policymakers were of the opinion that referrals occur within the clinical care team to ensure confidentiality; but the policy documents states that patient referral should be negotiated by the clinical care team.

Conclusion

Further discussion and clarification is required to determine whether referrals should occur within the clinical care team or the clinical care team should negotiate with the patient regarding referrals to other services, whilst maintaining confidentiality.

Discussion

The issue of confidentiality must also explore privacy and security of data.¹³ Eliciting data from the client relating to their perception of the confidential nature of both HIV and SRH services would have proven useful.

The final report on the National Assessment on Law Ethics and Human Rights (LEHR)¹¹ acknowledged that privacy and confidentiality, or the lack thereof, appeared to be the most virulent obstacle in addressing HIV and AIDS care, treatment, prevention and stigma. The report stated that the health care professionals were targeted as the principal culprits of breaches of confidentiality and stated that the general public expressed deep skepticism at the possibility of seeking treatment at the hospital if they were found to be HIV+ve.

Recommendations

1. The LEHR has made specific recommendations regarding confidentiality and it is suggested that the present laws be amended to incorporate these changes.
2. Further exploration of the confidential nature of HIV and SRH services, privacy and security of information is required. Until this is done and the identified gaps in the breaches of confidentiality addressed, then it is recommended that the use of an HIV/AIDS clinical care team, which was implemented to improve confidentiality, continue providing care and support for PLWHA.

5.4 STIGMA AND DISCRIMINATION

It is perceived that stigma and discrimination in the Federation is quite high and is providing a barrier to utilizing HIV services including VCT. Decreasing the degree of stigma and discrimination, perceived or actual, can occur by strengthening HIV and SRH linkages.

Desk review of policy documents

1. There are plans to develop a national SDD (stigma, denial and discrimination) reduction strategy and action plan.
2. The Ministry of Health will develop anti-discriminatory and confidentiality protocols for health workers.
3. The NAS will evaluate the Human Rights desk to monitor and address cases of HIV-related discrimination.
4. FBOs will participate in projects.
5. A human rights desk was established to address issues relating to stigma and discrimination.

Interview with policymakers

1. How do the HIV and SRH policies address HIV-related stigma and discrimination?

The participants were asked to give rating of 1-10. For the SRH-related policies an average rating of 3.3 was given and for HIV-related policies an average rating of 9.3 was given.

2. There are no anti-discrimination laws protecting PLWHA, although plans are in place to pass one.

Interview with system managers

1. 4 out of 5 of the system managers agreed that capacity building on SRH and HIV integrated guiding principles such as avoidance of stigma and discrimination.

2. PLWHA did not access home-based care due to their perception of stigma and discrimination.
3. Stigma and discrimination (score of 7.6) has a greater impact than the laws (score of 8.7) in driving MSM underground.

Interview with service providers

1. What do you think is or will be the likely impact of linking SRH and HIV services on the following service dimensions (see figure 2)?

- Stigmatization of HIV clients

Rating scale	# of service providers who think it will impact in the following way
1- decrease	9
2-no change	1
3-increase	1

- Stigmatization of SRH services

Rating scale	# of service providers who think it will impact in the following way
1- decrease	8
2-no change	2
3-increase	1

The majority of service providers indicated that linking SRH and HIV will destigmatize SRH services and HIV clients.

2. The participants thought that stigma and discrimination drive SW and MSM underground.

Interview with clients

1. Would you feel comfortable if you were seen immediately by the doctor/nurse after an HIV-positive patient when visiting the doctor or nurse at the clinic?

No	8 (17%)	CI 8-31%
Yes	26 (55.3%)	CI 40-70%

The majority of clients who responded stated that they would feel comfortable.

Gaps within each level

1. Although stigma and discrimination relating to PLWHA was noted to be a major impediment in St Kitts and Nevis to linking HIV and SRH services, the majority of clients stated that they would feel comfortable if seen immediately by the doctor/nurse after an HIV-positive patient when visiting the doctor or nurse. It was noted by the participants in the follow-up meeting that only the domain explored was fear of casual contact and refusal of contact with PLWHA. This domain was not adequately explored as other issues such as disclosure, provider-bias and confidentiality are factors which can significantly affect stigma and discrimination.
2. SRH-related policies do not address stigma and discrimination.
3. There are no anti-discrimination laws protecting PLWHA.

Conclusion

Stigma and discrimination, although adequately addressed in the HIV policies, was not adequately addressed in the SRH policies. Clients' perception of stigma and discrimination was not adequately explored in the rapid assessment.

Discussion

A Behavioral Surveillance Survey (BSS, 2005-2006) indicated that 50-52% of the general population in St Kitts correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions around HIV transmission.¹⁴ This data is similar to that ascertained in the rapid assessment.

The LEHR document has stated that "HIV is not yet accepted as a chronic illness and healthcare providers are accused of stigmatizing and discriminating against PLWHA."¹¹ This suggests that stigma and discrimination in St Kitts and Nevis may not only be occurring at the client level, but significant discrimination may be occurring at the service provider level. Further exploration of stigma and discrimination against PLWHA by health care providers will provide an insight of the effect of capacity building on the avoidance of stigma and discrimination.

Recommendations (from follow-up meeting)

The participants at the follow-up meeting suggested the following steps:

1. Develop General Health Policy for stigma and discrimination with clearly articulated penalties for breach of these policies.
2. The recommendations put forward by the LEHR document for the amendment of laws will prove useful in achieving our goal of strengthening the linkages of HIV and SRH. Such amendments will include penalties for breach of these policies.
3. Liaison with the LEHR consultant currently working in the Ministry of Labour.
4. Increase public sensitization on human rights and facilitate easier access to the human rights desk.
5. A focal point should be identified to address management of stigma and discrimination in St Kitts and Nevis, this should be given priority and would be the responsibility of the Permanent Secretaries in the Ministries of Health.

5.5 VCT SERVICES

Emphasis is placed on strengthening VCT programmes and services, particularly in SRH-related services in an effort to increase the knowledge of the HIV status among the population.

Desk review

1. The VCT within the family planning is mainly provider-initiated testing.
2. Persons who present themselves at the VCT sites will have the option of having the sample taken at the site.
3. The Ministry of Health will update and implement HMIS for VCT services and report annually on public and private sector services.
4. VCT will be available at CHS, hospital laboratories and private medical offices provided that they have appropriate physical infrastructure and staff complement with the requisite training and familiarity with the National VCT protocol.
5. In St Kitts and Nevis, VCT providers will be trained and certified in the provision of VCT.
6. Support services for VCT include ongoing counselling, care and support, and referrals.
7. Pre-test counselling should be undertaken prior to testing as a means of disseminating information and gaining consent.
8. Counselling sessions will be conducted with strict attention to privacy and confidentiality.

Interview with policymakers

1. The policymakers indicated that the general population was targeted through the provision of VCT and PITC.
-
-

Interview with system managers

The system managers indicated that collaboration exists in the coordination of VCT services.

Interview with service providers

1. 5 out of 5 groups of SRH service providers indicated that VCT services are integrated with SRH services at the clinics.
 2. 3 out of 4 groups of HIV service providers indicated that VCT services are integrated with HIV services at the HIV facilities.
-

Clients

None of the clients received VCT services.

Gaps between desk review and policymakers

Although the policymakers indicated that the general population was targeted through the provision of VCT and PITC, the desk review did not place any emphasis on PITC.

Gaps between system managers, service providers and clients

Although the service providers indicated that all the health centres offered VCT services, none of the clients received VCT services on the days of the interviews.

Conclusion

On the day of the interview, none of the clients received VCT services. Perhaps greater emphasis needs to be placed on PITC in the policy documents.

Discussion

The probable factors affecting the result were discussed at the follow-up meeting. These include the following:

- Use of the VCT terminology. The patient may have received the service but was not aware of the terminology.

- A different clinic type that did not offer VCT services was conducted on the day of the survey.
- Space for privacy of conducting VCT services was not adequate.
- There was a shortage of staff and training.

The use of the VCT terminology could indeed have been a factor. It was originally intended that interview-administered questionnaires be dispersed to the clients, however due to the inability to acquire any personnel to assist in the conduction of the interviews, the questionnaires were self-administered and this could indeed have impacted this result. During the interviews the all SRH service providers indicated that VCT services were integrated with SRH services, and the clinics surveyed were ANC (21), Family Planning (11), Pap Smear (3), Postnatal Clinic (3). Is it that VCT services are only offered on specific days in these services?

Most service providers indicated in the interview that the shortage of equipment and space were not a constraint for providing integrated service, but identified shortage of staff time and training as medium constraints if offering linked SRH and HIV services. The data from the Caribbean Region HIV and AIDS Service Provision Assessment Survey 2006 indicated that in St Kitts all the public facilities with an HIV testing system had at least one trained counselor in VCT services and in Nevis, 14% met the strict definition of having all items present for a complete system for pre- and post-test counselling.

The participants at the follow-up meeting thought that service providers were familiar with the national policy on VCT and/or HIV testing and indicated that they build partnerships with others involved in HIV/AIDS prevention and care services in the community to enable referral to other providers. VCT services are promoted in the community using the media and traditional channels of communication. They thought that high quality services to guarantee confidentiality was delivered. Short waiting time, as well as ensuring that the staff delivering services are well trained, well supported and motivated in their work was being addressed. An attempt is being made to develop the

HMIS to enable data routinely collected to be compiled and used to evaluate services, but the goals of the services were not determined at the outset to ensure that proper monitoring information is collected.

One participant in the survey noted that it is useful if not only the prevalence of VCT is recorded, but the number of clients to be tested for the first time. This would give an idea if there is an increase or decrease in new patients being tested and our strategies can now be revisited. Presently it is unknown how many of these clients are re-tests.

Recommendations

1. The group at the follow-up meeting suggested that the HMIS be developed, including the presence of computers at the clinics to facilitate data entry. The anticipated time frame for completion is January 2010 and it is the responsibility of both the IT department and the Ministry of Health.
2. Efforts should be made to increase the number of VCT conducted at the clinics. This may be achieved by placing greater emphasis on PITC.
3. Disaggregation of data for VCT to identify clients being tested for the first time and repeat testing.

5.6 HOME-BASED CARE

Home-based care is a part of the comprehensive care plan of PLWHA.

Desk review

1. The Ministry of Health and the Department of Social and Community Development will increase quality and coverage of home- and community-based care for chronically ill patients and orphans.
 2. For sustainability, the national home care programme must be included in the annual health budget.
 3. FBOs are expected to provide pastoral and community care to PLWHA.
-

Interview with policymakers

1. The policymakers indicated that plans are presently in place for improved quality home-based care.
-

Interview with system managers

1. The Roman Catholic Church was identified as being proactive in providing home-based care. Other FBOs may get involved if they have personnel and allow them to be trained. It was perceived that even though FBO provided home-based care to its members, the PLWHA did not particularly access the service due to their own perception of stigma and discrimination.
 2. The CBOs may play a role, but their involvement was not established.
-

Interview with service providers

1. 4 out of 5 groups of SRH service providers indicated that home-based care was an essential HIV service integrated with SRH services at the clinic.
 2. 1 out of 4 groups of HIV service providers indicated that home-based care was an essential HIV service offered at the HIV facility.
-

Gaps within each level

1. 4 out of 5 groups of SRH providers indicated that home-based care was an essential HIV service integrated with SRH services at the clinic, but these service providers also indicated that they were not usually required to give home-based care to PLWHA.
2. The role of the FBOs and CBOs in providing home-based care to PLWHA needs to be firmly established.

Conclusion

The CHS provide general home-based care, but CHS providers are not usually required to give home-based care.

The role of the CHS, FBOs, CBOs in providing home-based care needs to be firmly established.

Discussion (from follow-up meeting)

The participants at the follow-up meeting engaged in a discussion relating to the identified gap pertaining to home-based care and how this gap can be addressed.

They thought that the gap can be strengthened by harmonizing “home-based care” ie building teams with health care providers, social workers, NGO, FBO and CBO interested and trained in home-based care. This should be spearheaded by the Ministry of Health through the health centres, and should not be specific to SRH and HIV, in an effort to decrease discrimination.

Further exploration is required in strengthening the linkages between HIV and SRH. After reviewing a list of objectives adapted from the HIV Policy and Procedure Manual¹⁵ the participants identified mobilizing resources (human and material through organizations, private sector and individuals) and coordinating them towards providing care of PLWHAs and their families as an additional domain that may require further exploration. Other issues that require exploration includes identification of all persons/organizations providing home-based care, mobilize the resources and then coordinate the service.

They identified additional actions and projects which is required if the linkage between HIV and SRH is to strengthen as it relates to home-based care. These projects should be carried out by the Ministry of Health – CHS and be completed by September 2010. They include the following:

- I. Identification of resources.
- II. Building a multisectoral team to provide home-based care.
- III. Developing a strategy/policy and implementing the plan.
- IV. Monitoring and evaluating the effectiveness of the policy, strategy and plan.

However, it has been identified that home-based care is not a great priority, although there may be a greater need for home-based care as the availability of funding decreases.

Recommendations

1. Identification of resources, build a multi-sectoral team, develop and implement a strategy/policy/plan and monitor and evaluate the effectiveness of the policy, strategy and plan, to be completed by September 2010.
2. Establish a general home-based care plan that will incorporate PLWHA.
3. Identify all persons/organizations providing home-based care and coordinate services.

6 PROMOTE SAFE AND HEALTHIER SEX

Promoting safe and healthier sex is a domain that requires advocacy pertaining to condom access, safer sex services for young women and other key populations including PLWHA and provision of a full range of SRH services to all populations.² Emphasis should be placed on dual protection and the empowerment of women to negotiate for safer sex, resulting in addressing issues such as gender-based violence, emergency contraception and HIV post exposure prophylaxis to survivors of sexual assault.²

Table 2 demonstrates the advocacy and policy dialogue and services associated with this domain. This domain includes the following linkages:

- Dual protection
- Attitudes towards key population
- Attitudes towards PLWHA
- Gender equality (*discussed in chapter 9.3*)
- Gender-based violence (*discussed in chapter 9.3*)
- Engagement of men in responses
- Decentralization strategies

6.1 DUAL PROTECTION

Dual protection refers to protection from both STI/HIV and unwanted pregnancies. One of the main features during promotion of safer and healthier sex is the utilization of condoms for dual protection within all family planning and HIV prevention programmes. However it is acknowledged that condoms are not 100% effective against preventing pregnancies¹⁶, so utilization of two methods to prevent STI/HIV and unwanted pregnancy is ideal.

Desk review

1. As part of Family Planning, patients are encouraged to use methods that prevent transmission of STI along with methods that prevent pregnancy. It is also recommended that spermicides be used with condoms.
 2. The PSI, founded to improve reproductive health utilizing commercial marketing strategies,¹⁷ will undertake male and female condom social marketing and undertake biennial condom availability surveys.
 3. The MOH will improve STI surveillance.
-

Interview with policymakers

1. The policymakers who responded thought that the national HIV policy/strategy included SRH issues such as programming for dual protection.
2. **What specific SRH and HIV policies support condom access and are they focused on dual protection or STI or unwanted pregnancy separately?**

Most persons were not aware of existing policies supporting condom access. One group identified the HIV policy and procedure manual containing guidelines supporting condom access and these guidelines are aimed against STI including HIV. However, plans are in place for improving condom access by mounting new condom vending machines particularly in the nightclubs to increase access to condoms.

Interview with system managers

1. 4 out of 6 system managers indicated that there was joint planning for dual protection during condom programming.
 2. 3 out of 4 system managers identified a separate supply system (pertaining to condom supply) hindering effective service delivery.
-

Interview with service providers

3 out of 5 SRH service providers have identified condom provision as an essential HIV service integrated with SRH services.

Interview with clients

1. 11 clients attending Family Planning were interviewed; use of condoms to prevent pregnancies was discussed with 3 clients and the use of condoms to prevent STI/HIV was discussed with 2 clients.
 2. 21 clients attending the Antenatal clinic were interviewed; use of condoms to prevent pregnancies was discussed with 3 clients and use of condoms to prevent STI/HIV was discussed with 6 clients.
 3. 3 clients presented for Pap smear services; use of condoms to prevent pregnancy was discussed with 1 client and use of condoms to prevent STI was discussed with 1 client.
 4. 3 clients presented for Postnatal Clinic; use of condoms to prevent pregnancy was discussed with 2 clients and use of condoms to prevent STI was discussed with 2 clients.
-

Gaps within each level

1. Out of the 39 client respondents who sought SRH services, 9(23%) clients were advised on the use of condoms to prevent pregnancy and 11(28%) clients were advised on the use of condoms to prevent HIV/STI.
2. Lack of local policies supporting condom access so it could not be determined what percentage of patients seeking SRH services is expected to receive advice on condom usage.

Conclusion

Less than a third of the clients who sought SRH services were advised on condom usage. There was approximately equal advice on the usage of condoms to prevent pregnancy and to prevent HIV/STIs. There are no local policies supporting condom access.

Discussion (from follow-up meeting)

The discussion garnered from the follow-up meeting addressed the limitations of the rapid assessment and identified actions that can be taken to strengthen the linkage between SRH and HIV as it pertains to dual protection.

Although the rapid assessment was meant to show trends the group noted that they may be limitations in interpreting the results. These include the following:

- I. Was the survey conducted on repeat or new clients?
- II. Was a service plan established for each client and what stage were they in the service plan?
- III. Accessibility of condoms.
- IV. Comfort level of clients.

Participants thought to adequately explore dual protection require a larger sample size, the prevalence of condom demonstration and the use of condoms by patients and partners. After looking at requirements for successful integration of family planning, HIV and STI prevention services,¹⁸ they concluded that the social forces and gender relations affecting sexual negotiations between women and men and the need for reorganizations of the Family Planning programme were hindering successful linkages.

Recommendations (identified from the follow-up meeting)

- I. Formulation and distribution of a condom access policy by the Ministry of Health.
- II. Formulation of a Monitoring and Evaluation Plan by the Ministry of Health.
- III. Inter-sectoral coordination organized by the Ministry of Health.
- IV. Training for service providers.
- V. Involvement of clients in their care plan (eg focus group discussions).

6.2 ATTITUDES TOWARDS KEY POPULATIONS (YOUTH, MSM, CSW)

The aim is to support policy development on comprehensive safer sex services for key populations and broaden SRH services to reach key populations. This would necessitate a change in attitudes towards key populations from service providers, community and policy levels.

Desk review

Attitudes towards key populations

1. The HIV policies stated that emphasis will be placed on altering community attitudes.
2. The needs for supportive public policies and legal reform have been assessed, setting the stage for concerted advocacy action.

Attitudes towards the youth

1. Address Adolescent Sexual and Reproductive Health Services that are youth friendly.
2. MOH will collaborate with the Division of Youth and UNFPA to address out of school youth.
3. Promote condom use and run multimedia campaigns.
4. Conduct teachers' refreshers training in life skills and train a cadre of midwives in additional friendly protocols.
5. Lab screening for RPR and VCT in sexually active adolescents in health centres.
6. Address ARAS that is youth-friendly.

Interviews with policymakers

1. **How do the HIV and SRH policies address attitudes towards key populations?**

The participants were asked to give rating of 1-10. The SRH-related policies were not rated and the HIV-related policies were given a rating of 8.

2. The key populations were targeted with the assistance of the Caribbean HIV/AIDS Alliance group and the implementation of Behaviour Change Communication (BCC) programmes.
3. What is the legal age for marriage, HIV testing, accessing SRH services, consent of sexual intercourse and how it compares with sexual debut? Are the legal ages respected?

All were aware of the present legal ages and that the legal age for consent for sexual intercourse has been raised from 16 to 18 years. This was identified as being done to be consistent with the age of majority and to protect adolescents from sexual abuse. There was an acknowledgement that this will impact the legal age for accessing SRH services, but the majority thought that the age for accessing SRH services presently remains at 16. Concerns were voiced regarding the perceived impact in accessing health services.

There was mixed reviews on the average age for sexual debut in males and females. For females, responses range from 15-16, whilst for males it ranged from 13-15.

Most persons thought that the ages were not respected or monitored as caregivers do not turn away individuals because of their ages. Others indicated that they are respected to a certain extent as persons under 16/18 were asked to return with an adult. Some identified that the discrepancy with the legal age for access of health services and the average age of sexual debut were conflicting. There were questions raised as to if elevating the age of consent from 16 to 18 was a wise choice due to legal implications although no one was aware of anyone who has been previously charged. Recommendations have been made to amend the Probation and Child Welfare Board Act allowing healthcare professionals to apply their discretion in treating persons under 16 years old.

4. What are the laws affecting key groups (SW and MSM) and what is their impact?
All were aware that actions of these groups of individual were illegal. Some identified that the laws were broad and were not particularly directed at these

groups. These laws were later identified as the Small Charities Act, Buggery and Sodomy and the Bill of Rights. But all were adamant that the existence of these laws drive the population underground.

Interviews with system managers

Attitudes towards key populations

The minority (2 out of 5) indicated that capacity building addressed attitudes towards key populations.

Attitudes towards youth

Almost all the system managers were uncertain about how organizations of young people were involved in responses to HIV and SRH programming.

Attitudes towards CSW and MSM

All the system managers noted that the laws are illegal and they have a negative impact driving this population underground, however it was noted that stigma and discrimination had a greater impact in driving this group underground.

Interviews with service providers

Out of the 5 groups interviewed, only 1 group identified that specific HIV information and services for key population is integrated with SRH services at the health centres.

Gaps within each level

1. The minority (2 out of 5) of system managers agreed that capacity building on HIV and SRH addressed attitudes towards key populations.
2. Only 1 group (out of 5) of service providers indicated that specific HIV information and services for key populations is integrated with SRH services at the health centres.

Conclusion

There is a need to increase capacity building on HIV and SRH services which addresses attitudes towards key populations and improve specific HIV information and services for these populations at the health centres.

Discussion

The participants in the survey noted that emphasis was placed on youth-friendly services and a supportive environment. According to the Caribbean Region HIV and AIDS Service Provision Assessment Survey 2006, Youth-friendly Services (YFS) refers to facilities that have youth-friendly programmes for HIV- and AIDS-related services and that have trained providers and guidelines for the service.¹² In Nevis, none of the seven facilities with an HIV-testing system in Nevis had youth-friendly HIV testing services and in St Kitts, 4 out of the 11 facilities with an HIV testing system have youth-friendly HIV testing services. It was noted that youth-friendly prevention services may prove key to curbing the epidemic as it is crucial to reach young people early ‘before adolescents start developing lifelong sexual habits’¹². It is reported in the LEHR, that there is normative evidence of the involvement of young girls from ages 14-18 who are involved in transactional sex and anecdotal evidence of mothers forcing their children into sex work as a means of supporting their family.¹¹

The desk review revealed that there is a need for supportive public policies and legal reform particularly as it relates to the key populations. Although the 2009-2013 HIV/AIDS Strategic Plan noted that there was no evidence for a concentrated epidemic in SW and MSM,¹⁹ emphasis must also be placed on this group to enable and empower these categories to negotiate for safer sex. Modern approaches to sex work stress decriminalization and emphasize regulation of the industry by occupational safety and health controls that will benefit both workers and their customers.¹¹

The issue of human rights and a balance with social expectations still exists as it relates to decriminalizing MSM and CSW. The LEHR proposes the amendment of the Indictable Offences Act to exempt health authorities or NGOs from prosecution where they initiate social and education programmes with sex workers and enact regulations under the

Public Health Act guiding interventions with this population, and initiating an education programme with the input of sex workers targeting clients (anonymously) to encourage safer practices including the use of condoms.¹¹ The LEHR noted that decriminalizing of MSM will require significant public debate before any change is made.¹¹

Recommendations

1. Increase capacity building on HIV and SRH services which addresses attitudes towards key populations particularly the youth. This could begin by providing YFS.
2. Improve specific HIV services and information for MSM, CSW and the youth at health centres.
3. Encourage and commence public debate relating to decriminalizing MSM and CSW.

6.3 ENGAGEMENT OF MEN IN RESPONSES

Promoting safer and healthier sex involves strategies geared at altering male sexual behaviour and attitudes.

Desk review:

1. The HIV policies are geared towards targeting men with messages of responsible male behaviour to address the vulnerability of women and improve male participation in the care for PLWHA.
 2. The SRH policies are more specifically geared towards involvement of the males with plans to conduct a KAPB survey, develop a policy on men's health, develop a comprehensive strategy to attract men to health services including the establishment of a men's clinic.
-

Interview with policymakers

1. How do the HIV and SRH policies address the low engagement of men in responses?

The participants were asked to give rating of 1-10. For SRH policies an average rating of 8 was given and for the HIV-related policies average rating of 8.6 was given.

A programme which will be coming on stream to sensitize men was also identified.

Interview with system managers

1. Most of the system managers agreed that capacity building on SRH and HIV integrated guiding principles such as gender sensitivity (4 out of 5) and male involvement in responses (3 out of 5).
 2. An effort is being made to increase male attendance at the PMTCT.
-

Interview with service providers

1 out of the 21 patients attending ANC indicated that the service provider spoke about men's health.

Gaps between system managers, service providers and clients

Clients attending antenatal clinics were not generally engaged in a discussion on men's health. Particular mention was made of the efforts to improve the attendance at the Antenatal clinics.

Conclusion

Clients attending the antenatal clinics were not generally engaged in a discussion on men's health.

Discussion

A major limitation in the study was availability of resources. Regrettably there were insufficient resources so the proposed interview-administered questionnaire had to be amended to a self-administered questionnaire, distributed in most cases by service providers. Therefore it is unclear if there were any distribution biases as no men participated in the rapid assessment survey.

The gap may be lessened if mothers are encouraged to bring their partner to ANC during each session and they are involved in the care of the foetus. During these sessions stimulating discussions can be held pertaining to the family's health. A participant at the follow-up meeting noted that *“there is a concept that the men's role ended at the time of ejaculation and that the ANC involves primarily women and it is often forgotten that reproduction requires involvement of the sperm(male).”*

Recommendations

1. Encourage male involvement at the Antenatal Clinics – PPMTCT.
2. Formulation of a men's policy to guide the General Operational Plan.

6.4: DECENTRALIZATION STRATEGIES

Decentralization strategies included categories such as gender equality, sexual debut and capacity building. The role of gender equality was discussed under structural determinants - promoting an enabling environment and the impact of sexual debut was discussed in attitudes towards key populations. To avoid repetition these two factors will not be discussed in this chapter, but readers can refer to chapter 9.3 (gender equality) and chapter 6.2 (attitudes towards key populations).

Desk review

1. Mainstream and integrate HIV/AIDS intervention in systems that are functional and effective as a result of investment in systems strengthening e.g. decentralized service delivery.
 2. Strengthen mainstream HIV and AIDS in public sector planning budgeting processes across ministries and lower levels. Inclusion of civil society organizations.
 3. Engage and support faith-based groups to move beyond abstinence into projects to address taboo, stigma and discrimination and to provide community care to PLWHAs.
 4. Support relevant ministries and departments to mainstream HIV in their own strategies, work plans and budgets, through strategic planning support.
 5. Strengthen organizational as well as the technical capacity of civil society organizations, including NGOs, FBOs and the private sector.
 6. The broader strategic plan aims at scaling up HIV/sexual health education, increase early diagnosis and treatment of STI in the public and private sector, improve STI surveillance and update the HMIS to capture relevant service statistics for HIV/AIDS/STI management.
-
-

Interview with system managers

1. The system managers identified the MOH alone as the development partner for the SRH programme, whilst there were many developmental partners for the HIV programming supporting decentralization.
 2. The system managers thought that integrating HIV and SRH services would result in an inadequate family planning staff and the need for a formal SRH unit.
-

Interview with service providers

The largest constraint identified for linking SRH and HIV services was low staff motivation and the greatest impact of linking SRH and HIV services is the need for equipment, supplies and drugs.

Gaps within each level

1. The system managers identified the MOH alone as the development partner for the SRH programme, whilst there were many developmental partners for the HIV programme supporting decentralization.
2. There is a need for increased staff motivation, equipment, supplies and drugs if there is linking of SRH and HIV services.

Conclusion

There is a need for more developmental partners for the SRH programme and staff motivation, equipment, supplies and drugs to strengthen linkages between HIV and SRH.

Discussion

The participants at the follow-up meeting thought that building a network of national development partners primarily for funding, support, advocacy and technical assistance can address this gap.

These participants noted that the data between 1984 and 2007 from the CHS report suggests HIV is more prevalent in the reproductive age group (20-49 yrs) and there is minimal observed gender difference. It was also noted that from 1995-2005, there have

been a decrease in teenage pregnancies between the ages 15-19 yrs and a slight increase in ages less than 15 yrs. However, this data in does not suggest that teenagers are now abstaining or practicing safer sex, as pointed out by a participant, numerous factors could be involved including increased abortions. They noted that there is need for further intervention from the Maternal and Child Health (CHS), child probation and the legal departments if the linkage between SRH and HIV is to be strengthened.

The New York Call to Commitment suggests countries should promote a coordinated and coherent response to HIV/AIDS.

Recommendations (from follow-up meeting)

1. Building a network of national development partners primarily for funding, support, advocacy and technical assistance.
2. Further intervention by Maternal and Child health services, child probation and the legal departments to address the early sexual debut in the Federation.

7 OPTIMIZE THE CONNECTION BETWEEN THE HIV/AIDS AND STI SERVICES

This category advocates for investment in STI management as a key strategy to reduce HIV transmission and implementing HIV services in STI programmes.

The category involves the following linkages:

- a) Integration of services
- b) Stigma and discrimination (*discussed in chapter 5.4*)
- c) Funding
- d) Logistics and supplies
- e) Contact tracing
- f) VCT services (*discussed in chapter 5.5*)

7.1 INTEGRATION OF SERVICES

Integration of services involves the implementation of HIV/AIDS services in STI programmes. Such services include safer sex information and counselling, provision of condoms and VCT services. VCT services have been discussed in a previous chapter.

Desk review

1. The SRH policies adopted a different cervical screening regime for PLWHA.
2. The HIV operational plan will include the undertaking of studies to establish baseline data on aspects such as STI to facilitate better targeting and more effective resource use.
3. The HIV policies address sexual and reproductive health services.
4. The operational plan aims to increase the proportion of patients presenting with STIs at health facilities that are appropriately counseled, diagnosed and treated.

Interview with policymakers

1. **Who are the champions supporting SRH and HIV linkages?**

All participants thought that the following supported bi-directional linkages:

- National SRH and AIDS policies
- Integration of services offered by the HIV and SRH units.

There were mixed reviews but some participants indicated that the following supported bi-directional linkages:

- Endorsement of international consensus documents. Informant interviews suggested that the endorsement was primarily related to HIV.
- Formulation of Plans
- Strategy developed and implemented to lobby for leadership support for integrated policies and services. Informant interviews revealed that most of the lobbying previously conducted was in relation to HIV due to the existing high associated stigma.

2. Is there joint planning of HIV and SRH programmes? How is it undertaken?

All participants agreed that there were joint planning mechanisms between HIV and SRH department. This was primarily due to the HIV & SRH providers being a part of implementation of general programmes. The AIDS Secretariat handles the promotional aspect and the clinical aspect is handled by the Community Health Services (CHS).

Interview with system managers

1. The system managers gave a rating score of 7 for SRH services integrating services for HIV and HIV services integrating SRH.
2. To what extent have SRH services integrated HIV and HIV services integrated SRH?

Everyone thought that there is joint planning of HIV and SRH programmes at some levels such as stakeholder's consultations and coordinator levels. Attempts are being made to bring both entities together primarily as overseas funding is coming to an end. When asked about joint planning pertaining to specific plans and programmes, there was mixed reviews. 4 out of 6 supported joint planning in dual protection in condom programming, 3 out of 6 supported joint planning in National HIV Strategic Plan, 1 out of 6 supported joint planning in the proposals of the global fund, but no one supported the integration of HIV into poverty reduction strategy papers. During the informant interview with a participant directly involved in the National HIV Strategic Plan, it was clarified that joint planning did occur at the proposals for the global fund and the integration of HIV into poverty reduction strategy papers.

Interview with service providers

1. Please rate each of the following as to how large a constraint it is to offering linked SRH and HIV services at this facility (see figure 1).

	1- not a constraint	2- small constraint	3- medium constraint	4- large constraint	mode
Shortage of equipment for offering integrated services	5	2	3	1	1(not a constraint)
Shortage of space for offering private and confidential services	5	-	2	2	1(not a constraint)
Shortage of staff time	2	2	4	3	3(medium constraint)
Shortage of staff training	1	1	5	5	3(medium constraint), 4(large constraint)
Inappropriate/insufficient staff	1	-	2	3	4(large constraint)
Low staff motivation	3	3	1	4	4(large constraint)

Constraints were identified to offering linked SRH and HIV services. Shortage of equipment for offering services and shortage of space for offering private and confidential services was not identified as a constraint. Shortage of staff time and training were identified as medium constraints and low staff motivation and inappropriate or insufficient staff were cited as large constraints.

2. What do you think is or will be the likely impact of linking SRH and HIV services on the following service dimension?

	1-decrease	2- no change	3- increase	mode
Stigmatization of HIV clients	9	1	1	1 (decrease)
Stigmatization of SRH services	8	2	1	1 (decrease)
Cost of services to facility	1	7	5	2 (no change)
Cost of services to clients	3	8	-	2 (no change)

The majority of service providers thought that there was no change in the costs of services to facility and clients and no change in destigmatization of SRH services and HIV clients.

3. Which of the following essential SRH services are integrated with HIV services at this HIV facility?

Management of PLWHA – 1

Prevention and management of STI – 3

4. Which of the following essential HIV services are integrated with SRH services at this SRH facility?

HIV counselling and testing – 5

Provider-initiated counselling and testing – 5

PMTCT – 5

VCT – 5

HIV prevention, information and services for the general population – 4

Home-based care – 4

Psycho-social support -3

Condom provision- 3

Specific HIV information and services for key populations – 1

Clients

Less than 20% of the services received by clients accessing SRH services were HIV related. The percentage of SRH services offered in HIV services could not be accessed.

1. 11 clients attending Family Planning were interviewed; use of condoms to prevent pregnancies was discussed with 3 clients and the use of condoms to prevent STI/HIV was discussed with 2 clients.
2. 21 clients attending the Antenatal clinic were interviewed; use of condoms to prevent pregnancies was discussed with 3 clients and use of condoms to prevent STI/HIV was discussed with 6 clients.
3. 3 clients presented for Pap Smear services; use of condoms to prevent pregnancy was discussed with 1 client and use of condoms to prevent STI was discussed with 1 client.
4. 3 clients presented for Postnatal Clinic; use of condoms to prevent pregnancy was discussed with 2 clients and use of condoms to prevent STI was discussed with 2 clients.

Gaps between system managers, service providers and clients

Less than 20% of the services received by clients accessing SRH services were HIV-related, yet the system managers gave a rating score of 7 for SRH services integrating services for HIV and HIV services integrating SRH.

Conclusion

The SRH policies minimally addressed HIV-related issues and 1/5 of the services received by clients accessing SRH services were HIV-related. The deficiency in the SRH policies may partially explain why less than 20% of the services received by accessing SRH services were HIV-related.

Discussion (from follow-up meeting)

It was noted that the SRH policies were outdated and there is a need for updating SRH policies to make them more relevant, in addition to addressing HIV issues.

Recommendation (from follow-up meeting)

It is envisioned that there be a review of the SRH policy and this should be the responsibility of the health planner. The next step would be the dissemination of this policy.

7.2 FUNDING

Optimizing the connection between HIV and STI services cannot occur without adequate economical support. The IPPF and UNFPA have therefore recommended advocating for investment in STI management as a key strategy to reduce HIV transmission.

Desk review

1. Joint sources of funding and testing for HIV and VDRL. Assistance from various agencies and organizations were identified to fund combined HIV/VDRL testing
2. Develop guidelines on mainstreaming AIDS/STI intervention into mainstream planning and resource allocation programmes.

Interview with policymakers

1. **Do the donors support SRH and HIV-related work within the same programmes or do they focus on each separately?**

All participants thought that the overseas funding agencies focused primarily on financing HIV/AIDS, however a few indicated that there is an anticipated decrease in overseas funding and the contribution from the MOH (which presently contributes less than a half of the budget) will have to increase. The MOH is therefore playing a significant role in financial support for linkages between HIV and SRH.

Mixed feelings were associated with funding and costing being made a priority in the national HIV strategy /policy. One group of policymakers identified the receivership of international funding for implementation of national HIV policies as having made funding a priority. Further exploration revealed that a consultant was hired to cost the HIV strategic plan and to implement a resource mobilization plan.

Interview with service providers

The majority of service providers thought linking HIV and SRH will not result in any change to the cost of service to the facility and clients, but rather increase the need for equipment, supplies and drugs.

Gaps within each level

1. The service providers indicated that there will be an increased need for equipment, supplies and drugs.
2. The policymakers indicated there will be an anticipated decrease in overseas funding.

Conclusion

With an anticipated decrease in overseas funding, the service providers indicated that there is an increased need for equipment, supplies and drugs which is being addressed with the mainstreaming of AIDS/STI interventions into local resource allocation programmes.

Discussion

There is an expected gap in the sourcing of funds, therefore it is expected that either attempts are made to secure additional overseas funding and/or there is an increase economic contribution from local governments. Both these issues were addressed in the policies.

7.3 LOGISTICS AND SUPPLIES

Optimizing the connection between HIV/AIDS and STI services require significant attention to be paid to the logistics and supplies.

Interview with policymakers

1. Almost all of the policymakers identified the unexecuted HIV strategic plan as the existing HIV policy, however, one participant thought that there was no formal strategic or operational plan as the present plan is outdated and the new HIV strategic plan is yet to be implemented.
2. All agreed that there was no national SRH strategy or policy, although plans are in place to develop a General Operations Manual for use in the CHS that will include SRH. The first draft has already been disseminated for input. There were ambivalent views as to what guides the national programme, some policy makers thought the programme was guided by regional documents whilst others postulated that it was part of the local Family Health Plan. Therefore responses were mixed as to whether it includes HIV prevention, treatment, care and support.

Interview with system managers

1. When identifying logistics that support or hinder effective service-delivery; they identified the following as hindering service delivery:
 - 3 out of 4 identified a separate supply system
 - 2 out of 4 indicated planning and supply of commodities.
 - 2 out of 4 indicated separate monitoring and recording of SRH and HIV.
2. **Who are the major development partners for the SRH programme?**

Most participants identified the Ministry of Health or government as the major development partners for the SRH programme. In both St Kitts and Nevis the Family Planning Association is inactive and they are no known private entity involved in SRH.

3. Who are the major development partners for the HIV programme?

The following were identified:

- I. Ministry of Health(MOH),
- II. Faith-based organizations(FBO),
- III. Community-based organization(CBO),
- IV. FACCTS
- V. Regional organizations eg PANCAP
- VI. Funding agencies

The MOH was identified as initiating the process of HIV programming by accessing international funding. The Roman Catholic Church was identified as being proactive in providing home-based care. Other FBOs may get involved if they have the personnel and allow them to be trained. It was perceived that even though FBOs provided home-based care to its members, the PLWHA did not particularly access the service due to their own perception of stigma and discrimination. The CBOs may play a role, but their involvement was not established:

‘The issue may be that there are not enough committed personnel and those who are committed do not have sufficient time, we are adhering from the motto ‘Country above self’.

It is envisioned that FACCTS could play a greater role but its present role and function needs revisiting. Due to the perceived stigma and discrimination of PLWHA, membership is scant.

Everyone who answered claimed that people from the HIV programmes are not involved in the SRH planning process, 4 out of 5 persons who answered indicated that people from the SRH programme are involved in the HIV planning process. They were involved in the formulation of the HIV Strategic Plan and the Operational Plan. 3 out of 4 persons indicated that there was no collaboration between SRH and HIV for programme management and implementation. It was voiced that the HIV unit generally do not get invited to meetings. Persons indicated that collaboration exists in the coordination of activities, (through VCT, workplace programmes, establishment of the men’s wellness clinic), monitoring

of activities, integrated supervision of activities (distribution of educational promotion products) and integrated budgets (through the cultural foundation and media houses). The major difficulties voiced are the absence of a formal SRH programme management. Therefore SRH are integrated into the general community health planning programmes.

When asked to what extent have SRH services integrated services for HIV and have HIV services integrated SRH, the average point allocated was 6.8.

The institutions providing integrated services for HIV and SRH were identified as the Ministry of Health and the government clinics; in particular the family planning clinics, ANC, PNC. One person thought the NGO may play a part in providing these integrated services. Some of the highest priority needs identified are more family planning nurses, decentralization of family planning services and training of staff, (HIV staff needs more SRH training and SRH staff need more SRH and HIV training) . The consensus was that the involvement of these groups was limited.

4. Who are the major champions supporting HIV and SRH linkages (policy level, funding level, technical level)?

No one identified any major champions at the policy or funding level, however multiple champions were identified at the technical level. These include the Caribbean HIV/AIDS Alliance group, Ministry of Health, seminars to improve linkages, PMTCT programmes and Family Planning Programmes. Others thought there were no formal champions, but rather persons utilize their own initiatives.

5. To what extent are PLWHA, young people, key populations involved in the SRH and HIV response?

Feelings were mixed as to the extent to which PLWHA are involved in the SRH response. The general consensus was that there was minimal involvement, although efforts are being made to get PLWHA involved in HIV programming which commenced with the establishment of a human rights desk. Two people thought there was limited participation as the PLWHA were not coming forward to participate in HIV programming. However it was noted that both the youth and

PLWHA were targeted in the HIV response. Persons were asked to rate these extents and an average rating of 3.7 was given to PLWHA, 6.0 was given to young people. The minority responded to the extent to which there is involvement of key populations and a score of 3.5 was given.

Almost everyone were uncertain about how organizations of young people were involved in responses to HIV and SRH programming, although one participant observed that there was no formal involvement. Organizations identified include the Sadlers Community Improvement Group, HOPE and Sandy Point Young People as being involved.

Interview with service providers

1. The greatest impact of linking SRH and HIV services is the need for equipment, supplies and drugs.
2. Most service providers thought that shortage of equipment and space were not a constraint for providing integrated service, but identified shortage of staff time and training as medium constraints and inappropriate/insufficient staff and low staff motivation as a large constraint.
3. **How has the integration of services influenced staffing challenges?**

In relation to staffing for SRH and HIV programmes, the answers were centered on inadequate family planning staff and the need for a formal SRH unit. Four out of five persons agreed that there may be burnout, three indicated a need for recruitment, two indicated a result in task shifting and two indicated a change in quality. There was mixed views as to how integration of the services influenced these challenges. One person thought it would affect it in a positive way, some expressed that there needs to be more integration of the management of PLWHA at a community level. Another disagreed:

“As a small society we have to look at confidentiality, therefore emphasis should continue to be placed on HIV prevention from a community health point of view.”

It was suggested that recruiting more nurses may assist in providing a solution to some of these challenges.

Gaps within each level

A separate supply system (especially for condom distribution) was identified as hindering effective service delivery and there was an identified need for equipment, supplies and drugs should linkage between HIV and SRH occur.

Conclusion

There is a requirement for equipment, supplies, drugs and a single supply system if optimizing linkages between SRH and HIV.

Discussion (from follow-up meeting)

The participants identified an increase in trained staff, more space, more equipment, supplies and drugs if we are to close this gap.

They indicated that educating the community and focusing more on health promotion may reduce the number of clients attending the health centres and thus decreasing the need for more space. Such educational strategies include utilizing the media, community centres and the schools. However there is still a need to train health care workers and upgrade existing facilities and equipment.

Recommendations (from follow-up meeting)

1. Decentralize health education. This should be done through the Health Promotion Unit.
2. Training of health care workers facilitated through the Ministry of Health.
3. Upgrade of existing facilities facilitated through the Ministry of Health.

7.4 CONTACT TRACING

Contact tracing is defined as the process of identifying contacts of a person with an infectious disease in order to inform them of their exposure, assess the risk of transmission and if appropriate, provide screening and treatment.²⁰ Contact tracing therefore encompasses both STI and HIV/AIDS services.

Desk review

1. Test results remain confidential, and may only be disclosed in the absence of an overriding legal or ethical duty, with the individual's informed consent.
2. The HIV policy and procedure manual states that

“Your provider will talk to you about the importance and benefits of notifying your partner of their possible exposure to HIV. Your provider may ask you to provide the name(s) of your partner, and whether it is safe for you if they are notified. If the HIV positive individual does not have a plan to notify his/her partners, the Health care provider may notify them without revealing the index patient's identity. If this notification presents a risk to the index patient, the Health Care Provider may defer notification for a period of time sufficient to allow the index patient to access the appropriate support services prior to notification.”

Interview with policymakers

1. The majority of policymakers thought that the HIV policy included the contact tracing system.
2. One policymaker (general) noted that the contact tracing system was not a priority, whilst another policymaker (HIV-related) thought that it was a priority.
3. Topics unanimously identified as conflicting topics were disclosure of HIV status and contact tracing as it relates to certain groups of individuals where mandatory HIV testing and disclosure of HIV status is instituted. There were arguments that the doctors' role is to protect his/her patient and they are obligated to confidentiality as it relates to their patient. One person thought that ‘a doctor should make a call to contacts and indicate that they should get tested’, whilst the other member of the group thought that this would be inappropriate. Community-based workers were trained in contact tracing through PAHO.

Gaps within each level

One policymaker noted that it was not a priority and it was identified by another group as a conflicting or contentious topic.

Gaps between policy documents and policymakers

Although the HIV policy document acknowledged the importance of contact tracing, the issue appears to be a conflicting topic, particularly between HIV and SRH policymakers.

Conclusion

Contact tracing is a conflicting and contentious topic.

Discussion (from follow-up meeting)

The issue of contact tracing sparked a heated debate during the follow-up meeting. The participants thought that there should be encouragement of the current system of patient disclosure if the patient feels that it is safe to do. Efforts should be made to provide a safe and enabling environment and providers must continue to protect their patients' confidential information or face a penalty.

Some policymakers think that contact tracing is not a priority, whilst another policymaker was adamant that it is a priority. Another policymaker thought it was a priority, but the question is how it should be carried out. Care should be taken to demonstrate to the partner that they will not put their partners at risk. This sparked a heated debate as questions were asked if in such a small society this is at all possible. The debate concluded with one participant indicating that we can look at other islands with contact tracing and evaluate it to see if it can work in our setting. The Director of NACHA, indicated that what was needed was a contact tracing workshop and NACHA will facilitate the workshop in the near future.

Recommendations

NACHA will facilitate a contact tracing workshop in the near future.

8 INTEGRATE HIV/AIDS WITH MATERNAL AND INFANT HEALTH

Integrating HIV/AIDS with maternal and infant health encompasses developing policies to provide appropriate HIV/AIDS care and treatment options relating to maternal and infant health. This includes the inclusion of PMTCT in antenatal care settings, strengthening maternal health services for women living with HIV/AIDS and counsel PLWHA on their reproductive choices.

This category therefore looks at the following linkages:

- PMTCT programme
- Attitudes towards PLWHA

8.1 PREVENTING MOTHER TO CHILD TRANSMISSION (PMTCT)

An effective PMTCT programme is the cornerstone of integrating HIV/AIDS with maternal and infant health.

Desk review

1. The PMTCT programme is offered within the maternal health services (of which the ANC is a component of). Whilst attending the ANC, HIV testing should be conducted after appropriate testing.
 2. Follow-up care is offered to the HIV positive woman post partum with referral to family planning services.
-

Interview with policymakers

One of the HIV-related policymakers indicated that the HIV policies contained family planning within the PMTCT programme. The other policymakers, representing a more unbiased view, acknowledged that the HIV policies did not deal with family planning in the PMTCT programme. However the key informant confirmed that family planning occurred within the PMTCT programme.

Interview with system managers

During the informant interview the system manager acknowledged that efforts were made to involve fathers into the PMTCT programme, renaming it the PPMTCT programme (prevention of partner to mother to child transmission).

Interview with service providers

All groups of service providers noted that PMTCT are integrated with SRH services in the health centres.

Interview with clients

Only one person presented for PMTCT services, so an adequate assessment of services rendered within the PMTCT programme could not be assessed.

Gaps within each level

No identifiable gap could be ascertained as there were insufficient clients presenting for PMTCT interviewed for us to establish a trend.

Recommendations

Emphasis should be placed on strategies to improve male attendance and participation in the PMTCT programmes.

8.2 ATTITUDES TOWARDS PEOPLE LIVING WITH HIV/AIDS (PLWHA)

Embracing a positive attitude towards PLWHA and acknowledging their human rights is essential in integrating HIV/AIDS with maternal and infant health. In St Kitts and Nevis, it has been postulated that stigma and discrimination towards PLWHA is quite high, but there are no objective studies conducted to support this theory. Therefore stigma and discrimination and attitudes towards PLWHA go hand in hand.

Desk review

1. The policies are geared towards increasing the participation of PLWHA and social support at the community level.
2. It is expected that the FBOs provide care to PLWHA.
3. By 2013, 90% of all people express supportive attitudes towards PLWHA.
4. Improve male participation in the care for PLWHA.
5. The rights of PLWHA will be addressed by strengthening the HIV/AIDS supportive policy and legal framework.
6. Fertility and reproductive choices will be discussed upon referral to the family planning services.

Interview with policymakers

1. A mean score of 8 out of 10 was allocated to the extent at which the HIV policies addressed the rights and SRH needs of PLWHA.
2. The policymakers all indicated that the HIV operational plan identified explicit activities to improve access, coverage and quality of care for HIV in PLWHA.
3. There are no anti-discriminatory laws protecting PLWHA.
4. One of the HIV policymakers indicated the HIV policies contained fertility and reproductive choices for PLWHA. The other participants, representing a more unbiased view indicated that the HIV policies did not address fertility and reproductive choices for PLWHA.
5. 2 out of 3 groups thought that the right of PLWHAs to be sexually active and bear children was a conflicting topic.

Interview with system managers

1. 3 out of 5 indicated that capacity building on SRH and HIV integrated guiding principles such as attitudes towards PLWHA.
2. The human rights desk was established to address the rights of PLWHA.
3. The system managers thought that although there are no specific laws concerning reproductive choices for PLHA, there should be a general respect for human rights.

Interview with service providers

1. The majority of service providers thought linking HIV and SRH services will destigmatize HIV clients.
2. This interview was limited in assessing attitudes towards PLWHA as the SRH facilities interviewed did not generally offer care to known cases of PLWHA. One participant thought that it would affect it in a positive way, some expressed that there needs to be more integration of the management of PLWHA at a community level. Another disagreed:
“As a small society we have to look at confidentiality, therefore emphasis should continue to be placed on HIV prevention from a community health point of view.”

Interview with clients

1. The majority of clients who responded 26(55%) stated that they would feel comfortable if seen immediately by the service provider after an HIV-positive patient when visiting their health provider and 8(17%) stated that they would not feel comfortable.

Gaps within each level

1. There are no anti-discrimination laws protecting PLWHA.
2. The policymakers thought the rights of PLWHA to be sexually active and bear children was a conflicting issue.

Gaps between policy documents and policymakers

Although the HIV policies acknowledged the rights of PLWHA to be sexually active and bear children, most of the policymakers thought it was a contentious and conflicting issue.

Conclusion

Linking HIV/AIDS and SRH services may prove useful in addressing attitudes towards PLWHA , but anti-discrimination laws protecting PLWHA should be in place.

Recommendations

1. Amend the present laws to protect PLWHA as proposed by the LEHR.
2. Further exploration of the rights of PLWHA to be sexually active and bear children.

9 CREATING AN ENABLING ENVIRONMENT

Cross-cutting issues concerning the creation of an enabling environment underpin the framework and such issues include human rights, community involvement and participation and mechanisms to address structural determinants (eg gender equality, elimination of gender-based violence, access to services).²

These issues were explored in this rapid assessment.

9.1 HUMAN RIGHTS

Emphasis has only recently been placed on human rights in the health sector with the advent of HIV/AIDS. This began with the establishment of a human rights desk and proposals for amendments to laws through a recent assessment of the law, ethics and human rights in St Kitts and Nevis concluded in 2007.

Desk review

1. Everyone has the right to information, privacy, care without discrimination, a full partner in health care decisions, speedy complaint resolution, voluntary decision about the choice of a method and respect for the individual.
2. Eliminate compulsory testing for new citizens/residents.
3. The rights of PLWHA will be addressed by strengthening the HIV/AIDS supportive policy and legal framework.

Interview with policymakers

1. The policymakers noted that there were no anti-discrimination laws to protect PLWHA, although plans are in place to pass one.
2. Topics unanimously identified as conflicting topics regarding a rights-based approach within SRH and HIV-related services were mandatory versus voluntary testing, disclosure of HIV status and contact tracing, mandatory HIV testing and disclosure of HIV status. Some policymakers indicated that the discrepancy with the legal age for access of health services and the rights of PLWHA to be sexually active and bear children were conflicting topics. No-one thought that provider-initiated HIV testing was an issue.

Interview with system managers

3 out of 5 of the system managers indicated that capacity building on SRH and HIV integrate guiding principles and values on reproductive rights and choices.

Interview with service providers

The key informant identified the human rights desk as being established to address the rights of PLWHA, and there has been no known legal action by PLWHA against employees, communities and services based on discrimination of HIV status. The monthly incidence of reports was zero.

Gaps within each level

1. The majority of policymakers thought that the right of PLWHA to be sexually active and bear children was a conflicting topic.
2. The human rights desk was established to address the rights of PLWHA, however there is a lack of reporting to this desk.

Gaps between policy documents and policymakers

Although the policy documents addressed the general human rights of everyone, the majority of policymakers thought that the right of PLWHA to be sexually active and bear children was a conflicting topic.

Conclusion

There is a lack of reporting to the human rights desk which may be enhanced by providing a supportive and legal framework. The right of PLWHA to be sexually active and bear children is a conflicting topic.

Discussion (from follow-up meeting)

The participants at the follow-up meeting suggested that we can educate the populace of their human rights and the presence and function of the human rights desk. Further exploration of the human rights desk was not done by the group at the follow-up meeting assigned this task due to insufficient time. It was envisioned that recommendations would have been made by the participants to improve the function of the human rights desk.

The Primary functions of a human rights desk (adapted from the human rights desk in Grenada)²¹ is to:

- Receive and document violations of human rights against people living with and affected by HIV/AIDS and to seek redress.
- Keep current with the National Regional and International treaties of which our state is a signatory to.
- Conduct research on available laws and legislation current, past and future.

Assessment of the factors restricting the function of the human rights desk is required. During the survey, it was suggested that the following may be prohibiting factors:

- I. Location of the human rights desk
- II. Lack of resources
- III. Impact of stigma and discrimination

It was mentioned that perhaps the best way of addressing the aforementioned factors was to create a general human rights desk, not specific to PLWHA.

Recommendation

1. Establish a general human rights desk instead of a human rights desk for PLWHA.
2. Continue with educational strategies addressing human rights.
3. Providing a supportive and legal framework as suggested by the LEHR.

9.2 COMMUNITY INVOLVEMENT AND PARTICIPATION

Community involvement which involves assisting HIV/AIDS programmes in St Kitts and Nevis is limited. Efforts are being made to involve the workplaces, FBOs, and CBOs particularly pertaining to the fight against HIV/AIDS.

This category explores the presence of workplace policies and the assistance of FBOs with home-based care for PLWHA. Due to overlap in linkages home-based care was discussed in chapter 3.6.

Workplace policy

Although plans are in place for the development of workplace policies from regional and international levels, focus must also be placed on instituting local workplace policies.

Desk review

1. The Department of Labour will promote and propose workplace policies and interventions.
2. Private sector firms will design and implement workplace programmes and develop non-discriminatory workplace policies.
3. One-off health facility/school/workplace surveys to assess quality of service delivery.

Interview with policymakers

1. **Has a workplace policy been developed and adopted by the government?**
A workplace policy has been developed by the Ministry of Labour via an initiative of the ILO. This policy was based on the regional workplace policy and has yet to be instituted.

Gaps within each level

The Ministry of Labour has developed a workplace policy, but it has not yet been instituted.

Conclusion

The policies promoted the presence of workplace policies and the Ministry of Labour is working to address this.

Discussion

It was hoped that more discussion would have surrounded this linkage in the follow-up meeting. The ILO has recognized that local initiatives should be instituted to implement workplace policies. Recently the Leeward Times reported on a one-day workshop held in Nevis on Thursday 25th June to sensitize participants drawn from several workplaces on how to organize an HIV/AIDS work force programme.¹⁶ During the follow-up meeting, a very brief presentation was made by the Director of the HIV/AIDS unit in Nevis who gave an outline of the strategies employed in Nevis. Time did not allow for a discussion on this topic to be facilitated and how similar programmes may be adapted in St Kitts.

Recommendations

Similar strategies that have begun in Nevis to facilitate workplace policies and programmes, be adapted for St Kitts.

9.3 STRUCTURAL DETERMINANTS

Mechanisms to address structural determinants look at gender equality, elimination of gender-based violence and access to services. Access to services was discussed in chapter 5.1 under the linkage accessibility and affordability.

Gender equality

Desk review

1. HIV/AIDS strategies and policies shall acknowledge and address gender inequalities.
 1. The Department of Gender will increase the quality and coverage of HIV prevention interventions for teen mothers, men and low income women.
 2. The Departments of Social Development, Gender Affairs, and Youth will facilitate the economic and emotional well-being of low-income women and men and reduce the need for transactional sex for economic survival.
-

Interview with policymakers

1. **How do the HIV and SRH policies address gender inequalities?**

The participants were asked to give rating of 1-10. For the SRH-related policies an average rating of 7 was allocated and for the HIV-related policies an average rating of 9.3 was allocated.

Particular attention was placed on gender inequality whilst developing the National HIV Strategic Plan 2009-2013. *'We solicited the input from the gender department to assist in the development of the HIV strategic plan.'*

2. Emphasis will be placed on women in difficult situations and those involved in transactional sex.
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Interview with system managers

4 out of 5 system managers indicated that capacity building on SRH and HIV integrated gender sensitivity.

Interviews with clients

1 out of the 21 clients who attended the ANC indicated that a discussion was held regarding women's rights.

Gap between system managers, service providers and clients

Only 1 out of 21 clients attending the ANC indicated that a discussion was held regarding women's rights although the system managers indicated that capacity building on SRH and HIV integrated gender sensitivity.

Discussion

Due to the nature of the interview (primarily self-administered questionnaires), it may have been difficult for the clients to qualify human rights and a more detailed description (which was not possible with the type of questionnaire utilized) may have been required.

Elimination of gender-based violence

Desk review

1. Upon visiting the health centres, document the family and social history including domestic violence.
 2. Specific objectives in the health centres Operational Plan is to assess the presence of high risk factors such as intimate partner abuse.
-

Policymakers' interviews

- Are there laws against gender-based violence, how effectively are they enforced and is the public well informed about the existence of these laws. Is there an observable change in reporting of cases since the implementation of the law?

All agreed that there were laws against gender-based violence, (later identified as the Domestic Violence Legislation) but responses were skewed as to how effectively they are enforced. The mean score was calculated at 5.5. There were diverse opinions as to whether the public was well informed about the existence of these laws. When asked participants scored a mean average of 6. Most spoke about the outreach programmes instituted by the gender department. There was a concern that there may have been a favoring of the target population towards women. Some indicated that one of the difficulties associated with reporting of cases was the failure of law enforcers to press charges or take the charges seriously.

Interview with service providers

2 out of 5 service providers indicated that prevention and management of gender-based violence are offered at the health centres.

Interview with clients

1 out of the 21 clients who attended the ANC indicated that a discussion was held regarding domestic violence.

Gaps within each level

1. 2 out of 5 service providers indicated that prevention and management of gender-based violence are offered at the health centres.
2. 1 out of 21 of clients attending the ANC indicated that a discussion was held during their visit regarding domestic violence.

Comparison of desk review with identified gap

The General Operational Plan presently in the draft stage has identified specific objectives to assess the presence of high risk factors in the health centres such as intimate partner abuse.

Conclusion

It is expected that with the dissemination of the General Operational Plan, there is an increase in identification of domestic violence cases in health centres.

Discussion (from follow-up meeting)

The participants identified the development of a referral system with the Departments of Gender, Community and Social development, outreach centres and Child Probation Officers.

They identified additional actions and projects which may assist in strengthening the linkage between HIV and SRH. These include policy formation, collaboration with stakeholders (especially national men's group), involvement of the Ministry of Education through guidance counselors who will be asked to incorporate gender-based violence into the schools' curriculum, involve the legal department and law enforcers.

Recommendation (from follow-up meeting)

1. Meetings with stakeholders during the formulation of the General Operational Plan (if not already done).
2. Strategies geared at improving community involvement and active participation.
3. Establish a Monitoring and Evaluation plan.

10 DISCUSSION

This chapter provides a summary of the next steps that can be taken to strengthen the linkages between HIV/AIDS and SRH.

It also engages in a discussion on the linkages not addressed in the chapter and reviews the importance of these linkages in St Kitts and Nevis.

10.1 NEXT STEPS

This divides the recommendations from the preceding chapters into suggested immediate, intermediate and long term steps.

Immediate steps

- I. Implementation of amendment to the law as suggested by the LEHR to facilitate accessibility of healthcare in the youths by ensuring legal protection of service providers.
- II. Efforts should be made to improve privacy and confidentiality of information in the public health system.
- III. Develop general health policy for stigma and discrimination with clearly articulated penalties for breach of these policies and identify a focal point to address management of stigma and discrimination.
- IV. Liaison with the LEHR consultant currently working in the Ministry of Labour to address stigma and discrimination.
- V. Facilitate easier access to the human rights desk by forming a general human rights desk and encourage its removal from the HIV/AIDS unit.
- VI. Development of an adequate HMIS system.
- VII. Improve efforts for VCT and disaggregate data to identify clients being tested for the first time and repeat testing.
- VIII. Involvement of clients in their care plan.
- IX. Formulate a men's policy to guide the operational plan and further promote PMTCT.
- X. Build a network of national development partners primarily for funding, support, advocacy and technical assistance.
- XI. Completion of the draft Operational Plan which would include SRH policies geared towards linkages.
- XII. Decentralize health education.
- XIII. Upgrade existing health centres to include more space and privacy, youth friendly services, improve HMIS.
- XIV. Facilitation of a contact tracing workshops by NACHA.
- XV. Facilitate workplace policies and programmes in St Kitts.

Intermediate steps

- I. Screening of tuberculosis should become standard in PLWHA.
- II. Formulation of a condom access policy by the MOH including a M&E plan and involves intersectoral coordination.
- III. Establish Youth Friendly Services (YFS) in the Community Health Services.
- IV. Encourage and commence public debate relating to decriminalizing MSM and CSW.
- V. Encourage further exploration of the rights of PLWHA to be sexually active and bear children.

Long term steps

- I. Ensure that PLWHA have access to home-based care/palliative care.
- II. Establish a general home-based care plan that will incorporate PLWHA, utilizing a multi-sectoral approach.

10.2 DISCUSSION OF LINKAGES NOT ADDRESSED

It was noted that linkages between HIV and SRH were all addressed in the HIV policies with the exception of ‘criminalizing HIV transmission’ and ‘developing and adopting workplace policy with SRH and HIV components.’ Criminalizing HIV transmission has not been proven to be helpful in hindering transmission of HIV, but the institution of workplace components with HIV and SRH components have been shown to reduce stigma and discrimination.

‘Criminalization’ refers to the application of criminal law to prosecute HIV transmission or exposure to another person. Although in some countries, criminal law is being applied to those who transmit or expose others to HIV infection,¹⁰ there is no data indicating the broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission.²² Rather, it is thought that such application risks undermine public health and human rights, the UNAIDS therefore urges governments to limit criminalization to cases of intentional transmission.²² There is also the question of proof and the potential for miscarriage of justice is great.²³ The Final Report on the National Assessment on Law, Ethics and Human Rights conducted in St Kitts and Nevis has revealed that the issue of willful transmission of HIV was thoroughly debated and the participants in the discussion recognized the futility of proving willful transmission.¹¹ Therefore supporting the lack of recommendation made for criminalizing the transmission of HIV/AIDS.

The Caribbean Regional Strategic Framework for HIV/AIDS 2002-2006 stated that the development of strong workplace-based HIV prevention and care programmes with full involvement of employers’ and workers’ organizations is key for the region.¹⁴ This is because the HIV/AIDS epidemic has a strong impact on the labour force and will increase the prevalence of poverty and inequities because of its impact on both individuals and economies.²⁴ This issue is being addressed foremostly as a regional issue extending into an international response. At its March 2007 meeting, the governing body of the International Labour Organization(ILO) agreed to place the issue of HIV and AIDS and the world of work on the agenda of the June 2009 International Labour

Conference. It is intended that the discussions will lead to the development of an autonomous recommendation on HIV and AIDS in the world of work by 2010.²⁵ In June 2007 in Trinidad at the second Pan American Business Coalition Forum on HIV/AIDS welcomed the Caribbean Congress of Labour (CCL) as its newest partner in the effort of the private sector to reduce the prevalence and incidence of HIV/AIDS in the Caribbean.²⁵

DRAFT

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Appendix 1

For all policies:

Linkages	General	HIV	SRH
Gender issues			
Gender inequality		P4	
High level of engagement of men in response	P6	P4	P2
Laws against gender-based violence		P4	
HIV-related stigma and discrimination			
HIV related stigma and discrimination		P3, P4	
Key populations			
Social attitude towards key population		P3, P4	
Legislation towards key population		P1, P3, P4	P2
Policies toward key population	P6	P3, P4	P2
Community attitude towards key populations		P3, P4	
Legal age (marriage, independent HIV testing, access to SRH services, consent for sexual intercourse)	P6	P4	
Condom access			
Policies to support condom access		P3,P4	
Referrals			
Address referrals to other service	P6	P4	
Workplace policy			
Develop and adopt workplace policy with HIV and SRH components	-	-	-
Funding			
Joint sources of funding are promoted		P3,P4	
Address sufficient funding for reproductive health and HIV-related supplies		P3,P4	
Accessibility and affordability			
Geographic accessibility of health care		P4	
Geographic accessibility of HIV services		P3	
Geographic accessibility of SRH services	-	-	-
Demographic accessibility of health care		P1, P4	
Demographic accessibility of HIV services		P3,P4	
Demographic accessibility of SRH services	P6	P4	P5
Affordability of health care		P1, P4	
Affordability of HIV services		P3,P4	
Affordability of SRH services	-	-	-
Decentralization			
Decentralization strategies		P1, P3, P4	
Confidentiality			
Confidentiality	P6	P1	
Human rights			
Respect for human rights	P6	P1	P5
Criminalizing HIV transmission			
Criminalize HIV transmission	-	-	-

For SRH policies

Linkages	General	SRH
<i>Dual protection</i>		
Programming for dual protection	P6	P5
<i>Contact tracing</i>		
Contact tracing system		
<i>PMTCT programme</i>		
Family planning within the PMTCT programme		
Fertility and reproductive choices for PMTCT		
SRH policy include HIV prevention issues such as PMTCT within maternal health services	P6	
<i>Inclusion</i>		
HIV issues in the national SRH policy are part of the national plan and legislature	P6	
<i>VCT</i>		
SRH policy include HIV prevention issues such as VCT within family planning	P6	
<i>Human rights</i>		
Right-based approaches within SRH-related services	P6	
<i>Activities</i>		
Within the broader SRH operational plan, formulize activities to improve access, coverage and quality of care, including for HIV, for the general population, key populations, PLWHA, men and women		
<i>Accessibility and affordability</i>		
SRH policy include HIV treatment issues such as HIV treatment for PLWHA		
<i>Care and support</i>		
SRH policy include HIV care and support issues such as BCC on HIV within SRH services		
<i>Monitoring</i>		
HIV issues in the national SRH policy are priorities through monitoring		
<i>Funding</i>		
HIV issues in the national SRH policy are priorities through funding/cost		

For HIV policies

Linkages	General	HIV
Family planning within the PMTCT programme		
Fertility and reproductive choices for PMTCT		
Programming for dual protection	P6	
Contact tracing system		P1
SRH issues in the national HIV policy are part of the national plan and legislature		P3,P4
Rights-based approaches within HIV-related services	P6	P1, P3, P4
Within the broader HIV operational plan, formulize activities to improve access, coverage and quality of care, including for SRH, for the general population, key populations, PLWHA, men and women		P3, P4
Address the rights and SRH needs of PLWHA in the HIV policies		P3, P4
SRH issues in the national HIV policy are priorities through monitoring		P3, P4
SRH issues in the national HIV policy are priorities through funding/cost		P3,P4

Appendix 2

Linkages	Strategic Plan	Operational Plan
Gender inequality	❖	
High level of engagement of men in response	❖	
HIV related stigma and discrimination	❖	❖
Social attitude towards key population	❖	❖
Legislation towards key population	❖	❖
Policies toward key population	❖	❖
Community attitude towards key populations	❖	❖
Laws against gender-based violence	❖	
Legal age (marriage, independent HIV testing, access to SRH services, consent for sexual intercourse)	❖	
Policies to support condom access	❖	❖
Address referrals to other service	❖	
Develop and adopt workplace policy with HIV and SRH components		
Joint sources of funding are promoted	❖	❖
Address sufficient funding for reproductive health and HIV-related supplies	❖	❖
Geographic accessibility of HIV services		❖
Demographic accessibility of HIV services	❖	❖
Affordability of HIV services	❖	❖
Decentralization strategies	❖	❖
Confidentiality		
Respect for human rights		
Criminalize HIV transmission		
Family planning within the PMTCT programme	❖	
Fertility and reproductive choices for PMTCT	❖	
Programming for dual protection		
Contact tracing system		
SRH issues in the national HIV policy are part of the national plan and legislature	❖	❖
Rights-based approaches within HIV-related services	❖	❖
Within the broader HIV operational plan, formalize activities to improve access, coverage and quality of care, including for SRH, for the general population, key populations, PLWHA, men and women	❖	❖
Address the SRH needs of PLWHA in the HIV policies	❖	❖
SRH issues in the national HIV policy are priorities through monitoring	❖	❖
SRH issues in the national HIV policy are priorities through funding/cost	❖	❖

Appendix 3

Linkages	Desk Review	Policymakers interview	Systems Interview
<i>VULNERABLE FACTORS</i>			
<i>Gender issues</i>			
Gender inequality	•	•	•
High level of engagement of men in response	•	x	•
<i>HIV-related stigma and discrimination</i>			
HIV related stigma and discrimination	•	•	•
<i>Key populations</i>			
Attitude towards key population	•	•	•
Policies toward key population	•	•	
<i>LEGISLATIVE FRAMEWORK SUPPORTING LINKAGES</i>			
Laws against gender-based violence	•	•	n/a
Legal age (marriage, independent HIV testing, access to SRH services, consent for sexual intercourse)	•	x	n/a
Laws affecting key groups	•	•	•
Anti-discrimination law	n/a	x	x
<i>LOGISTICS AND SUPPLIES</i>			
<i>Condom access</i>			
Policies to support condom access	•	•	n/a
<i>Effective service delivery</i>			
Logistics hindering effective service delivery	n/a	n/a	•
Staffing challenges	n/a	n/a	•
<i>PARTNERSHIP</i>			
<i>Referrals</i>			
Referrals to other services	•	n/a	x
<i>Workplace policy</i>			
Develop and adopt workplace policy with HIV and SRH components	x	n/a	n/a
<i>Decentralization</i>			
Decentralization strategies	•	•	n/a
<i>Dual protection</i>			
Programming for dual protection	•	n/a	n/a
<i>VCT</i>			
SRH policy include HIV prevention issues such as VCT within family planning	•	n/a	n/a
<i>PMTCT programme</i>			
Family planning within the PMTCT programme	x	n/a	n/a
Fertility and reproductive choices for PMTCT	x	n/a	x
SRH policy include HIV prevention issues such as PMTCT within maternal health services	•	n/a	n/a

	Desk review	Polymakers interview	Systems interview
Integration			
HIV issues in the national SRH policy are part of the national plan and legislature	•	x	n/a
SRH issues in the national HIV policy are part of the national plan and legislature	•	•	n/a
SRH policy include HIV treatment issues such as HIV treatment for PLWHA	x	n/a	n/a
Activities			
Within the broader SRH operational plan, formulize activities to improve access, coverage and quality of care, including for HIV, for the general population, key populations, PLWHA, men and women	x	x	n/a
Within the broader HIV operational plan, formulize activities to improve access, coverage and quality of care, including for SRH, for the general population, key populations, PLWHA, men and women	•	•	n/a
Involvement of PLWHA, young people and key populations in the SRH response	•	•	x
Care and support			
SRH policy include HIV care and support issues such as BCC on HIV within SRH services	x	n/a	n/a
FUNDING			
Joint sources of funding are promoted	•	•	n/a
Address sufficient funding for reproductive health and HIV-related supplies	•	•	n/a
HIV issues in the national SRH policy are priorities through funding/cost	x	n/a	n/a
SRH issues in the national HIV policy are priorities through funding/cost	•	n/a	n/a
ACCESSIBILITY AND AFFORDABILITY			
Geographic accessibility of health care	•	n/a	n/a
Geographic accessibility of HIV services	•	n/a	n/a
Geographic accessibility of SRH services	x	n/a	n/a
Demographic accessibility of health care	•	n/a	n/a
Demographic accessibility of HIV services	•	n/a	n/a
Demographic accessibility of SRH services	•	n/a	n/a
Affordability of health care	•	n/a	n/a
Affordability of HIV services	•	n/a	n/a
Affordability of SRH services	x	n/a	n/a
CONFIDENTIALITY			
Confidentiality	•	•	•
HUMAN RIGHTS			
Respect for human rights	•	x	n/a
CRIMINALIZING HIV TRANSMISSION			
Criminalize HIV transmission	x	n/a	n/a

<i>CONTACT TRACING</i>	Desk review	Policymakers interview	Systems interview
Contact tracing system	•	n/a	n/a
<i>MONITORING</i>			
HIV issues in the national SRH policy are priorities through monitoring	x	n/a	n/a
SRH issues in the national HIV policy are priorities through monitoring	•	n/a	n/a
<i>PLANNING, MANAGEMENT AND ADMINISTRATION</i>			
Joint planning of programmes	n/a	•	•
<i>ADEQUACY OF EXISTING POLICIES</i>			
HIV policies support linkages	•	•	n/a
SRH policies support linkages	x	x	n/a

Appendix 4: Sample of client exit interview

Questionnaire






Good Day!

The United Nations and the Ministry of Health, St Kitts are conducting an assessment of services relating to Sexual and Reproductive Health (SRH) and HIV. This information may help to improve polices and services. It will only take five minutes of your time.

We would appreciate if you could fill out the questionnaire below. Your opinions and information that you give during the interview will remain confidential and the questionnaire will not have your name.

1. Name of clinic: _____
2. Date of interview: _____

Please tick the appropriate box

3. Which section of the clinic did you come to? 
 - Family planning
 - Sexually transmitted Infections
 - Postnatal Clinic
 - Antenatal Clinic
 - Pap Smears
 - General clinic
 - don't know
 - Other _____
4. Are you male or female?
 male  female

Please fill in the following:

5. How old are you? _____
6. Why did you came to the clinic

Please tick the appropriate box

7. What services did you receive today?
 - family planning
 - prevention and management of Sexually Transmitted Infections
 - postnatal services
 - HIV counseling and testing
 - prevention of HIV
 - condom services
 - preventing transmission of HIV from mother to baby
 - social support
 - nutrition support
 - physical examination
 - don't know
 - Other _____
8. Were you sent to any other place?
 yes no
9. Did you get all the services you wanted today?
 yes no not sure
Other _____

If no, please answer question 10 and 11.
If yes, please go on to question 12.

10. If no, what other services would you have liked to get from this clinic today?

11. If no, why did you not receive all the services you wanted?

Sexual and Reproductive health(SRH) refers to all sex-related and reproductive services eg Antenatal clinic, family planning, postnatal clinics, infertility, management of sexual problems, sexual abuse

12. Do you prefer to have sexual and reproductive health and HIV at the same health centre, or do you prefer different health centres?

- prefer same health centre
prefer a different health centre
no preference
don't know
Other _____

13. Why? _____

14. Do you prefer sexual and reproductive health and HIV services from the same nurse/doctor or do you prefer to another nurse/doctor?

- prefer same nurse/doctor
prefer referral to another nurse/doctor
no preference
don't know
Other _____

15. Why? _____

16. Would you feel embarrassed to talk about HIV with a doctor/nurse of the same village or neighbourhood?

- yes no a little don't know
prefer not to answer

17. Why? _____

18. Would you feel comfortable if you were seen immediately by the nurse/doctor after an HIV-positive patient when visiting the doctor or nurse at the clinic?

- yes no don't know prefer not to answer

19. Why? _____

20. Please tick each option that your doctor/nurse spoke to you about today? (You make tick more than one)

- family planning
use of condoms to prevent unintended pregnancy
use of condoms to prevent Sexually Transmitted Infections/HIV
use of female condoms
Sexually Transmitted Infections
HIV prevention
Counseling and testing
breast cancer screening

- Pap smear
- HIV is treatable with medication
- child health services
- vaccination
- labour and delivery
- women's rights
- men's health
- health needs of young people
- Anything else that interested you _____

21. How satisfied are you with the services you received today?
- very dissatisfied (not satisfied)
 - somewhat dissatisfied (not satisfied)
 - mostly satisfied
 - very satisfied
 - don't know
 - does not wish to answer

22. What might have helped you to be more satisfied with the services you received today? _____

Thanks for your kind assistance



Appendix 5

Table illustrating demographics of each participating health centre

	BHC (n=8)	CHC (n=5)	CTHC (n=7)	GHC (n=6)	NTHC (n=6)	SPHC (n=14)
Gender						
• <i>Male</i>	0	0	0	0	0	0
• <i>Female</i>	8	4	7	6	6	14
• <i>Not known</i>	0	1	0	0	0	0
Age range						
• <i><18 yrs</i>	0	1	0	0	1	3
• <i>18-25 yrs</i>	3	1	1	2	2	4
• <i>26-35 yrs</i>	3	0	2	2	3	3
• <i>36-50 yrs</i>	2	3	3	1	0	4
• <i>>50 yrs</i>	0	0	1	0	0	0
Section of clinic attended						
• <i>STI</i>	0	0	0	0	0	0
• <i>PNC</i>	0	0	1	0	1	1
• <i>ANC</i>	4	2	1	5	3	8
• <i>Family Planning</i>	2	4	3	0	2	1
• <i>General</i>	0	0	2	0	0	3