AN HIV AND AIDS SITUATIONAL ASSESSMENT: BARRIERS TO ACCESS TO SERVICES FOR VULNERABLE POPULATIONS IN SAINT KITTS AND NEVIS

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

OFFICE OF THE REPRESENTATIVE TO BARBADOS

MEASURE EVALUATION

AUGUST 2007

TR-07-61

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This report was made possible by support from the U.S. Agency for International Development (USAID) through Cooperative Agreement GPO-A-00-03-00003-00. The authors' views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

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ABBREVIATIONS AND LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
CAREC–SPSTI	Caribbean Epidemiology Centre—Special Programmes on Sexually Transmitted Infections
CARICOM	The Caribbean Community and Common Market
CCH	Caribbean Cooperation in Health
CDB	Caribbean Development Bank
CMO	Chief Medical Officer
CSME	CARICOM Single market and Economy
CSP	Clinical Service Provider
CSW	Commercial Sex Worker
FACTTS	Facilitating Access to Confidential testing, Treatment and Support
FBO	Faith-Based Organisations
FHI	Family Health International
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
HIV+	Human Immunodeficiency Virus-positive
HSPA	HIV and AIDS Service Provision Assessment
ILO	International Labour Organisation
IRB	Institutional Review Board
MOH	Ministry of Health
MSM	Men who Have Sex with Men
MSM/W	Men who Have Sex with Men who also have sex with Women
NACHA	National Advisory Council on HIV/AIDS
NAP	National AIDS Program
NEHAC	Nevis HIV/AIDS Committee
NGO	Non-Governmental Organisation
NIA	Nevis Island Administration
NSP	National Strategic Plan
OECS	Organization of Eastern Caribbean States
PAHO	Pan American Health Organisation
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
SNHAG	Saint Kitts/Nevis HIV/AIDS Group
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
US	United States
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

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ACKNOWLEDGMENTS

Immense gratitude is extended to all those who gave freely of their time and expertise in assisting with the development, coordination and execution of this situational assessment for St. Kitts and Nevis.

Special thanks are due to Mr. Elvis Newton, Permanent Secretary in the Ministry of Health, who supported the implementation of this assessment and provided the insight into the needs for strategic planning.

Special acknowledgement goes out to the dedicated members of the respective in-country teams for Saint Kitts and Nevis for their contributions of time, sharing of information, support with recruitment of participants and review of the draft report; without them the assessment would not have been possible. Of worthy mention are—

- Mrs. Gardenia Destang-Richardson, acting director of the National AIDS Secretariat, Saint Kitts, who acted as the focal point for the strategic process and worked tirelessly to arrange, coordinate, and provide logistical and technical support to the assessment and to the research team.

- Ms. Nadine Carty Caines, HIV/AIDS Officer of the Nevis HIV/AIDS Coordinating Unit, Nevis, who did a tremendous job coordinating interviews, and assisting the research team during its activities in Nevis.

- Dr. Kathleen Allen-Ferdinand, Chairperson of the National Advisory Council on HIV/AIDS (NACHA) who provided substantial insight into the issues affecting vulnerable populations in Saint Kitts and Nevis and helped to inform the direction in which the research team took its research.

- Dr. Hazel Williams-Roberts, Director of Community Health Services who played a key supporting role in sourcing relevant documentation, helped with the recruitment of participants, and in lending her technical expertise to the assessment.

We would not have actualized the implementation of this assessment without our partner in the Eastern Caribbean: the Caribbean HIV/AIDS Alliance. Working with Mr. Kevin Farara, Programme Coordinator for Saint Kitts and Nevis was the critical component in accessing the very private and hard to reach social networks of the vulnerable populations identified in this report. He was instrumental in achieving the objectives of the assessment by serving as an on-the-ground recruiter, escort, coordinator, organiser, mentor and reviewer. Mr. Ozzi Warwick supported this project from its inception by assisting in developing the protocols, participating in data collection as well as providing members of the Alliance staff (Ms. Nadine Kassie) to support the data collection process.

We would also like to thank Mr. Neal Goodwin, Proprietor for Stonewall's Café in Basseterre, who facilitated the incentive process for study participants. The Ocean Terrance Inn served as the "home away from home" for the research team and we appreciate their support as well.

In particular, many, many thanks to all those members of the public, health sector personnel, and staff of the governmental and non-governmental agencies—without whom this report would not be possible—who participated in the interviews, accommodated the interviewers' busy schedules, and provided some most valuable information.

Thanks to the Caribbean regional partners who provided critical insight and input to the usefulness of such an assessment: Ms. Nicola Taylor consultant for the Caribbean Regional Office of the United Nations Programme for HIV/AIDS (UNAIDS) for her assistance, technical support, and advice throughout the process; to Ms. Beverly Edwards,, Caribbean HIV/AIDS Alliance; to Ms. Elizabeth Lloyd of the Caribbean Health and Research Council (CHRC); to Mr. Salorne MacDonald and Ms. Pamela Faura of Population Services International (PSI) who offered technical advice in the early design of the assessment.

The research assessment team from MEASURE Evaluation consisted of Dr. Ifeoma Udoh, Resident Technical Advisor and Project Director; Ms. Alana Lum Lock, and Ms. Nelia Hoffman, M&E Research Associates. Mr. Oswald Warwick, Technical Advisor and Ms. Nadine Kassie, Programme Assistant from the Caribbean HIV/AIDS Alliance both served as interviewers. Staffs from Macro International Inc. were key in this process as well namely, Dr. Erin Eckert; Mrs. Jennifer Winestock Luna; Mr. Phil Moses, Dr. Jack Herman, Chairperson of the Institutional Review Board; and Macro's Publishing and Media Resources department who did an amazing job working within the tight deadlines that were required of them.

Financial support and technical guidance to implement this assessment was provided by the United States Agency for International Development (USAID), Barbados. Ms. Mary Freyder and Ms. Angela Davis served as Senior HIV/AIDS technical advisors from USAID and were key in moving the discussions forward as well as promoting a working relationship between MEASURE Evaluation and Caribbean HIV/AIDS Alliance to implement such a project.

EXECUTIVE SUMMARY

OVERVIEW

The Ministry of Health in Saint Kitts and Nevis are planning to undertake the revision of its current strategy plan. A key step in this process is the implementation of "Situational Assessment," which provides the opportunity for examining and using current data sources, to access the current socio-cultural contexts for key stakeholders and community members in relationship to HIV and AIDS, and to provide recommendations to strengthen strategic planning, and therefore the national response to HIV and AIDS.

This year, MEASURE Evaluation and the International HIV/AIDS Alliance worked to support Saint Kitts and Nevis in implementing the Situational Assessment presented here. It was proposed that MEASURE Evaluation support this gap in data on vulnerable populations by conducting the assessment and with approval from the Permanent Secretary in December; implementation began in January 2007.

The goal of the assessment was to understand the vulnerability of certain groups to HIV and AIDS infection, the community barriers to accessing HIV-specific services, and recommendations for addressing those barriers. This assessment also seeks to understand how service providers—namely clinical—and governmental/non-governmental organisation (NGO) persons understand who might be vulnerable to HIV, and obtain their insight in implementing services targeting these populations.

The information provided in this report should be not be used in a vacuum to inform strategic planning and community programming efforts in Saint Kitts and Nevis; rather what is presented here can be used in collaboration with most current and available data sources.

The key objectives of this qualitative assessment were to—

- Develop stakeholder driven definitions and profile of the groups that are at high risk for HIV infection (vulnerable groups) in both Saint Kitts and Nevis
- Understand the barriers to providing HIV and AIDS services to vulnerable groups from three key perspectives: clinicians/health care workers, program managers and implementers, clients who are accessing services
- Determine needs for services and provide concrete recommendations for programming targeting vulnerable groups
- Provide concrete recommendations for strengthening and implementation of programs for inclusion to the revised National Strategic Plan

SUMMARY OF KEY FINDINGS

The following is a summary of key findings by group within which individuals were recruited for the assessment:

Men who have sex with Men (MSM)

Interviews were conducted with 23 MSM. Twenty-one interviews were conducted in Saint Kitts and two in Nevis.

- Multiple partnerships exist both among MSM and men having sex with both men and women.
- There is engagement in some form of transactional sex among MSM, that is exchanges of sex for gifts or favours
- There is a good awareness of factors that influence risk of HIV infection in the MSM community and familiarity with the risks of being sexual active, having more than one partner, and not always using protection; but this knowledge is not often reflected in behaviours
- Most of the men also admitted that they had not disclosed their sexuality to their families or health care professionals for fear of stigma and discrimination.
- Only 1/3 of respondents had ever been tested for HIV.

Commercial and Transactional Sex Workers

There are two types of engagement in sexual negotiations in Saint Kitts and Nevis—commercial sex work and transactional sex.

- Those involved in commercial sex work include both foreign Spanish-speaking girls and women and local English-speaking girls and women.
- Those involved in transactional sex most often include local girls and women.
- Spanish-speaking women and local women involved in sex work are moving between Saint Kitts and Nevis.
- Spanish-speaking women we interviewed did not identify themselves as sex workers, — which is similar to the issue of local women not distinguishing themselves as CSWs— because they are not "visibly" practicing sex work, they are not street based nor do they necessarily operate out of bars or brothels or work with a pimp; they are not even engaged in the CSW activity full time. Spanish bars may be a venue for sex work, but they are also seen as community centres for the women to socialise.
- Tourists will work with taxi drivers and hotel staff to set up dates with local sex workers.

- Local women involved in transactional sex will often exchange sex for favours—including paying bills, buying groceries, buying clothing and electronics, or in many cases, receiving a cell phone top-up (extra money added to post-paid phones). Exchanges will also involve money.

At-risk Women

- Despite the fact that many women in long-term relationships indicate that they feel vulnerable to HIV because of men not being faithful to them; they do not use condoms based on the longevity of the relationship.

- Women who often have unfaithful partners do nothing about it, because of the economic support and security that comes from their partners.

- There in an element of intergenerational sex—the women interviewed were aware of young women who have sex with older men, often with married men.

- Low self-esteem among women makes them vulnerable to staying in bad relationships with men.

People Living with HIV and AIDS (PLWHA)

The interviewers were able to speak with four people in Saint Kitts who are HIV-positive.

- Stigma and fear of a lack of confidentiality in the public health care system associated with picking up HIV medications at the pharmacist means PLWHAs often feel more comfortable accessing medications off-island through a friend or having to travel themselves to obtain them.

- Doctors often have to go and pick up medications at pharmacies themselves to protect the identity of their HIV+ patients from the public and other health care professionals.

- There was an expressed need for professional and psychosocial support and trained counsellors in both the private and public sector.

- There is a reported great satisfaction and comfort with the relationship with clinical providers among the PLWHAs interviewed.

Members of Faith-Based Communities

This assessment conducted informal interviews with clergy in Saint Kitts, as well as three members of the Rastafarian community in both Saint Kitts and Nevis.

- There was an expressed desire by the clergy to be more involved in activities related to the care of PLWHA.

- There was a feeling that the church should be a domain of reconciliation and compassion, and perhaps this is not being emphasized enough to those living with HIV.

- The clergy also expressed that the church's role was in promoting abstinence, especially among young people.

- Rastafarians mention that the preference to using herbalists as health care providers—this choice is influenced by a dissatisfaction with both the level of professional care received by medical staff as well as the medical treatment options provided by the system, and preferences for less invasive treatments that do not require drawing of blood or use of needles

- Rastafarians respondents stated a general preference for not using condoms, but felt they were not different from other males. Decisions to use were sometimes personal, but also based on theories about the effectiveness of condoms and the conspiracy theory behind an international drive to promote them.

- Rastafarian men may engage in multiple sex partnerships, although they may or may not have a steady girlfriend. Often these partnerships might be with non-Rastafarian women, as many Rastafarian women already have a 'king man' or steady partner.

Youth

A discussion group with young people in Saint Kitts yielded the following:

- There was generally no great concern about contracting HIV within the group—many reported that they were not engaged in sexual activity. This response was more common within the 18–26 age group.

- Regarding access and use of condoms to prevent transmission, the group felt that among young people there was discussion about HIV and many discussions about sex and condoms, but that discussion about sex and condoms were divorced from discussions of HIV; they were more centred on condom use as a means of contraception.

- Young people felt that factors that influenced these sexual behaviours and attitudes included (a) male promiscuity and its acceptance in Kittitian society, (b) the lack of societal role models for both young males and females and (c) the influence of religion.

- Respondents felt that many young people are hesitant to buy condoms, even though they are aware that they should use them. Reasons provided include shyness and religious upbringing, as it is difficult for an underage and unmarried young person to go to a pharmacy to ask for condoms, especially in a small society.

- They were not aware that public clinics offered VCT services.

- They highlighted that the "top-up phenomenon" is a big issue among young men and women and that youth are using their text messaging on cell phones to engage in transactional sex (i.e., an "I want a top-up" message means to trade sex for a top-up)

Clinical Service Providers

Thirteen interviews were conducted with clinical service providers in Saint Kitts and Nevis; they yielded the following:

- Most clinical service providers interviewed worked in both the public and private sectors.

- A consistent message that emerged from discussions with clinical care providers, especially doctors and nurses, was their inability to provide VCT services consistently, and their need for dedicated staff to provide VCT.

- Providers were aware of the public's fear of lack of confidentiality in facilities. It was mentioned that in general, people do not want to go to the hospital to be tested for HIV because of a perceived lack of confidentiality.

- Even though providers were aware of perceived lack of confidentiality, few providers could cite past breaches in confidentiality. Despite this, providers take extra precaution to protect the status of their patients.

Governmental and Non-governmental Organisations

Formal interviews were conducted with both governmental and non-governmental organisations in both Saint Kitts and Nevis; they yielded the following:

- Many Ministries outside of the Ministry of Health are engaged in HIV and AIDS-related work. There is a strong programmatic focus on prevention programs with youth, condom distribution and establishing policies to protect PLWHA against discrimination in the workplace and in the general community. There is room, however, for scale-up in other programmatic domains, especially in programs targeting vulnerable groups.

- There is a need to integrate monitor and evaluate programs implemented by NGO's and Ministries outside of the Ministry of Health.

- Many respondents said that the biggest barrier to providing HIV and AIDS services to vulnerable groups about them.

CHAPTER 1: SAINT KITTS AND NEVIS COUNTRY PROFILE

1.1 BACKGROUND

The twin island Federation of Saint Kitts and Nevis is located in the Caribbean Sea, occupying a total of 261 sq km (Saint Kitts 168 sq km, Nevis 93 sq km). The nation is roughly one and one-half times the size of Washington, DC and is approximately one-third the distance from Puerto Rico to Trinidad and Tobago. The country is home to 48,781 Kittitians and Nevisians, primarily of African origin, with some of British, Portuguese, and Lebanese descent. A member of the Commonwealth of Nations, Saint Kitts and Nevis received its independence from the United Kingdom in 1983. The official language is English and the legal system is based on English Common Law. Religion is Anglican, with other Protestant denominations and Roman Catholic minorities. Industry includes banking, tourism, sugar processing, and export-oriented manufacturing.[1] According to a 1999-2000 survey, Saint Kitts' unemployment rate was 5.6 percent and Nevis' was 8.6 percent.[2] The 2004 St. Kitts and Nevis Statistical review indicated that the population of Saint Kitts and Nevis is young: 37 percent of the population in Nevis and 40 percent in Saint Kitts are under the age of 19. The population is about evenly split between men and women.[3] Life expectancy at birth is 69 years for males and 72 years for females.[4] There is a fairly high teen pregnancy rate in Saint Kitts and Nevis with 19.8 percent of live births occurring with teenage girls.[5] The total fertility rate for the nation is 2.29 children born/woman (2007). The 2007 estimated population growth rate was .623 percent (2007) and the net migration rate was -3.51 migrants/1,000 population (2005).[6] Education is compulsory and the literacy rate was estimated to be 98 percent in 2001.[7]

1.2 HIV AND AIDS IN SAINT KITTS AND NEVIS

HIV and AIDS are currently believed to be concentrated in high-risk populations rather than in the general population. The first case in Saint Kitts was identified in the mid 1980s. Since that time, the Federation has witnessed a significant rise in the incidence of HIV. As of 2006, there were 273 cumulative AIDS cases.[8] The burden of the epidemic is shifting from men to women.

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[1] Central Intelligence Agency (CIA). 2007. CIA World Factbook. Washington DC: Central Intelligence Agency. Available at http://www.cia.gov/cia/publications/factbook/geos/do.html.
[2] Pan American Health Organization. Saint Kitts and Nevis Country Profile. Available at http://www.paho.org/English/DD/AIS/cp_659.htm.
[3] Poverty Reduction Strategy for Saint Kitts and Nevis draft.
[4] World Health Organization. Core Health Indicators: Saint Kitts and Nevis. Available at http://www.who.int/whosis/database/core/core_select_process.cfm?country=kna&indicators=selected&language=en
[5] Saint Kitts and Nevis Ministry of Finance, Development and Planning: Statistics Division. 2004. Saint Kitts and Nevis Statistical Review. Basseterre, Saint Kitts.
[6] CIA. 2007
[7] PAHO. Saint Kitts and Nevis Country Profile.
[8] Communication with Dr. Kathleen Allen-Ferdinand

There has been a reversal in the male to female ratio from 1.5: 1 in 1998 to 1.2:1 in 2004. The most affected age group continues to be persons 25 to 44 years especially among females. HIV infection among males tends to cluster in the 15 to 24 and 45+ age groups.[9] Estimates of HIV prevalence stands at 1.5 to 2.0 percent of the population. The number of HIV tests done annually has increased from fewer than 1,000 in 1988 to 2,836 in 2004. [10]

HIV poses a significant problem for small countries such as Saint Kitts and Nevis. AIDS morbidity and mortality are concentrated in the 25-49 age group, the most economically productive segment of the population. Failure to contain the disease could result in the depletion of the human resources needed to support the service-sector and strain the economy. Furthermore, HIV and AIDS can strain the health sector/system, which already accounts for 10- to 16 percent of the national budget.[11]

Various factors are likely to contribute to a marked increase in HIV, unless prevention and control programmes are initiated. These include a recent rise in the incidence of sexually transmitted infections (STIs) following a decline in the 90s; low condom use; early initiation of sexual activity among youth (boys initiate sexual activity between age 14 and 17 and girls start between 12 and 14); tolerance for male promiscuity; high levels of gender inequality; a pattern of older males seeking younger girls; strong religious beliefs that are not conducive to discussions of condom use; high levels of stigma and discrimination against persons living with HIV and AIDS (PLWHA) which contribute to failure to seek testing, treatment and under-reporting of HIV; a tourist sector that is characterized by large numbers of tourists and migrant workers; and a high proportion of female headed households (up to one third of the total number of households), many of which are low-income.[12]

Many of these factors are borne out in the behavioural surveillance surveys conducted in six countries of the OECS in 2006 (including Saint Kitts and Nevis).[13] As demonstrated in the table below, an extremely low percentage of individuals surveyed had an accepting attitude towards PLWHA. Concerns around confidentiality of HIV testing remain a major issue, which could affect uptake of counselling and testing services negatively. In addition, a fairly high percentage (46 percent) of youth engages in multiple sexual relationships, and of those, only 16 percent reported using condoms consistently.[14]

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[9] United Nations General Assembly Special Session on HIV/AIDS (UNGASS). 2006. Country Report- St. Christopher and Nevis. Available at http://data.unaids.org/pub/Report/2006/2006_country_progress_report_st_kitts_nevis_en.pdf (Accessed August 22, 2007).
[10] UNGASS. 2006.
[11] The World Bank 2002.
[12] Ameen, A., Lloyd. E. 2004. *Assessment of the National HIV/AIDS Programme (NAP) of the Federation of St. Kitts and Nevis*. Caribbean Health Research Council: Trinidad.
[13] Caribbean Epidemiology Center (CAREC). 2007. *Behavioural Surveillance Surveys (BSS) in Six Countries of the Organisation of Eastern Caribbean States (OECS) 2005-2006 Final Report.* CAREC-SPSTI, Port of Spain.
[14] Ibid.

Table 1.2a: Results for selected BSS Indicators

	Saint Kitts & Nevis General Population	
INDICATOR	15-24 years	25-49 years
Percent of respondents with accepting attitudes towards people living with HIV and AIDS (Denominator: All people surveyed)	1%	5%
Percent of respondents who have had sex with a non-marital non-cohabiting3 partner in the last 12 months (Denominator: People who had sex in the last 12 months)	98%	56%
Percent of respondents with multiple5 non-marital non-cohabiting sexual partners in the last 12 months (Denominator: People who had sex in the last 12 months)	46%	23%
Percent of respondents reporting the use of a condom the last time they had sex with a non-marital non-cohabiting sexual partner (Denominator: People with non-regular non-commercial partners in the last 12 months)	56%	52%
Percent of respondents reporting consistent condom use with non-marital non-cohabiting sexual partner (Denominator: People with non-regular non-commercial partners in the last 12 months)	16%	29%
Percent of respondents who think it is possible to get a confidential HIV test in their community (Denominator: All people surveyed)	60%	62%

A more expanded version of the above Table 1.2a can be found in Appendix C.

Saint Kitts and Nevis also participated in the Caribbean Region HIV and AIDS Service Provision Assessment in 2005. The HIV and AIDS Service Provision Assessment (HSPA) focuses on the formal public health sector in Saint Kitts and Nevis. The findings provide information on both basic- and advanced-level HIV and AIDS services and the availability of recordkeeping systems for monitoring HIV and AIDS care and support. Table 1.2b demonstrates key findings for Saint Kitts and Nevis that shed light on provider stigma, confidentiality, recordkeeping, youth-friendly HIV testing services. For Saint Kitts, there is a need to implement policies on confidentiality and privacy measures in public facilities with an HIV testing system. In Nevis, there is a need to implement youth-friendly HIV testing services and increase sensitization campaigns for health

care providers. On both islands, there is a need to implement nutritional rehabilitation services in facilities with an HIV testing system (see section on PLWHA for recommendations). [15,16]

Table 1.2b Results for selected HSPA Indicators

INDICATOR	Saint Kitts	Nevis
Percent of providers with an accepting attitude towards PLHIV (Denominator: Total number of providers interviewed)	63% of 30 providers interviewed	47% of 17 providers interviewed
Percent of public facilities with an HIV testing system with visual and auditory privacy in all counselling areas (Denominator: Total number of facilities with an HIV testing system)	46% of 11 facilities	71% of 7 facilities
Percent of public facilities with an HIV testing system with an observed policy or guideline on confidentiality of HIV test results in all relevant service sites (Denominator: Total number of facilities with an HIV testing system)	18% of 11 facilities	57% of 7 facilities
Percent of public facilities with an HIV testing system that offer nutritional rehabilitation services (Denominator: Total number of facilities with an HIV testing system).	18% of 11 facilities	14% of 7 facilities
Percent of public facilities with HIV testing system that offer youth-friendly services (Denominator: Total number of facilities with an HIV testing system)	36% of 11 facilities	0% of 7 facilities

[15] MEASURE Evaluation. 2006. *Nevis Caribbean Region HIV and AIDS Service Provision Assessment.* Calverton, MD: Macro International Inc.
[16] MEASURE Evaluation. 2006. Saint Kitts Caribbean Region HIV and AIDS Service Provision Assessment. Calverton, MD: Macro International Inc.

A more expanded table highlighting findings from the HSPA can be found in Appendix D.

1.3 NATIONAL RESPONSE TO AIDS EPIDEMIC

The 2000 national strategic plan (NSP) for Saint Kitts and Nevis prioritizes 1) prevention, 2) care, treatment and support, 3) advocacy, 4) research, surveillance and epidemiology, and 5) program coordination and management. [17] National Advisory Council on HIV and AIDS heads the project and has multisectoral representation. Other areas being addressed are support and legislation for civil rights of PLWHA, policy recommendations and local prevention and control of the HIV and AIDS epidemic. Currently a monitoring and evaluation framework has been adopted and implemented with national level indicators harmonized to donor-required indicators. [18]

1.4 MAJOR CHALLENGES FACED

Despite the progress that has been made, many challenges remain. The number of new HIV infections continues to increase in spite of current efforts.

Social and Cultural Norms

Strong stigma against PLWHAs serves to drive the epidemic underground making it difficult to conduct effective prevention, care and treatment. The OECS BSS reported that only 1-5 percent of population 15-49 years Saint Kitts and Nevis expressed accepting attitudes towards people living with HIV and AIDS. While there appeared to be a compassionate response by individuals to hypothetical questions on willingness to care for HIV-positive family members and willingness to allow an HIV-positive student, teacher or co-worker to conduct their normal school/work activities, there was a low willingness for food-related contact.[19] This may reflect persistent fear of HIV transmission through food and suggests that stigma on the islands might be susceptible to change with proper education and sensitization. According to the Saint Kitts and Nevis UNGASS report:

> …stigma and discrimination associated with HIV and AIDS continues to exist. This affects the willingness of PLWHA to be more visible champions for change and advocates for human rights. It may also act as a deterrent to persons who want to get tested for HIV. While there has been some increase in the awareness of the general public, technical support is needed to develop and implement a comprehensive strategy to address stigma and discrimination. While there has been a thrust towards greater involvement of PLWHA in programme planning and implementation, they remain invisible on the front line in the fight against HIV and AIDS. Further the ability

[17] Saint Kitts and Nevis Strategic Plan 2001-2005.
[18] UNGASS. 2006.
[19] CAREC. 2007.

> of PLWHA to provide peer support to each other has been limited because of fear and reluctance to disclose serostatus even among PLWHA.

Several strides have been made to address discrimination against PLWHA, such as the establishment of a human rights desk located in the National AIDS Secretariat, as well a formal complaint procedure.

Institutional Capacity

Another challenge facing Saint Kitts and Nevis is the lack of knowledge about the dynamics and behavioural factors driving the HIV and AIDS epidemic. According to the Saint Kitts and Nevis UNGASS report:

> HIV surveillance is weak compounded by the limited capacity to conduct behavioural research. This has contributed to a poor understanding of the scope and magnitude of the local epidemic as well as the underlying factors that contribute to its continued escalation. Without this information, it is very difficult to determine which interventions are more likely to mitigate the impact of HIV and AIDS. While tremendous progress has been made in the scale up of comprehensive care and treatment, an array of essential support services remain largely inadequate. This includes provisions for psychosocial support, home based care and laboratory capacity for monitoring CD4 counts and viral load.

Human Resource Capacity

Throughout the Caribbean, low human resources capacity is a constraint faced by many national AIDS programmes. There are very few technically trained individuals; many of whom often migrate. The national AIDS programmes in both Saint Kitts and Nevis currently are limited in terms of human resources. While the programmes are both supported as functioning agencies within the Ministry of Health, the dual and sometimes triple roles that key staff plays mean that there is a strain in the management of the HIV programme. At the time of this report, Saint Kitts NAP did not have a designated finance officer, behaviour change program coordinator, or support staff. Rather, these roles are shared within the Ministry. This can make it difficult to implement, monitor and evaluate activities. The Ministry of Health is actively addressing these issues. The Nevis programme could benefit from having an M&E staff person as well. The NACHA, the National Advisory Council on HIV and AIDS Coordinating in Saint Kitts, which has the responsibility to programme the World Bank funding, has a somewhat active membership. Yet, barriers to participating in this process have not been assessed. There is a need to scale up the staffing in both Saint Kitts and Nevis NAP offices.

CHAPTER 2: ASSESSMENT METHODOLOGY

2.1 OVERVIEW

A comprehensive HIV prevention and care strategy should include efforts targeting groups (or "vulnerable groups") that engage in high-risk behaviour for HIV infection. Vulnerable groups can engage in high-risk behaviours within a network of sexual partners. Therefore, entry into these groups can have a major impact on whether an epidemic becomes prevalent in the general population.

To plan programs targeting vulnerable groups effectively, it is crucial to have current information about the groups themselves and any contributing factors to their high-risk behaviour. On November 8, 2006, a meeting implemented by MEASURE Evaluation and International HIV/AIDS Alliance was held in Basseterre, Saint Kitts to discuss Prevention Activities and Strategic Information Needs for Vulnerable Groups. One of the major themes resulting from this meeting was the overall lack of information about vulnerable groups in Saint Kitts and Nevis. While stakeholders were more familiar with groups such as high-risk youth; information on groups such as Commercial Sex Workers (CSW) and Men who have Sex with Men (MSM) was deficient and in some cases unknown.

The National AIDS Program (NAP) developed and implemented a Strategic Plan for the National Response to HIV/AIDS in Saint Kitts/Nevis, covering the period of 2001-2005 as "a broad national plan to guide the country's response to the epidemic". The process of revising the plan commences in September 2007 and a key component of information needed is the input of the countries constituents to better inform the priorities for programming and providing appropriate HIV- and AIDS-related services, including activities targeting vulnerable groups.

2.2 OBJECTIVES OF THE ASSESSMENT

MEASURE Evaluation in collaboration with the International HIV/AIDS Alliance conducted a situational analysis to address information needs for vulnerable groups in Saint Kitts and Nevis. The analysis provides qualitative information on the characteristics and HIV and AIDS programming needs of vulnerable groups in Saint Kitts and Nevis. The goal of the situational analysis is to provide information to the key stakeholders in Saint Kitts and Nevis to develop key recommendations for HIV and AIDS programming targeting vulnerable and inform the direction of the revised National Strategic Plan.

The key objectives of the situational assessment were to—

- Develop stakeholder driven definitions and profile of the groups that are at high risk for HIV infection (vulnerable groups) in both Saint Kitts and Nevis

- Understand the barriers to providing HIV and AIDS services to vulnerable groups from three key perspectives: clinicians/health care workers, program managers and implementers; clients who are accessing services

- Determine needs for services and provide concrete recommendations for programming targeting vulnerable groups

- Provide concrete recommendations for strengthening and implementation of programs for inclusion to the revised National Strategic Plan

2.3 METHODOLOGY

This assessment used qualitative methods of data collection. Qualitative methods allowed for descriptive information, perceptions, and insight to the needs of the various groups included in the process. Both group discussions and unstructured one-one-one interviews were conducted with different cadres of participants. In addition, the study conducted informal interviews with stakeholders in the community familiar with vulnerable groups and participant observation in places where vulnerable groups congregate. Demographic quantitative data was also collected using short, closed-ended surveys at the beginning of each interview. The assessment was approved for human subject research by the Macro International Inc. institutional review board as well as the Chief Medical Officer of Saint Kitts and Nevis in May 2007.

2.4 SAMPLING DESIGN

Convenience sampling was used in the selection of the participants. This method was selected for the vulnerable groups because (1) the overall population size of the island and the population of the vulnerable groups are relatively small (2) many of these group members either operate 'underground' or are part of closely knit networks and protective of their identities, thus locating them in large numbers prove difficult (3) the nature and sensitivity of the topic area was not the most appealing to participants. This method was selected for the clinical service providers and governmental and non-governmental organisations because the sample size for these groups was also relatively small and limited numbers of these professionals meant that their multitasking and schedules did not always allow them to be readily available.

As Saint Kitts and Nevis have identified the priority of revision to the National Strategic Plan this year, they have organized an "In-country Team" of key individuals from the Ministry of Health, the National AIDS Program, the National Advisory Council on HIV/AIDS (NACHA) and the Department of Gender and Social Affairs, Department of Youth and Department of Labour to direct, advise and guide the process of revising the plan. These organisations as well as faith-based organisations, key community leaders and the International HIV/AIDS Alliance were used as "sources" for the recruitment of the participants. Since some of the vulnerable groups identified were quite broad (i.e., "at-risk" women), the in-country team guided the data collection team in locating places where these groups congregate. For example, since economic stability is a driving factor in the decision-making capability of women, members of the in-

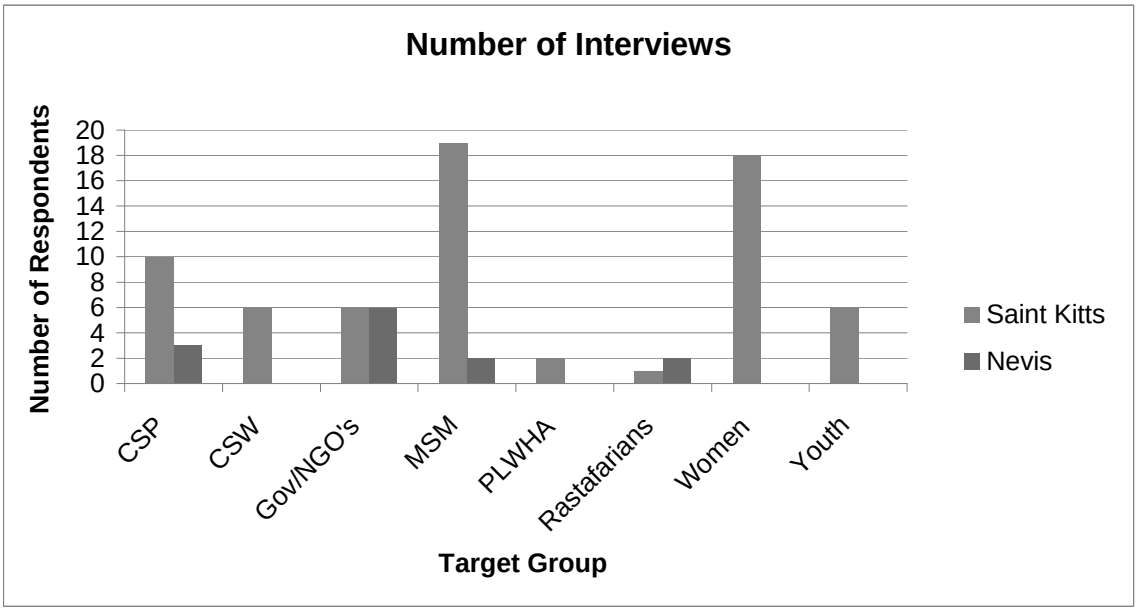
country team suggested that women from industrial sites be sampled, since they earn the minimum wage and may be experiencing economic hardship.

Listed below are characteristics of each of the groups from which data was collected. It is important to note that these characteristics facilitated the sampling of the participants and are not definitions of the groups themselves (especially the vulnerable groups).

- **Clinical care providers—**Individuals who offer primary or clinical health services in Saint Kitts and Nevis
- **Individuals working in governmental or non-governmental organisations—** Persons in key positions in governmental ministries or departments, as well as community based institutions, coordinating or implementing programmes/activities that contribute to the HIV and AIDS prevention and care efforts in Saint Kitts and Nevis
- **Spanish speaking commercial sex workers (CSWs)—**Spanish-speaking migrant women who are involved in sex work in Saint Kitts and Nevis
- **English Speaking CSWs—**Kittitian and Nevisian women who are exchanging sex for money or gifts to supplement their means of living (such as groceries, bills, material goods etc.).
- **Men who have sex with men (MSM)—**Homosexual and bisexual men
- **"At risk" women—**Married women and women who are economically disadvantaged
- **Young adults—**Individuals over the age of 18 but under the age of 36
- **Members of the faith-based community—**Christian clergy and Rastafarians
- **People Living with HIV and AIDS—**HIV-positive individuals

Figure 2.2 illustrates the numbers of individuals interviewed in each target group, for both Saint Kitts and Nevis.

Figure 2.4: Number of Interviews



2.5 CONTENT

A broad discussion guide was derived for each target group. The table below illustrates main areas of query within the discussion guide for each group:

Table 2.5: Content of discussion guides by target group

Clinical Service Providers	• Personal work experience • Health services provided • Awareness of vulnerable groups • Patients/clients accessing facility • Barriers to provision of health services to vulnerable groups

Commercial Sex Workers	• Awareness of vulnerability to HIV and AIDS • Sexual behaviours • Sexual/social constructs • Social/personal issues • Health service needs • Future plans
Individuals working in government and non-governmental organisations	• Personal capacity • Knowledge and perceptions of vulnerable groups • Organizational linkages with HIV and AIDS services or vulnerable groups • Perception of role of organization in HIV and AIDS • Knowledge of programs and services available for HIV and AIDS
Men who have sex with men	• Sexuality • Awareness of vulnerability to HIV and AIDS • Sexual behaviour • Sexual/social constructs • Social/personal issues • Health service needs • Future plans
"At-risk" women, PLWHA, Rastafarians, youth	• Awareness of vulnerability to HIV and AIDS • Sexual behaviour • Health service needs

2.6 IMPLEMENTATION

The data collection team consisted of a five-member team from MEASURE Evaluation and the International HIV/AIDS Alliance. The Project Director was from MEASURE Evaluation. International HIV/AIDS Alliance was key in the development and implementation of this assessment. The Programme Officer from International HIV/AIDS Alliance, responsible for Saint Kitts and Nevis was instrumental in implementing the recruitment strategy, especially with the at risk populations, as well as mobilizing and informing key members of the in country team and the community in Saint Kitts as a whole of the work of the data collection team..

All of the interviewers were trained in qualitative methods, the questionnaires and measures to protect confidentially prior to implementation of the study. Training took place on site in Saint Kitts prior to data collection. Three members of the data collection team were Spanish speakers, which supported conducting interviews with Spanish-speaking sex workers. The assessment was conducted during May- June 2007. There were two phases to data collection comprising of two scheduled 10-day visits to Saint Kitts and Nevis. During each visit, a team of two was sent by ferry to conduct interviews to Nevis. Data collection took approximately 18 days.

2.7 PROCESS FOR DATA MANAGEMENT, ANALYSIS AND REPORT WRITING

During data collection, data were entered into notebooks and stored in locked safes. Electronic data consisted of voice recordings of individuals who gave consent to be recorded. These files were stored on a password-protected computer. The analysis of qualitative data took place in three phases. During phase I, team members met twice in Trinidad to conduct preliminary analysis and review of notes. The team discussed findings and key information from the interviews. During phase II, the data from each target group was reviewed to identify themes and content resulting from the interviews. Data were summarized in compilation sheets per main theme. Using assessment objectives and problem analysis, the data were systematically analyzed and responses compared. In addition, all quantitative data from the demographic forms were entered and analyzed using Excel. During phase III, final analysis of qualitative and quantitative data from each target group was divided between the Project Director and the MEASURE Evaluation research team members for final review and report writing. The final report was written by MEASURE Evaluation, with input and vetting from International HIV/AIDS Alliance and stakeholders from Saint Kitts and Nevis.

CHAPTER 3: VULNERABLE GROUPS: FINDINGS AND ANALYSIS

3.1 MEN WHO HAVE SEX WITH MEN (MSM)

3.1.1 OVERVIEW

The interviewers were able, through accessing the extensive networks established by the International HIV/AIDS Alliance program (see Section 2.4), to conduct interviews with 23 men who have sex with men (MSM). Twenty-one interviews took place in Saint Kitts while two were conducted in Nevis. The interviews were able to garner relevant information across four main issues: Sexuality and sexual behaviours, awareness of vulnerability, social and personal issues, and service needs/access. The interviews were also able to capture the human and emotional aspect of the gentleman and allow for some insight into their future hopes and aspirations. These highlights may bring some awareness to issues of human rights, stigma and discrimination.

3.1.2 FINDINGS

Self-identification

During the one-on-one interviews, interviewers were able to take comprehensive notes (and some recordings) with the informed consent of the participants. Upon review, some general observations and themes began to emerge across the four key categories of questions. One key understanding from the interviewer observations was the complexity of the description of how the participants defined their sexuality. Although stated in different ways, there were three main categories in which the men defined themselves: (1) self-identified men who have sex with men who are open in disclosing their sexuality ("out") in both within their MSM social networks and in the general public; (2) self-identified MSM who are only "out" in their MSM networks but not in the general public, and (3) those who do not self-identify as being an MSM and are not active in MSM networks, although they may have sexual encounters with men. These men may also be having sex with women. There is much in the discourse and literature on the cultural identity of being "gay" versus the behaviour of being a man having sex with men. For the purposes of this assessment, we are encouraging a critical look at behaviours of MSM, rather than focusing on discourse surrounding gay identity.

Bisexuality and Multiple Partners

Another key issue of importance and relevance for programming recommendations is bisexuality. A number of men (n = 13) were either having sex with women as well as men, or had been in previous and/or current relationships with women. The term "down low" has become a popularized way of identifying men who are having sex with men and women and whose female partners may not know about their sexual activity. However, of importance here

is that several of the men also said that they felt their female partners were aware that they were having sex with men; that they may not have had open discussions with their female partner, but that they knew of their sexuality and either were in denial or ignored this.

Several also mentioned that their sexuality had been a progression, a movement between being "bisexual" and "homosexual". Some older respondents admitted to being gay at present but had slept with women when they were younger. One gentleman describes himself as "previously bisexual" but now solely has sex with men. Another interestingly says:

"I am homosexual with heterosexual tendencies…," and that…"I do not condone 'heterophobia' "….

When asked to clarify what he meant by this, he expressed that he is a gay man and engages in sexual activity with men, but continues to find women attractive.

Quite a number of the men who identified as gay or bisexual described being in relationships with women, or having gay friends who were in relationships with women. A description that came out of this conversation was "gay with an alibi", meaning that their women partners were covers for their sexuality.

The issue of multiple partnerships is complex here and is a key area of focus for intervention. Multiple partnerships exist with men having sexual relationships with multiple persons concurrently, as well as men having sex with both men and women. Messages targeting safer sex practices for multiple partnerships should be an element of interventions development in Saint Kitts.

Figure 3.1.2a: Relationship Status: MSM

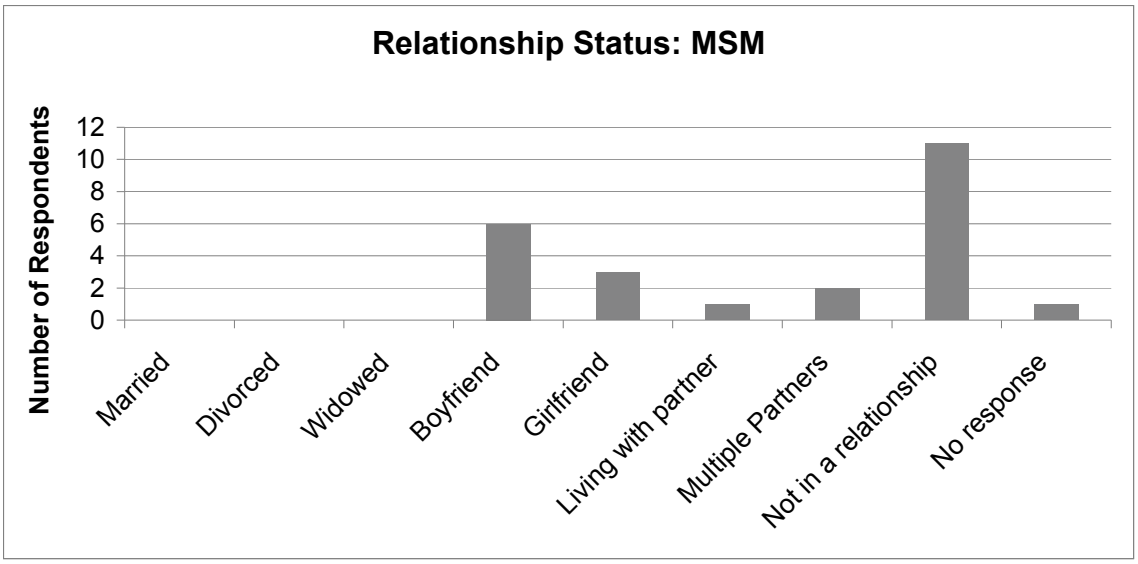
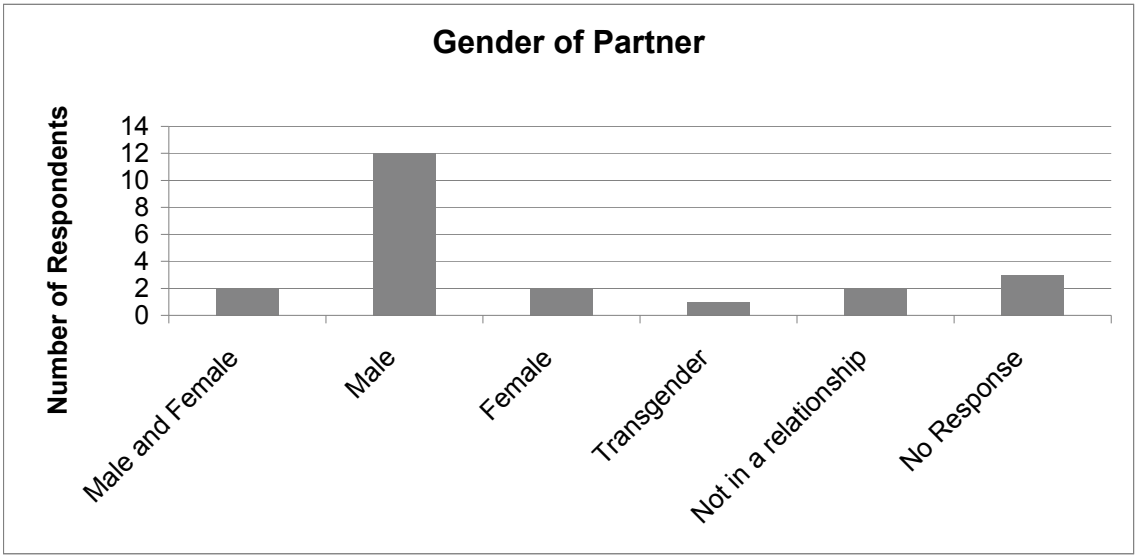


Figure 3.1.2b: Gender of Partner: MSM



Drug and Alcohol Use

None of the men we spoke to reported alcohol abuse. When asked the question, "How often do you use alcohol?" 13 responded, "Sometimes," and 1 responded, "Always."

Table 3.1.2a: Alcohol use: MSM

	Alcohol Use		Of those that drink, frequency of alcohol use	
	Drinks Alcohol	Does not drink alcohol	Sometimes	Always
Saint Kitts	12	7	12	0
Nevis	2	0	1	1
Total	14	7	13	1

Alcohol consumption seemed to be only linked in a social sense with these gentlemen, meaning when out with friends, in social settings, etc. A review of interview notes document that a few

men did mention that alcohol use was a factor in their sexual interactions with men. Many met "occasional" partners (not regular sex partners, but partners with whom they may have only one or a few sexual interactions), while 'liming' (a term meaning to socialise) and felt that when drinking and connecting in a sexual way, discussion of condoms broke the "mood." This mirrors what much research has documented in the use of alcohol being an inhibitor to using condoms.

One of the men interviewed openly admitted to using crack/cocaine. This interview also shed some light on not only the occurrence of drug/alcohol use with this particular person, but more importantly with visitors to the island and with neighbourhoods where individuals are purchasing their drugs. As an active crack user, the interviewee expressed that he felt people more associated and stigmatised him with his drug use rather than his sexuality. He also self-identified as bisexual, having had both male and female sex partners. He shed light on the issue of tourist engaging in buying drugs. His experiences were mostly with tourists who came for diving purposes. As this is only one person's experience, we cannot generalise this information across all sectors of tourism, but it is interesting to note the various instances of tourists engaging in drug or sex trade activities.

Transactional Sex among Men Who Have Sex With Men

The interviewers documented that during the course of their discussions that seven of the men interviewed engaged in some form of transactional sex. However, when directly asked the question as a part of the demographic form, only three admitted to engaging in transactional sex (see Table 3.2.1b below). Some exchanges between men were documented as exchanges for purchases, like cell phone top ups (extra money added to pre-paid phones), which is documented several times with other groups in this assessment (for example with women). Two interviewers noted that some exchanges may not have been solely done for the money as the exchange was for relatively small amounts (XCD $5-10) following a statement/comment such as "Give meh something, nuh…" after the sexual interactions—as if the money exchange would "cancel out" the sex and become the primary interaction. The interviewers discussed this occurrence and thought that this may be connected to wanting to deny the act of having just had sex with a man. This assessment recommends more information is needed to understand transactional sex within the MSM community.

Table 3.1.2b: Transactional sex: MSM

	Have ever Engaged in transactional sex	Does not engage in transactional sex	Of those that do transactional sex, number CURRENTLY engaging in transactional sex
Saint Kitts	2	17	2
Nevis	1	1	0
Total	3**	18	2

**This reflects responses from the demographic forms- during the course of interviews, an additional 4 admitted to transactional sex activity.

Other key points that came from interviews:

- Sometimes the MSM interviewed met partners at bars, beaches through the internet and cell 'phones connections- similar to young women, cell phone connections are noted throughout the interviewer notes across all populations
- A small number (2) of respondents felt that their sexuality could be controlled, that they believed that sexuality is by choice and that they could "stop being gay" and "behave themselves and be only with women"
- Some bisexuals felt that their female partners suspected
- Several men indicated in their interviews that they engaged in oral sex with their sex partners, but that with these partners they are not using condoms regularly. (More on oral sex in the awareness of risk section.)

AWARENESS OF VULNERABILITY

HIV and STD Infection Awareness

When asked "Do you think you are at high risk for HIV infection?" 13 responded, "Yes." The responses ranged from, "If you are sexually active, you are at risk" or "If you have more than one partner" or "If you have unprotected sex," which are third-person descriptions of risk and awareness. More personal responses such as "Yes, sometimes I feel I am at risk because I don't always use condoms." were also noted. The range of these responses seem to indicate that there is a good awareness of HIV in the MSM community and that MSM are familiar with the risks of being sexual active

Perceived vulnerability is actually higher on the issue of STDs; more men felt that they were at high risk of STD infections. When asked, "Do you think you at high risk for STD infection?" 19

answered, "Yes." Interviewers did not reflect the difference between why men felt they were at higher risk for STD than HIV, although the responses were similar to those of the question regarding HIV infection. This may indicate that there is more work to be done with messages targeting MSM for HIV infection.

An interesting point to note here is that a number of the men interviewed (n = 6) reported that they felt that they were a high risk even when they practice safe sex and used condoms "every time". This may suggest that they may see themselves as vulnerable because of their identities, not their behaviours.

Several respondents commented on their discussions with sex partners about using condoms. Of the 23 interviewed, 11 mention that they "do talk to him about using condoms" Comments like "sometimes its embarrassing, but I do talk about it with him" and "sometimes he is offended when I talk about it" were documented. A programmatic recommendation based on this feedback is the need to focus on increasing negotiation skills about condom use for men who have sex with men.

Condom Use

All respondents were asked, "Are you using condoms with your partners?" Then they were asked, "With all of your sex partners?" A large number (n = 17) answered "Yes" to these questions. But when probed: "Do you use condoms every time," the interviewer notes begin to document that comments such as: "Well, I use condoms with him, but when I learn him more [and] he learn me more, then we didn't use them much…"

It was also documented that men were making decisions about condom use based on whether they had knowledge of a partners HIV test results. If they knew he tested negative, then they would not use condoms. Although we were not able to capture whether or not respondents knew of when that test was taken (therefore being aware of the window of infection), there is a need for programming messages to continue targeting the issue of knowledge of HIV infection and how testing works, if men are in fact judging their use of condoms based on this.

A few discussed oral sex, mentioning that they were only having oral sex with their male partners. We were not able to document whether they were having insertive sex with female partners and only oral sex with men. Many did not use condoms during oral sex. A number did admit to insertive sex with other men without using condoms (n = 4).

It was also documented that individuals are making decisions on sexual partners based on how clean the person looked; for example, how the skin looked/if person looked unhealthy, etc.

Other key points that might need more investigation but also warrant programmatic focus are as follows:

- Many respondents discussed condom use with regular partners but not "occasional partners;" meaning that they were not using condoms with partners they may only be having

sex with once in a while, or on only one occasion. This was associated with alcohol and drug use.

- Some respondents did not use condoms with multiple regular partners
- One person mentioned that he is hesitant about purchasing condoms because of how pharmacy workers treated him. There is a need for more sensitization across health care providers on the issue of MSM.

Social and Personal Issues

Through interviews and participant observations of the MSM community gained through the Alliance program staff, interviewers note that the social networks of MSM in Saint Kitts are fairly active and aware of each other. In all the interviews conducted, the respondents stated that "most of their friends" were also "gay or bisexual" or "homosexual" (terms used by them), and that in these groups they were open a their friendships and partnerships with other men, and women.

Family and Work Life

This is a complicated issue as well, and more than likely, it is influenced by the stigma that men face by being openly gay. Most of the men also admitted that they had not disclosed their sexuality to their families. When asked, "Does your family know about your sexuality?" several said that they have not explicitly discussed this with their family members. Some said, "Well, my brother knows..." or "…my mother knows…." Many respondents felt that their families suspected but did not raise the issue. It is possible that families are reluctant to deal with the issue of sexuality. When asked about their partners, a few of the men stated that the presence of same-sex partners in their homes was explained to their families as merely "helping out a friend."

In work settings, sexuality is not discussed, although 4 men in particular made similar comments; that co-workers often suspect and tease but have "no proof" about their sexuality. For programming purposes, it is recommended that tolerance trainings and procedures be put in place to limit these kinds of situations in the work place setting.

Stigma and Discrimination

Because of fear of discrimination, many men stated that they do not always express or tell people of their sexuality publicly, especially around colleagues or health professionals. One gentleman was asked about telling his doctors and he said he would not disclose sexuality to health care professionals although his relationship with his doctor is "very good."

Nevertheless, there was no actual cited occurrence of acts of discrimination such as loss of job, change in/refusal of service provision and/or physical harm related to disclosure of sexual orientation. Not one of the men said that they ever felt threatened by stigma or felt that they had experienced discrimination in the work place and clinical settings. One person in particular

did express confidence, "Yes, they know I am gay, but I don't care. What can they do me? They say something nasty in the street and I give it right back!" He was comfortable and confident enough with his sexuality that he was not concerned about stigma.

In fact, one interviewer noted a particular instance when some men threatened to get into a physical situation with him. He immediately went to the police and the police were supportive in addressing the situation. His trust in the police is a major testament to the trust that exists in the community to work with enforcement officers in dealing with these issues.

The interviewers spent some time in a debriefing session after the key informant discussions with the MSM. One issue that emerged from these discussions is the need to really understand the role of stigma and discrimination within this particular group. A number of those interviewed indicated that they had experiences of being called derogatory names and having things thrown at them. The interviewers themselves witnessed an example of this during the Saint Kitts Music festival, which was taking place at the time of data collection, where a performer openly used the term "battyboy" (a derogatory term for a MSM) during her performance. Because several of the men had indicated that they are careful about whom they disclose their HIV status to, they were not really experiencing discrimination. Rather, these men had a fear of discrimination. This fear can be just as crippling and can add to the contextual factors that place men at risk and lead them to not access services such as HIV testing. This issue cannot be underestimated.

SERVICE NEEDS AND ACCESSING SERVICES

HIV and STD Testing

Participants were asked whether had they had ever accessed HIV or STD services, such as being tested. Of the 23, only 8 said that they had ever been tested for HIV. When asked specifically about what makes services either difficult to access or about why they are not getting testing, the overwhelming and predominant response to this was the complicated issue of confidentiality.

Confidentiality

In several places noted by interviewers, the comment of "Kittitians does talk", or "People like to talk too much" was a consistent message that came across. When probed further, what was documented was that there is a general feeling that in the Kittitian community, many engage in discussion about other people's lives. Whether personal, professional, or just everyday talk, nothing is taboo in terms of discussion and disclosure. In a small community context, it might be perceived as regular or normal to talk about other people's "business". However, the culture of small talk in Saint Kitts has ultimately had an impact on whether or not people feel comfortable accessing such sensitive services as HIV testing. The knowledge that "people does talk" is a major factor in an individual's decision to access HIV services. This definition of confidentiality may take a generation to instil and change, and may not be possible given that Saint Kitts and Nevis are small islands. Nevertheless, programming recommendations for HIV testing may need to consider messages that make HIV testing a "non-issue," or not a taboo subject.

When asked specifically about their clinical experiences, more than half (n = 16) say that they access private doctors and not public facilities. The majority of the interviewer notes document comments like" The clinics are not private enough" and "I don't want people to know my business so I do not go to public" to "Well, I can afford to go to a private doctor, and its better". The real issue of confidentiality in the public versus private setting was a major deterrent to these particular men in why they were not accessing HIV or STD services.

These issues especially become alienating when accessing services that may be specific to the sexuality of being an MSM. Almost all the men told interviewers that in accessing medical services, they have not disclosed to their providers their sexuality. Again, when asked why, the responses varied from "Well, I am sure my doctors know…" to " When asked about whether they felt that providers have an accepting attitude towards them, the answers varied from "Yes, of course." to "Well, he or she doesn't ask me and I don't tell them, so it is not an issue."

The programming recommendation here is that perhaps providers need some more insight and training on discussing sexuality and sexual practices with MSM. For example, how to communicate, ask questions without judgment, and provide appropriate messages targeting this population. Other recommendations on public versus private facilities are noted here as well regarding the issue of confidentiality. This will need to be an emphasis for strategic planning.

Future Plans

The interviews allowed the opportunity to ask the men about things in life that are important to them. The member of the MEASURE Evaluation and Alliance team who conducted the research and developed the questionnaires felt that this was a need to highlight the more human side of the participants. There is a realization that with research subjects who are over sampled and asked repeatedly the same questions, this would allow the men to express and articulate their wants and desires for their lives.

One of the questions posed to the men was 'What are you life goals….things in life you want to accomplish?" A number of people talked about wanting to own land, build a house- all typical aspirations probably familiar to other Kittians and Nevisians. When probed further and asked, "Where do you see yourself in the future", it was documented that nine men in particular indicate that they would want to have children, perhaps adopt, or "be a father."

Many men talked about contributing to their society, and wanting to engage in "building promising projects" in Saint Kitts and Nevis. Three men spoke about wanting to work to expand the tourism industry. Other men wanted to study to become architects, go back to school, become teachers, and travel. What the interviewers found interesting is that most of the men indicated that they wanted to do these things on Saint Kitts and Nevis and not leave.

When asked the question, "What do you want people to understand about who you are and your community?" thoughtful comments emerged such as "We want people to think we are just like them, that we are proud of being from Saint Kitts and Nevis, that we care about what happens to our people." A few talked about wanting to be treated fairly about their concern for

the current laws prohibiting sodomy, (although many mentioned that they did not necessarily feel it affected them directly, they were conscious of it.)

These thoughts are important to note towards bridging the gaps in society towards acceptability and community building with men who have sex with men. There is stigma within the community, and stigma and fear from others about who these men are. They have similar hopes and plans as we imagine most people have, and this acknowledgement can help to close the divide towards acceptance.

3.1.2 SAINT KITTS HIGHLIGHTS

Most of the interviews (21 out of the 23) with this population (MSM) took place in Saint Kitts. The research benefited greatly from the networks that the Caribbean HIV/AIDS Alliance program has established in providing outreach and groups intervention on the island. The recruitment for this process was conducted through the program officer. Through his rapport, interviewers were able to ask personal questions of sex and sexuality in order to learn more about this population.

Interviewers observed that the men ranged from being quite open about their sexuality, to some being "in denial". One interviewer observed and documented that one of the gentlemen did not admit to being an MSM but had friends who were. Therefore, with this particular person, the tone of the interview had to change to ask about his experiences with his friends. This same young man was subsequently met at the interview site by another gentleman who picked him up at the close of the interview.

3.1.3 NEVIS HIGHLIGHTS

One of the interviews conducted in Nevis was interesting in that it was an older gentleman who talked openly about not using condoms with "occasional" partners. He spoke of this within the context of alcohol use. If he was out and drinking when he met someone, he would more than likely not use condoms with this person. He also brought up the issue of transactional sex, where he may ask a partner after sex to "give muh a little something" as a way to mitigate the sexual interaction, because the amount of money exchanged was relatively small. This issue needs to be explored more thoughtfully in terms of understanding the role and occurrence of transactional sex among MSM.

3.1.4 RECOMMENDATIONS

Several key programming messages become clear from the discussions with MSM. Since bisexual men are difficult to identify, a key issue is the need to develop messages of practicing safe sex behaviours for bisexual men that can be incorporated into the national prevention campaign messages. This would be a huge step in addressing the need to target programming toward this

vulnerable population. To avoid discriminating against bisexuality, these messages should be developed using evidence-based methods and incorporating the concerns of this populations.

Communication messages for MSM need to be focused on increasing the use of condoms with both regular and non-regular partners. Condom negotiation skills, consistent condom use with both male and females and regular/non-regular partners and increasing knowledge of the "window period" with respect to HIV test results are all messages that would be well suited to this population.

Implementation of peer outreach programmes (or scaling up those that already exist such as those established by the Alliance) targeting social networks of men who have sex with men is also a key programming recommendation. Outreach workers could provide regular one-on-one messages as well as distribute condoms. There are scientifically developed and proven effective interventions such as Mpowerment, which can be adapted to incorporate Kittitian/Nevisian context. The National AIDS Program should consider funding for technical assistance, adaptation and tailoring of these types of interventions to be implemented.

Clinical care providers need to be trained on sensitively engaging their male patients in discussions about sexuality—whether they are self-identified or not as MSM. There needs to be more of a focus on the importance of messages targeting men's health at the national level.

Workplace tolerance and sensitization messages and training might also be needed as a method in national level programming targeting MSM.

3.2 COMMERCIAL SEX WORK AND TRANSACTIONAL SEX

3.2.1 OVERVIEW

The act of sex exchange and those who engage in it is a strong focus of HIV and AIDS programming, since it is viewed as an area where high-risk activity such as multiple partnerships and unprotected sex, are more likely to occur and where intervention is most needed. The aim of interviewing sex workers and those involved in transactional sex in Saint Kitts and Nevis was to provide a description of the individuals engaged in these activities (attitudes, behaviours and practices) and how these activities are organised in Saint Kitts and Nevis.

There are two types of engagement in sexual negotiations in Saint Kitts and Nevis—commercial sex work and transactional sex. For the purposes of this assessment, commercial sex work is defined as the exchange of sex for money as a sole source or main source of income. Transactional sex is the exchange of sex for gifts and favours, and may involve exchange for money, but not as a sole or main source of income.

3.2.2 COMMERCIAL SEX WORK: FINDINGS

In Saint Kitts and Nevis, based on the findings of this assessment, those involved in commercial sex work include both foreign Spanish-speaking women (including girls and women) and local English-speaking women (including both girls and women). Commercial sex work is said to also involve women of other nationalities as well as local males, but examining these aspects fell outside the parameters of the assessment.

Commercial sex work, prostitution, is not legalised in Saint Kitts and Nevis and thus neither the foreign nor the local women are organised, or have their activities regulated at a national level. They therefore operate discreetly out of bars in the case of the Spanish-speaking women, or out of their homes on a word-of-mouth basis, in the case of the local women.

Commercial Sex Work among Spanish Speakers

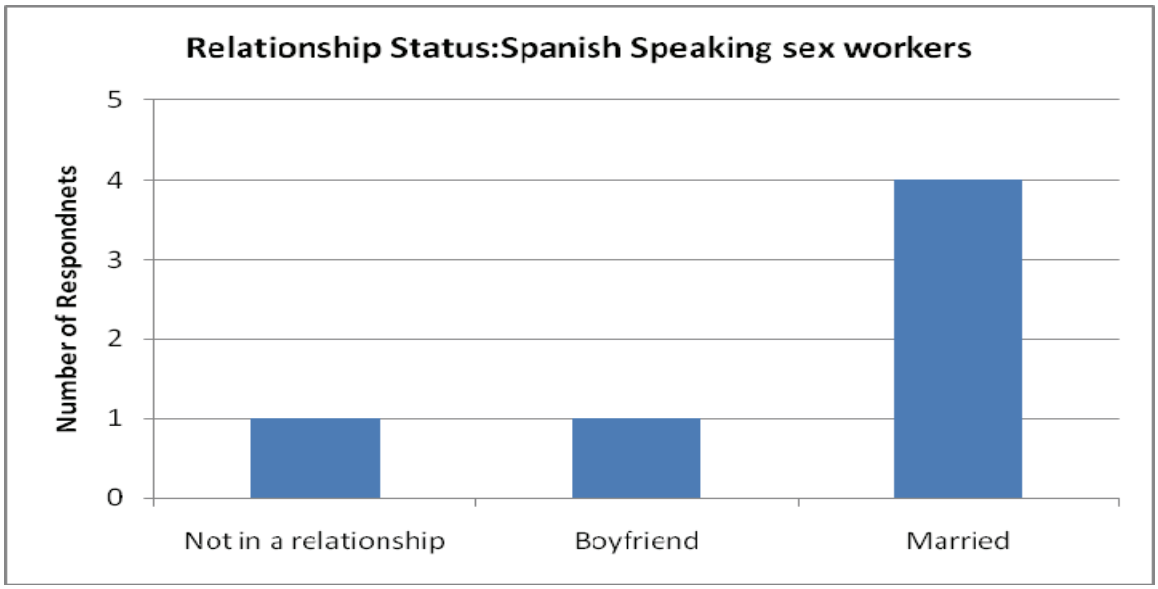
When asked about commercial sex work in Saint Kitts and Nevis, participants from various informant groups (civil servants, people working for NGOs, clinical service providers and community informants) automatically spoke of "Spanish girls" from the Dominican Republic. They explained that "Spanish girls" work out of "Spanish bars" in the Basseterre area in Saint Kitts, as well as in Nevis, where these bars are more difficult to locate.

For this assessment, accessing these women proved difficult. The illegal status of prostitution in Saint Kitts and Nevis, and their frequent status as illegal aliens mean that these women will keep a low profile and are often reluctant to be interviewed, as they face deportation. This assessment took place in the aftermath of the Cricket World Cup when immigration departments around the Caribbean were making broad sweeps for illegal residents. As a result of this, these women proved even more elusive.

This assessment arranged a discussion group with six Spanish-speaking women in Saint Kitts through a contact from the International HIV/AIDS Alliance Outreach programme. However, during the interview process these women refused to admit to doing any kind of commercial sex work saying that they were domestic workers and worked in bars. Thus, it was not possible to gain information on the numbers of clients, income from clients, condom use with clients, or a profile of clients and how sex exchanges were negotiated. Although these women did not provide information on the behaviours and practices of Spanish-speaking sex workers, they did provide information on Spanish-speaking women, their behaviours, and their access to health care services.

Four of the women were married; all had children and varying degrees of education from diploma and certificate to secondary schooling. They had families —husbands, and children who attended school. According to their reports, they had all been here from 4 months to 7 years. Only two spoke English.

Figure 3.2.2: Relationship Status: Spanish-speaking sex workers



Those who were married reported that they are faithful to one partner and therefore are at low risk for HIV infection. They do not use condoms with their spouses. Those who were unmarried reported insisting on condom use with each of their partners. According to them, risk factors were multiple partnerships and sleeping with "unclean" persons.

With regard to health care, the women visit private Cuban doctors, in keeping with the responses of clinical service providers, to bridge language barriers. They described having good relationships with these doctors and being able to discuss HIV and AIDS issues with them, which they in turn discussed with their children. One woman stated that she even puts condoms into her teenage son's schoolbag, despite his denial about being sexually active, because she is aware of what happens in schools. They reported having been tested for HIV for purposes of citizenship, and they felt that the service was confidential.

When asked if there were special places to meet new partners in Saint Kitts, they cited general places, such as on the street or in bars. This response is in keeping with those of other groups that were interviewed.

When asked about their plans and dreams for themselves, they responded returning to the Dominican Republic with their families, running a business and taking care of their children, not having to clean houses and possibly taking courses in child care and geriatric care. All stated that they would prefer to be living back in the Dominican Republic.

The informal discussions with outreach workers proved useful in providing some information on the lifestyles of Spanish-speaking sex workers. For instance, most of the women come to Saint Kitts and Nevis to work and support families in the Dominican Republic, a major preoccupation

for them. Some have left children behind. They operate out of bars and often work with a pimp, who may or may not be the bar owner, and live with others within the Spanish-speaking community where they feel safe. The women also move between Saint Kitts and Nevis. Spanish bars are multipurpose venues in Saint Kitts and Nevis; they not only serve as sites where individuals make go to meet a sex worker but function as community centres where families, mother, father and children, go to socialise and be amongst other Spanish-speakers. This was also one reason why it is difficult to target Spanish-speaking women as sex workers in these venues. Often, these women know that Kittitian and Nevisian society look down on them and thus they tend to find solace in each other's company.

Commercial Sex Work among English Speakers

The investigators attempted to, but were not successful in recruiting local English-speaking CSWs because local girls and women, both in Saint Kitts and Nevis, are not identified by the community as CSWs, and neither would they self-identify as CSWs. This term is reserved by the local population for Spanish-speaking women, mainly from the Dominican Republic. Much of what was discovered about the activities of local girls and women involved in commercial sex work was accomplished through informal interviews and discussions with bar owners, hotel workers and taxi drivers, the latter trying unsuccessfully in setting up interviews with some of these women.

The illegality of sex work is not the only thing that prevents local women from self-identifying as CSWs. Community pride prevents people from admitting that local women are involved in sex in exchange for money although a woman might be seen with multiple partners and might obviously be receiving financial support from these men. There is speculation that women in debt also find themselves in situations where, to avoid debtors' prison, they engage in paid sexual exchanges. There is also some belief that it is not only poor women who engage in these exchanges; it is not uncommon for a professional working woman to engage in sex work to support a certain lifestyle.

When asked how the local community describe these women, if not as CSWs, the responses were that the women were simply—

- "Liking plenty man"—having multiple partners, but not as sex workers
- "Farse"—same as above; also used for young girls in sexual relationships that they might not be ready for
- "Buss kite"—like a busted kite flying all over; loose and uncontrollable.

Another factor that influences why local women may be distinguishing themselves from CSWs is that they are not 'street walkers' nor do they operate out of bars or brothels or work with a pimp, in keeping with the common conceptions of prostitution. They may not even be engaged in the activity full time. It is said that women who are employed will often engage in sex-for-exchange occasionally to supplement an income, often unknown to their regular partners,

whether that be a married or long-term partner. It was reported that women engage in this activity when their partners leave the islands in search of other employment opportunities.

Local men are also not the women's only clientele. Foreigners request taxi drivers to find them local girls – a transaction which involves the driver calling one of the women and arranging the meeting. Informal interviews with hotel staff reveal that hotel guests also request women from male hotel staff with the specifics only being that she be "clean." Prices may range from as little as US$50 to US$600 or even more, depending on the type of client and service requested. Local women also leave the islands for the weekend, or for a week, to ply their trade in other Caribbean destinations or further abroad. It has been suggested that advertisements for sex with local girls can be found on Internet sites. The extent of condom use is unknown.

As a result of the reluctance of the local community and the women to admit to engaging in sex work, it is difficult to ascertain the age group of those involved in sex work, informal sources cite girls as young as or even younger than 16 engaged in sexual transactions, often with older men, including married men.

3.2.3 TRANSACTIONAL SEX WORK: FINDINGS

In Saint Kitts and Nevis, based on the findings of this assessment, transactional sex is a somewhat observed, but little-spoken-about activity involving mainly local girls and women. There is no evidence through this assessment that this activity is practiced among the foreign Spanish-speaking women.

Transactional sex in Saint Kitts and Nevis involves exchanges between girls and women of all ages. Informal reports indicate that transactional sex might be occurring with girls as young as or even younger than 16, and boys of their own age and often older men, including married men.

Transactional Sex among English-Speakers

Women involved in transactional sex will often exchange sex for favours occasionally with non-regular partners. Favours may include paying bills, buying groceries, buying clothing and electronics, or in many cases, receiving a cell phone top up (extra money added to pre paid phones). Exchanges will also involve money.

Women asking for favours do not see themselves as sex workers possibly because as stated previously, it is not seen as a full time activity or something that they do to make a living. Also, some of them may be acting the role of a mistress, seeing one specific man for a longer period than would a sex worker. These women also do not see their solicitation of men as being the same kind of solicitation made by a CSW.

The latest phenomenon of young girls, including schoolgirls, bartering sex for electronic equipment and cell phone top ups, is an issue that has come up both in discussions with youth as well as with women-at-risk and through informal sources. It appears that the size of electronic

equipment such as iPods, DVD players, cell phones and top-ups, make them perfect gifts for young girls to hide discreetly from their parents. The cost is also such that they can easily explain the acquisition of these items as gifts from friends, or having saved to purchase them. Although one criticism levelled by respondents is that parents are not being as vigilant as they should be, and are not asking enough questions about where and how these items are being acquired (see "at-risk" women's section).

An informal discussion with a key programming leader in Saint Kitts raised the issue of the increase in women being sent to prison because of debt. The phenomenon of women who are unable to pay bills and being sent to prison for short periods to relieve their debt was a major concern from this discussion. In order to mitigate having to go to prison, women may be motivated to engage in transactional sex to pay their bills. This interview documents that Friday afternoons are the "big spending day." After receiving their week's pay, women go to town to "pretty up" for the weekend—getting hair and nails done, buying new outfits, or even making credit purchases for electronics and furniture. When they run out of money, or when creditors begin collection procedures, it was reported that the women will start to ask their male friend to help pay their bills, which may ultimately end up in a sexual exchange. The discussion brought out the interesting recommendation for implementing interventions targeting economic empowerment classes for women.

3.2.4 SAINT KITTS HIGHLIGHTS

Spanish bars are easier to locate in Saint Kitts than in Nevis, recognisable by their blaring Spanish music. The general perception is that these bars function as brothels or pick up joints for sex workers, although given recent information on their dual function as cultural gathering spots, this may not be entirely true. Hence the claim by government officials that commercial sex work is underground despite the blatant visible existence of these places.

3.2.5 NEVIS HIGHLIGHTS

Efforts to locate and visit Spanish bars in Nevis were made but were unsuccessful during the data collection periods. The interview team did observe some activity at hotels where there were Spanish speaking women congregating and checking in to rooms. During some informal discussions with front desk staff at one hotel, it was mentioned that other Caribbean nationals, such as Guyanese, might be involved in the sex trades. Informal reports are that many of the foreign women, especially Spanish speakers, find spouses and settle in Nevis, and that stronger historical links between the Dominican Republic exist in Nevis than in Saint Kitts.

It is difficult to say which health care options these women seek when they are in need of medical treatment in Nevis as with those in Saint Kitts who seek out private Cuban doctors.

Although informal interviews revealed that there are local male sex workers or 'beach boys' who 'hook up' with older foreign men and women, activities involving these groups are hardly mentioned when discussing commercial sex work or transactional sex.

3.2.6 INTERVIEWER COMMENTS

- The treatment of commercial sex work among local women as a myth will continue to make it more difficult to access these women and to learn about what influences their behaviours. In the interim, commercial sex work continues to be seen and discussed as an activity in which only foreign women participate.

- Stigma and perceptions about Spanish-speaking women may actually make it easier to provide information to them on HIV and AIDS, since the assumption is that they are engaged in commercial sexual activities and are more open to discussion about the topic

- The relationship and comfort level that Spanish-speaking women have with the medical professionals they see presents a perfect opportunity for dissemination of HIV prevention materials and messages as well as finding out more about their lifestyles. However, this puts local English-speaking CSWs or any of the local girls engaging in seasonal transactional sex work at more risk than the Spanish-speaking women, because society and they themselves publicly deny their engagement in these activities.

- Not being able to include local English speaking CSWs means that there is still as incomplete profile, although anecdotal information about who they are and what they are exchanging was collected from informal discussion, as well as with the youth group. More needs to be done to reach these girls and women through the taxi drivers, bar owners and hotel personnel in order understand what that appropriate interventions may be to target them.

- The dreams and plans of the Spanish-speaking women show that their major preoccupations lie with supporting their families and children, and with surviving suggesting that interventions and messages focusing on economic empowerment may be appropriate.

- It may be worthwhile to look at the factors driving commercial sex work among local women to determine best strategies for addressing this issue. Questions that need to be answered include "How many are engaged in sexual transactions? Is it part time or full time? Is it driven by a lack of economic opportunities for women and an inability to meet basic needs or is it largely a response to international trends and lifestyle choices? Are condoms being used? Where do these activities take place?"

- In a number of other interviews with vulnerable populations, respondents cited 'unclean persons' as a high-risk group just as this group has. Unclean is defined by the physical appearance of unwashed and dirty skin. It is interesting that the HIV status of individuals is still judged by their physical appearance—often giving a false sense of security and perpetuating stigmas associated with appearance and not just behaviours.

3.2.7 RECOMMENDATIONS

- There should be regular condom distribution at locations where those involved in commercial and transactional sex are most likely to access them on a continuous basis. For Spanish-speakers, condoms should be made available consistently at 'Spanish bars'. For local women, condoms should be made available at the bars and restaurants especially around the Frigate Bay area. Condoms should also be distributed to places where women generally congregate, such as hair and nail salons, clothing stores, and where top ups are available.

- Taxi cab drivers and hotel workers are potential "gatekeepers" that could be considered for interventions regarding English-speaking sex workers. Stronger linkages need to be forged with taxi cab associations and with tourism.

- To target local women who are involved in transactional sex, there is a need to provide intensified peer outreach in places where these women congregate such as beauty shops, clothing stores (especially on Friday-"pay day") and restaurants to provide prevention messages, condoms, and IEC materials. A special effort needs to be made to work with private cell phone companies to promote condom distribution, as well as sensitizing company managers to the "top-up" phenomena.

- Developing interventions and messages which target economic empowerment and decision making skills for finance management may be beneficial

- Distribution materials should be made available in both English and Spanish

- Engage Spanish-speaking doctors to discuss and provide HIV and AIDS and STD materials and education to Spanish speaking women clients.

3.3 AT-RISK WOMEN

3.3.1 OVERVIEW

The general trend towards the "feminization" of HIV and AIDS has become a concern in Saint Kitts and Nevis. During the November 8 Meeting on Prevention Activities and Strategic Information Needs for Vulnerable Populations, stakeholders expressed their concern on the increased susceptibility of Kittitian and Nevisian women to HIV and AIDS due to social, economic and cultural reasons. For this reason, this assessment interviewed a number of "at-risk women." Per suggestion of the in-country team, this assessment recruited "at-risk" women from two distinct groups:

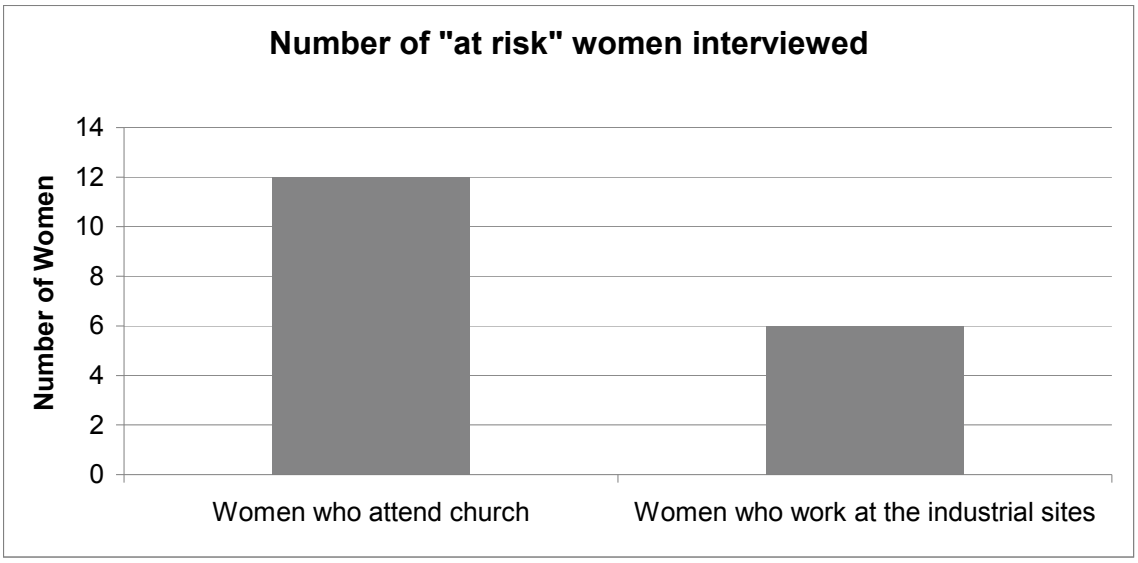
- Women who are economically disadvantaged and might rely on men for economic support.

- Women who are married and therefore might not have the power to make sexual decisions.

It was decided that for the former group, recruitment should be focused on women who work in industrial sites, since it is known that women working in industrial sites earn the minimum wage and may experience economic hardship. This assessment interviewed six women in three different industrial sites in Saint Kitts.

For the latter group, it was decided that recruitment should begin with the women in faith-based organizations, such as the church. Marriage and faithfulness is encouraged in the church. Understanding women's views who attend church gives insight into whether married women are truly an "at-risk" group. This assessment arranged a discussion group with 12 women who regularly attend church in Saint Kitts. (See Figure_3.3.1 for the number of women interviewed from each group.)

Figure 3.3.1: Number of "at risk" Women Interviewed



3.3.2 WOMEN WHO WORK AT INDUSTRIAL SITES-FINDINGS

Awareness of Vulnerability

All of the women who were sexually active or in relationships felt as though they were vulnerable to HIV and AIDS because of men not being faithful. The women in relationships generally trusted their partner to be faithful. However, as one respondent said, "you can't be 100 percent sure." One respondent who was not in a relationship said that if she were in a relationship she would be at risk for HIV and AIDS because her partner might have multiple partners or might "swing both ways."

Despite the fact that the women in long-term relationships did not completely trust their partner, they explained that they do not use condoms. When asked why they do not use condoms, one respondent said, "At the beginning of the relationship, I was very sceptical. But after you get comfortable and he relaxes and you been with your partner for 1 year, 2 years, you let your guard down. You think well, I don't have another partner, so you throw caution out the window." Two of the respondents did not use condoms with their long-term partner because of allergic reactions. However, for one respondent, even if she did not have the allergic reaction, she would still not use condoms because she generally trusts her partner. One woman was trying to get pregnant. One woman viewed condoms more as a form of contraception rather than a method to prevent disease.

All of the women interviewed were very knowledgeable about HIV and AIDS and wanted to see more action in the community and the workplace to address this issue. One woman had participated in a HIV prevention campaign in her community. Many of the women had gotten tested in the past along with their partners/husbands. Reasons for getting tested included insurance purposes, habit, and following recommendations from a clinical care provider.

Stigma

Many of the women had accepting attitudes towards PLWHA. One woman said that she would hug someone with HIV and another said that she has gone to the hospital to care for someone she thought was HIV-positive. Many of the respondents mentioned that people in their workplace are not educated about HIV and are not accepting of those who are HIV-positive. One respondent considered stigma to be the main problem in combating the HIV and AIDS epidemic in Saint Kitts.

Sexual Behaviours

Most of the women had gotten pregnant at a young age and discussed the impact this had on their lives. One woman explained that having a child at a young age increased her desire to be independent: "I had my first child when I was a teenager. After getting that first child, I think the realization came to me…I wanted to go out there and prove to everybody I could do it." Many of the women talked about general problems with teenage pregnancy. One young woman thought that being pregnant is currently the "in" thing to do among young women. Another woman explained that she believed at least 90 percent of the young women at the industrial sites were mothers and that there is an increased need to "parent the parents."

Two of the respondents were not married but lived with their partner. When asked why they were not married, one woman felt that she was too young. The other respondent said she did not want to get married because she did not want to lose her independence.

The women interviewed talked in detail about multiple partnerships. One respondent thought that men were unfaithful because "more women, less men. The men are dying out fast with all of the violence, the gun violence that is going around." Three of the respondents felt as though multiple partnerships are a problem with both men and women (esp. younger women). One woman mentioned that married women sometimes search for other men when their husbands

do not make enough income for material goods. Many of the women mentioned that they know women who have unfaithful partners and do nothing about it because of the economic support and security that comes from their partners. One respondent said that "to me it all boils down to desperation...you are not looking at the implication of disease, you are looking at an extra 200 dollars."

Some of the respondents said that they have friends or know young women who have sex with older men. One woman reported that "most of the time the woman thinks that they are her boyfriend but the man doesn't consider her to be his girlfriend." One respondent reported that she knows married men working at the industrial sites who have relationships with younger women. Although none of the women reported engaging in transactional sex, many of the women knew people who do engage in transactional sex. Economic necessity and the desire for material goods were reasons why women have transactional sex. One woman said, "If they are not working, obviously they need money and if they are working most them are drop-outs and their pay is small and the price of living here is high. They want the goods but they don't have the money. In exchange, they have sex." This respondent explained that this problem is especially pertinent among young women, who are drawn to older men that "flash money" at bars and clubs. Many of the respondents felt as though the wages at the industrial sites were sufficient to make a living and the driving factor for transactional sex is the desire for material goods.

Some of the women discussed parenting and how it affects the sexual decisions of children. Two women explained the difficulty of being a single mother. One woman explained that children are left unsupervised at night when mothers are working the shift system at the industrial sites. She said the children use the opportunity to exchange sexual favours for material things (clothes, tickets for the Music Festival). Another respondent said that neighbours or even the mother's partner take advantage of daughters while the mother is working. Three of the respondents discussed the importance of talking to children about sex. One respondent said that parents do not ask enough questions when their daughters come home with new clothes or a cell phone. Another woman explained that she is very open to her daughter about sex and contraception because she thinks she would not have gotten pregnant at an early age had her mother talked more about sex and the risks involved. Another woman reported that she talks to her children often about HIV and AIDS.

Many of the women talked about low self-esteem and how it can cause women to have bad relationships with men. At least one woman reported feeling below standard compared with people that are more educated, although she felt that educated women had equally low self-esteem. One woman expressed the need for self-improvement interventions. One woman felt that even educated men are not good role models, because they have multiple partnerships when they are married and smoke "splifs" (marijuana) on the street.

Health Service Needs

Many of the women discussed problems with confidentiality in the health care system. Many of them did indeed trust their doctors, but did not trust the nurses or other staff. One woman said that she has a friend who is a nurse who "chose to tell friends exactly what was wrong with the patient." Two of the women thought that services in the public health care facilities do not respect confidentiality, whilst private services are more confidential. One woman said that problems with confidentiality are due more to the size of Saint Kitts, "If I get tested and it is confidential and I have to get the antiretroviral drugs (ARVs) from time to time.... I mean, you know the guy in the lab; he knows what he is giving you. This place is so small. Everyone knows each other." Another woman explained that her friends are afraid to go to the pharmacy because they do not want people to gossip about why they are collecting a medication.

Many of the women were satisfied with their clinical care provider; however, they felt that the general health care system was not meeting their needs. Reasons for this were:

- Some women cannot afford private health care but consider public care of lesser quality. As a result of this, they prefer not to access public health care unless it is absolutely necessary
- Health care services are not geared towards young women. A health clinic for young women with older female doctors is needed.
- It is difficult for a person to get sick leave from public facilities. As a result of this, many women choose to go to private doctors because they are more likely to give sick leave.

3.3.3 WOMEN WHO WORK IN THE INDUSTRIAL SITES- RECOMMENDATIONS

- The women interviewed in this assessment were all concerned about multiple partnerships among men. Even though some respondents said that women are also unfaithful to their partners, the overriding theme in these interviews was that women are vulnerable to HIV and AIDS in Saint Kitts as a result of men being unfaithful. Since women are unable to negotiate whether their partner is faithful, programs should focus on HIV prevention messages/activities targeting men, especially young men. These messages/ activities could focus on cultural ideas of masculinity, positive masculine role models, fatherhood, women's equality and the importance of faithfulness in protecting oneself and one's partner.
- All of the women interviewed discussed the existence of women and men engaging in transactional sex and/or cross-generational sex. Young women may not be able to negotiate condom use when the partner is older or when the partner gives money or goods in exchange for sex. Therefore, young women need to be educated at an early age about the risks of having relationships with older men. Another option is to promote campaigns educating the public, especially young women about basic money management skills. The female condom could be promoted as a method to protect women, since it is women-

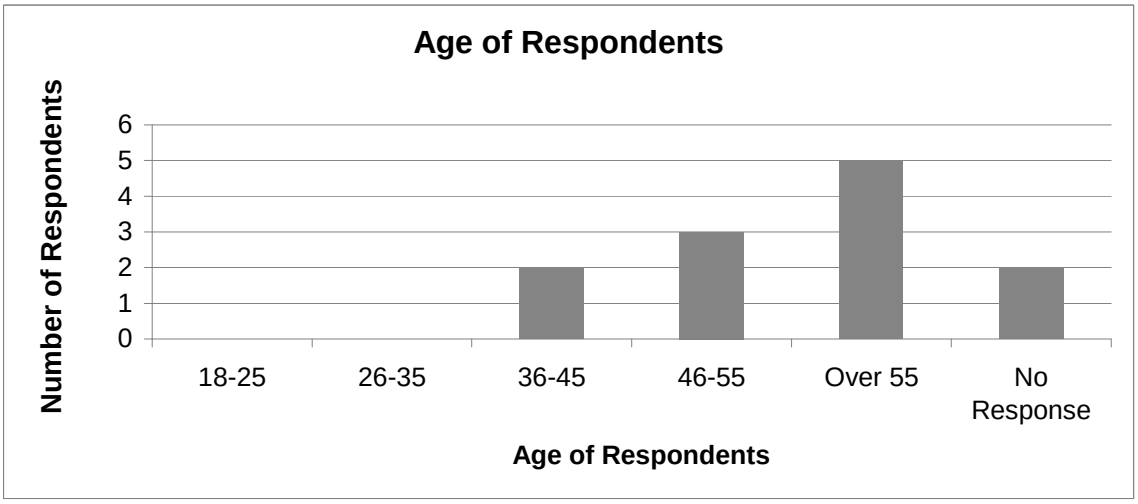
initiated. Women need to have a living wage so they have the freedom to decide when and whether to engage in sexual relationships. Peer outreach to women in places where women congregate—such as hair salons and boutiques, could be a possible form of intervention.

- Many of the women were concerned for the welfare of their children regarding HIV and/or teenage pregnancy. Some of the women reported discussing these issues with their children. Since parents can influence children's sexual decisions, campaigns that focus on parent-child discussions about healthy relationships and sexuality could be implemented at a national level.

3.3.4 WOMEN FROM FAITH-BASED COMMUNITIES: FINDINGS

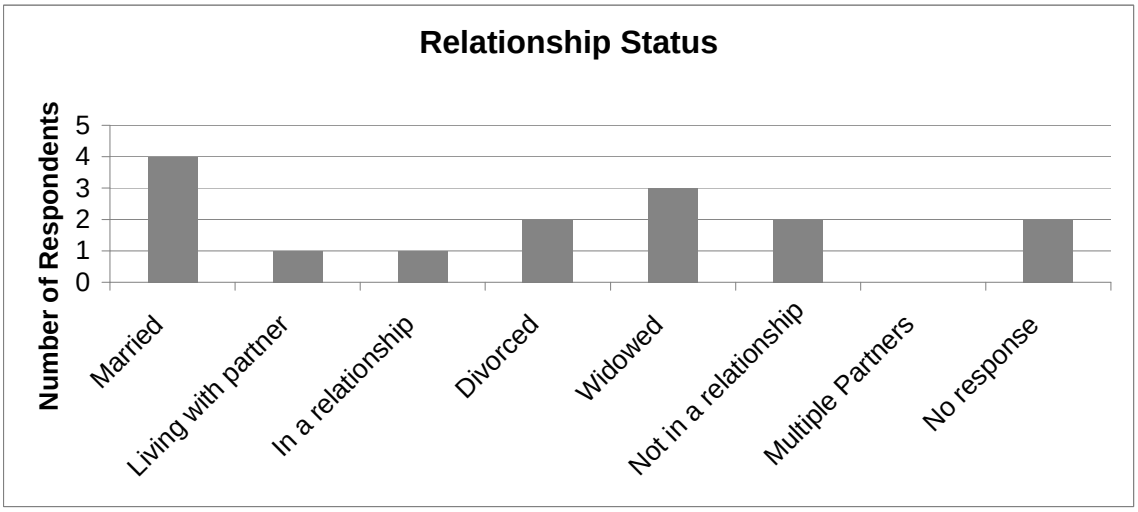
This study conducted a discussion group with women who regularly attend church services. All of the women were over the age of 36 and many were over the age of 55, as indicated in Figure 3.3.4a below.

Figure 3.3.4a Age of Respondents: Women from Faith Based Communities



Many of the women were either married or widowed as demonstrated in Figure 3.3.4b below

Figure 3.3.4b Relationship status: Women from Faith Based Communities



The age and relationship status of the respondents are important factors that may have influenced their opinions and thoughts about HIV and AIDS.

Awareness of Vulnerability

When asked whether they felt vulnerable to HIV and AIDS, the women did not respond individually, rather they spoke about women in general. The women acknowledged that AIDS is more "popular" among women in Saint Kitts because men have multiple partners and women do not ask their spouse (if married) to use condoms. There was discussion among the group about HIV testing and whether married women should get tested. Some women in the group said that all married women should get tested regardless of motive. Others in the group felt as though married women should only get tested if they suspect that their husband has been unfaithful. Some women in the group admitted to getting tested in the past for insurance purposes.

There was discussion about an instance where a woman was counselled not to divorce her unfaithful husband by members of the clergy. The woman decided to stay with her husband and subsequently contracted HIV. Many of the women in the group felt as though the clergy was not correct in counselling this woman to stay with her husband without encouraging the couple to get tested before resuming intercourse. Others in the group felt as though the woman could have asked her husband to wear condoms.

In terms of awareness of vulnerability, this group did acknowledge the vulnerable status of married women in Saint Kitts as a result of multiple partnerships among men. However, the individual response to this perceived vulnerability was variable. As demonstrated above, some women felt as though women have the power to make decisions regarding HIV prevention

(testing, condoms, etc.). Others felt as though outside forces (husbands, clergy, etc.) have a greater influence in women's power to make sexual decisions.

Knowledge

Throughout the discussion group, participants asked general questions regarding HIV transmission, which indicated that the group was willing to learn more about HIV and AIDS. Some of the women were misinformed about how HIV is transmitted. One example of this was a woman who was concerned about contracting HIV from her child and thought that perhaps she would need to wear gloves when disciplining her child. Throughout the discussion, the interviewers took the opportunity to clarify basic facts about HIV and AIDS. This may indicate that these women are not completely educated on basic knowledge about HIV transmission.

Stigma

Many of the women in the discussion group spoke about stigma and acknowledged that it is a problem in Saint Kitts. Some of the women explained that people who are HIV+ are shunned by their families and some have had to leave the island. There was discussion about the connection between knowledge of HIV and AIDS and stigma. Some of the women said that Kittitians are exposed to messages about HIV and AIDS but there is a disconnect between knowing about the disease and people continuing to stigmatize individuals who are HIV+. Others felt that increased knowledge about the disease would lead to less stigma.

Perception of Vulnerable Groups

When asked their opinion on vulnerable groups in Saint Kitts, the majority of the women cited youth. Reasons for this were that youth are promiscuous, they feel invincible, they have bad parents that do not discuss sex and they do not pay attention to the HIV prevention messages that exist. Many of the women felt that youth should be given messages that pertain to abstinence. When asked what types of methods would work to reach youth, the women cited the following:

- Conduct forums where people who are HIV+ speak about their experiences
- Use audio and visual means to reach youth
- Have rap artists promote positive messages about HIV
- Teach real-life situations where a young person has to make a decision regarding sex

Health Service Needs

There was discussion about confidentiality in the health system. Some women felt that they could trust their doctors but not the nurses or health staff. It was expressed that doctors could lose their reputation or job if confidentiality is breached; however, nurses are not accountable in the same way. Although many of the women expressed this concern, none of them had heard of nurses breaching confidentiality in the recent past.

There was also discussion about public vs. private services. Many of the women said that they would go to public services for more general care, such as blood pressure checks. However, for more detailed care, they prefer to go to private doctors because they felt that the care was of greater quality. In addition, the women expressed that the hours of operation in public services are inconvenient and therefore it is easier to go to private services.

Role of the Church

Many of the women felt as though the church should be more involved in HIV and AIDS prevention and care activities. One area that was discussed was home visitation of PLWHA by church members and clergy. It was acknowledged, however, that PLWHA would not disclose their status to a congregation or clergy as a result of stigma. Most of the women felt as though the church should be involved in promoting abstinence as a form of HIV prevention and condom promotion should be the domain of other entities (health centres). Even though the women acknowledged that youth are a vulnerable group to HIV and AIDS, they thought that the church would have difficulty targeting youth as a result of their dwindling church attendance. Some of the women reported their involvement in past HIV awareness activities through the church.

3.3.5 WOMEN FROM FAITH-BASED COMMUNITIES - RECOMMENDATIONS

- Awareness of vulnerability: Whereas the women in the industrial sites admitted to being personally vulnerable to HIV and AIDS (excluding those who were not sexually active), the women in this discussion group did not report feeling personally vulnerable. The dynamics of participating in a discussion group may have influenced why the women did not speak about their personal lives. Nevertheless, the women did feel as though in general, married women are vulnerable to HIV and AIDS because of men being unfaithful.

- Knowledge: Whereas the women in the industrial sites were very knowledgeable about HIV and AIDS, the women in this discussion group had many questions regarding basic facts about HIV transmission. HIV education outreach may not be reaching this population and programs should review the possibility of providing outreach to church members, especially women.

3.4 MEMBERS OF FAITH-BASED COMMUNITIES

3.4.1 CHRISTIAN CLERGY: OVERVIEW AND RECOMMENDATIONS

Even though Christian clergy would not be identified as a vulnerable group, as spiritual leaders, their perceptions and thoughts provide insight into the needs of vulnerable groups (perhaps within their own congregations) in regards to HIV services and prevention. This assessment

conducted informal interviews with clergy in Saint Kitts. As mentioned in the section above with women from faith-based organizations, the clergy expressed their desire of being more involved in activities related to care of PLWHA. The clergy recognized, however, that PLWHA would not come forward for fear of being judged. This opinion is reiterated by PLWHA in interviewed in this assessment (see PLWHA section), who reported that they do attend church but would not reveal their status to the congregation for fear of stigma. Nevertheless, the clergy felt as though the church should be a domain of reconciliation and compassion and perhaps this is not being emphasized enough to those living with HIV.

The clergy also expressed the church's role in promoting abstinence and cited a program that teaches personal development and life-skills to Christian youth to delay sexual debut. This program focuses on coping with peer pressure to have sex within a Christian context. The clergy also discussed counselling and speaking to church members about HIV and sexual decisions. They noted that most baptisms in the recent past have occurred with children of young single mothers. Considering this, pre-baptismal counselling could be a possible area of "intervention" for HIV prevention. In addition, marriage counselling was discussed as a possible area where clergy could promote HIV testing or discuss faithful relationships. As noted above, the women in the discussion group had discussed a case where a woman had contracted HIV after the clergy had encouraged her to stay with her unfaithful husband.

In other countries, spiritual leaders have taken the lead in providing care for PLWHA and reducing stigma about HIV and AIDS. Efforts to begin such work, however, should begin within the church itself. Educational campaigns to sensitize church members and clergy could be a good starting point for involving religious leaders in the fight against HIV and AIDS. As described above, clergy can also provide HIV prevention messages or promote testing and abstinence within their congregations through sermons or session based interventions, but need the tools and training to do so. In addition, there is a need to support faith-based organizations in implementing basic process monitoring and evaluation tools to help strengthen abstinence based programs (such as developing pre/post testing tools for group activities).

3.4.2 RASTAFARIANS OVERVIEW

Interviews were held with 3 Rastafarian males in Saint Kitts and Nevis. Rastafarians in this study were defined as those that shared and practiced Rastafarianism as a faith, its beliefs and philosophies as opposed to those who simply wore a Rastafarian hairstyle. In this regard, researchers found it difficult to locate and set appointments with Rastafarians in a methodological way. These Rastafarians were located through personal contacts and word-of-mouth while in-country, thus it was only possible to establish limited contact within the research period. Interviews also took place outside of the Rastafarian community setting. No Rastafarian women were interviewed. Two of the respondents were in relationships: one engaged in multiple relationships in addition to his regular partner, the other was in a long-term relationship and had children.

All of the men had varied educational backgrounds and were engaged in a variety of employment activities from self-employment to private sector employment. At least one respondent reported some attempts by National AIDS Program personnel in the past to engage the Rastafarian community in conferences and workshops on the topic of HIV and AIDS, attempts that they appreciated and would welcome, although these attempts have recently waned.

Of special interest is that all three respondents' decisions about health care options and sexual practices are influenced not only by their Rastafarian teachings, but also by popular theories on the creation and spread of HIV, explained below in more detail, which has encouraged their mistrust of modern medical practices.

3.4.3 RASTAFARIAN FINDINGS

Health Care

Of the 3 male respondents that were interviewed, 2 were consulting herbalists for health care and 1 would take 'bush tea' if he were sick. The choices to seek this alternative type of health care were made only after having experienced service and care both in the private and public health care system. Overall, a general dissatisfaction was expressed with both the level of professional care received by medical staff as well as the medical treatment options provided by the system.

Level of Professional Care

Each respondent felt that the patient-doctor relationship should be defined by courtesy and mutual respect. The patient should feel comfortable asking questions and should be able to trust that he/she is being given all relevant information without being made to feel inferior. Respondents felt that medical doctors did not provide adequate explanations to their questions and in some cases, seemed to resent being questioned, as if their authority were being challenged – an indication they suggest, that the doctors either felt that they were 'better' than the client, or that they may not be as well informed as they should be and resented the client finding out. Either way, refusal to inform the client was interpreted as a lack of transparency in the care being provided, which made the respondents suspicious of the explanations provided and the treatments offered. It was also felt that both nurses and doctors lacked customer service training and did not give adequate attention to their patients.

By contrast, according to the respondents, herbalists provided thorough explanations of all the treatments being offered, alternatives among treatments and pros and cons. They demonstrated that they were knowledgeable and well informed about their remedies and results. They were hospitable and courteous and clients felt that the service was personalized and more confidential, although it should be noted that no respondent could cite an instance when there was a known breach in confidentiality in the formal health care system or vouch that there were no breaches in confidentiality with the herbalist.

Treatment Options Available

Respondents felt that modern medical professionals do not provide enough information on treatment options, in that they often provide no alternatives to the medication or treatment they prescribed. If they did provide options, they did not provide enough information about these options and their side effects.

Also, unlike with modern medical professionals, respondents felt that herbalists provide natural remedies in keeping with Rastafarian philosophy about living in oneness and 'in tune' with nature whenever possible, living off the land and using nature's cures. The respondents were also vegetarian.

In addition, indications are that herbalists administer treatments in much less invasive ways. They do not take blood tests and do not provide treatment using needles. Rastafarians often spurn treatments that require the use of needles to draw blood or inject medication. Therefore, they do not receive vaccinations and often request that nurses and doctors do not administer treatments with needles when using formal health care in keeping with their beliefs and theories about the spread of diseases including HIV. Children are also not sent for vaccination – a point of contention when they must enroll in primary schooling and must be vaccinated.

To explain the aversion to needles, respondents stated that they conducted extensive personal research online and in literature that supports the following theories:

- The drastic spread of AIDS cannot be accounted for by sexual practices alone, pointing to the possibility that its spread is aided through vaccinations and other injected drugs. Therefore vaccinations put people at high risk for HIV infection

- HIV is manmade biological warfare, designed to reduce and control populations much like a form of birth control

- The World Health Organisation (WHO) agenda is not to be trusted, as it tends to take advantage of most vulnerable populations such as those of the Caribbean and Africa. This is supported by the rising incidences of infection in these regions, the same that received vaccinations during large vaccination drives in the past. Health care professionals are thus seen as perpetuating the WHO agenda and viewed with suspicion.

Despite these views, the respondents report having received HIV tests at both public and private facilities in the past, with one currently seeking regular testing. In the case of one respondent, his one-time test was to satisfy the requirements of an academic and insurance application. Being in a faithful, long-term relationship, he has not returned for testing. In the case of the other respondent, his involvement in multiple partnerships apart from his regular relationship means that he wants to check his status periodically. Therefore, he visits a private facility and reports not receiving either pre-test counselling or an explanation about the procedure. His preference for private care is also because he was upset that public-facility personnel repeatedly advise him to discontinue his use of marijuana.

None of the respondents reported being discriminated in the health care system.

Sexual Behaviours and Practices

Two of the respondents offered some interesting insights into Rastafarian beliefs on sexual partnerships and condom use. A decision can be made by Rastafarian men to engage in multiple sex partnerships, although he may or may not have a steady girlfriend. Often these partnerships may be with non-Rastafarian women, as many Rastafarian women already have a 'king man' or steady partner. Partners may or may not be told about one another. One respondent stated that in the Rastafarian community multiple partnerships are acceptable, as there is no strong belief in monogamy as in the Christian faith. The assessment did not uncover whether Rastafarian women also engage in these multiple partnerships.

With regard to condom use, respondents felt that there was an erroneous assumption that Rastafarians spread HIV because they do not use condoms. The issue is much more complex than this. Respondents stated a general preference for not using them as many other male. Preferences were sometimes personal, but also based on theories about the effectiveness of condoms and the conspiracy theory behind an international drive to promote them. These theories include—

- Condoms are not as effective in HIV transmission prevention as proposed, so it makes no real difference whether they are being used or not.

- Condom use is being promoted as a risk prevention method, but it is really a way to promote birth control to reduce world populations. Why else would messages say, Use a condom every time you have sex instead of Use a condom every time if you are not in a faithful relationship?

- Spermicide in condoms can promote infertility in a female. This is supported by the statistics that show an increase in the use of condoms and an increase in levels of infertility, which in turn supports the population reduction theory

For these reasons, one respondent who is in a faithful, long-term relationship does not practice condom use. One of the other respondents reports using condoms during his multiple sexual encounters, although he would prefer not to. He reports that condom use is based on a mutual decision, largely because he cares for his partner. Once he gets to know his partner better and the relationship builds, he wants to establish a "connection;" therefore he would usually raise the issue of discontinuing using condoms. Discontinued use would only take place after mutual consent from both partners. Most female partners consent. HIV and AIDS issues are discussed openly with partners, and although one respondent says he gets regular testing, his partners do not. Thus he gauges the HIV status of his partners from the negative HIV results he receives. Female partners are usually younger or in the same 26-35 age category.

Thoughts and Recommendations from Respondents

- Deaths from AIDS should be more highly publicized, anonymously, of course, but should quote real figures so that more people could know the seriousness of the disease.
- PLWHA should be part of a network and support system instead of being isolated. In this way it may be possible for persons who are HIV+ to be in relationships with each other and enjoy life
- Better education about HIV and AIDS and available treatments would eliminate fear of going to get tested and testing positive.
- 'HIV/AIDS should be a public issue, not a medical one' that is, HIV and AIDS should be seen and treated as any other disease or medical condition.
- Politics play too great a role in health care, determining which facilities will be better funded and thus narrowing the standard of health care in some areas.

3.4.4 SAINT KITTS HIGHLIGHTS

While it was possible to get a clearer picture of the general beliefs, philosophies and theories that influence the health seeking behaviours of Rastafarians, due to the small sample size, it is not possible to detect significant differences in Rastafarian behaviour or belief systems between Saint Kitts or Nevis.

3.4.5 NEVIS HIGHLIGHTS

Although two of the three respondents were interviewed in Nevis, one being Kittitian residing in Nevis, the similarities in beliefs, philosophies and theories indicate that these three factors, as well as their influence on the health seeking behaviours of Rastafarians cannot be said to be island-specific. The small sample size may also not have allowed researchers to detect significant differences in Rastafarian behaviour or outlook between islands.

3.4.6 RECOMMENDATIONS

- Messages targeting the Rastafarian community need to be culturally appropriate and need to address condom use and decision-making, for those who still choose to practice condom.
- Collaborate with traditional medical providers such as herbalists to reach the Rastafarian community to ensure that both traditional and non-traditional health care providers have information on each other's beliefs in order to be better able to frame messages. Collaborating with herbalists could yield information such as—who they are, where they are located, their background and training, their clientele, the reasons for clients' preferences

for traditional medicine and service—information that could be useful in pointing to limitations and gaps in the formalized health care system exist.

- Engage Rastafarians in open dialogue and public forums.

3.5 YOUTH

3.5.1 OVERVIEW

A discussion group was held with six young adults between the ages of 18–35 belonging to multiple youth groups in Saint Kitts. Recruitment was coordinated through a youth group leader. The research protocol approved both by the IRB in the US and locally by the CMO did not allow the team to interview young people under the age of 18. The results of one of the interviews conducted were not included in this report as the participant was under the age of 18. The research team was not successful in recruiting young people in Nevis because of an inability to make contact with a youth leader during a visit to that island.

The group was asked questions primarily on their vulnerability to HIV and AIDS, sexual behaviour, health service needs and to suggest interventions to deal with HIV and AIDS health issues among young people.

3.5.2 FINDINGS

Vulnerability

There was generally no great concern about contracting HIV within the group. Reasons given included—

- Not being engaged in sexual activity (for those not married or living with a partner). This response was more common among those within the 18–26 age group.

- Being married and faithful to one partner, although this respondent admitted that she was unaware of the actions of her partner.

While respondents felt that their low vulnerability to infection is a result of their own sexual behaviours and therefore within their control, they did feel that they could become infected through actions beyond their control such as an unfaithful spouse, or by being injected maliciously by someone with a needle. The ready agreement among participants on the possibility of being infected in the latter manner could indicate that other groups in society feel this way, possibly perpetuating the image of HIV+ persons, as persons who will set out to deliberately infect others, and thus encouraging the stigma and fear that people in society harbour against HIV+ persons.

Regarding access and use of condoms to prevent transmission, the group felt that among young people, there was discussion about HIV, and a lot of discussions about sex and condoms, but that discussion about sex and condoms were divorced from discussions of HIV. That is, discussions about condom use during sex were centred on condom use more as a means of contraception than prevention of HIV infection. However, climbing teen pregnancy rates in Saint Kitts attested to the fact that even thinking of condom use as a means of contraception is not enough to ensure regular condom usage.

One reason given that HIV and condom use may not be thought of as interlinked is that the risk perception among youth was that because Saint Kitts is small, if you have HIV people will know, and would have talked about it, therefore chances are you are safe with your current sexual partner since you haven't heard rumours about them. This response indicates that many young people may be operating under a false sense of security.

Sexual Behaviours

Questions on sexual behaviours and attitudes among young adults resulted in some interesting discussions about the factors that influencing sexual behaviours and attitudes to having sex at an early age, having multiple sexual partners and lack of condom use.

The biggest factors that influenced these behaviours and attitudes included (a) male promiscuity and its acceptance in Kittitian society, (b) the lack of societal role models for both young males and females and (c) the influence of religion.

Male Promiscuity and its Acceptance in Kittitian Society

There was general agreement within the group that many men, young and old whether in or out of relationships were not monogamous and that male promiscuity was generally tolerated and in some cases even expected or accepted. Men got respect for having more than one woman, a behaviour that is not generally tolerated in women. Respondents all had male friends who had multiple girlfriends and would think nothing of it. Respondents claimed that they felt that it was wrong and would talk to them about it. Respondents also knew girls whose male partners cheated on them, but who would stay anyway, for reasons not disclosed.

With regard to women, the lack of society's tolerance for them engaging in promiscuous behaviour, although not a deterrent to this type of behaviour, means that woman are not as open about their multiple partnerships. It was reported that many women would go willingly with a married man or a man who has a girlfriend, often to get a favour. Respondents felt that many girls and women are "easy", that is it does not take much to get a girl to offer sex if you buy them clothing or a gift, or if you simply tell them that they look good. This response was reiterated by "at-risk" women who explained that transactional or cross-generational sex is a symptom of economic depravity and a low self-esteem.

Lack of Societal Role Models for Both Young Males and Females

Respondents felt that neither young men nor woman had strong, positive role models in society. Instead, young men had older males who also engaged in promiscuous behaviour, and young women did not see their worth or potential beyond that of being pretty and desirable to men. In this regard, many young women were not only engaging males, but also soliciting them for favours. A common phenomenon is that of the cell phone 'top up'. According to the respondents, "the quickest sex is a top-up." The transaction involves a girl/woman sending a text message via cell phone to a man saying, "I want a top-up". The man in return will provide the 'top-up' with the understanding that they will meet later so that he receives a sexual favour in return. This type of transaction according to the group is just as common in schools as elsewhere and involves men of all ages, with proof of solicitation in the seemingly "innocent" text message that was sent.

Respondents felt that another dynamic to be explored is why parents are not asking children where they are getting cell phones or money to top them up (also mentioned in the "at-risk" women section).

In keeping with the responses of government educators and clinical service providers, girls as young as primary school level are engaging in sexual intercourse with sometimes very old men. Another issue that requires some attention could be the lack of condom use as older men may perceive that a young girl is less likely to get pregnant (hence no need to use a contraceptive) or a virgin and thus HIV-negative.

Influence of Religion

Respondents felt that many young people in general are hesitant to buy condoms, even if they are aware of why they should use them and where to obtain them. Reasons provided are a case of general shyness, but it was also felt that religious upbringing was a strong influencing factor as it was difficult for an underage and unmarried young person to go to a pharmacy to ask for condoms, especially in a small society.

Respondents felt that perhaps young people would prefer to obtain them from a more private facility, although responses from clinical service providers indicate that young people of school age may not be able to access condoms from a private physician (due to cost of visit and age at which parental consent may be needed for family planning).

Reports from clinical service providers that most of the condoms displayed for public access in offices were taken by schoolchildren (thus reducing this practice) supports that younger people know that they should use condoms, and are willing to use them, but find it difficult to access them.

The data given by the BSS on access to condoms and condom use among young people 15 to 24 years old show that 95 percent of them have knowledge of where to obtain condoms, 87 percent could obtain condoms within less than one hour of home or workplace, but that

only 56 percent used a condom at last sexual encounter and 16 percent used a condom at every encounter. These figures are not much higher for those in the 25 to 49 age category.

It appears that while a theory exists that the very young people 15 to 24 years old may be deterred from buying or asking for condoms due to fear of being judged or feelings of guilt, the barriers to condom use for those 25 to 49 may be a bit different and need to be examined.

Health Service Provision

Questions about health service provision were geared towards finding out what young people knew about and how they felt about health service provision including HIV testing. Their responses include the following:

- Of the 6 respondents, 1 went for regular yearly testing, 1 went during pregnancy as a requirement, 1 was tested for insurance purposes and the 2 donated blood or had blood work done and assumed that they were being tested for HIV as well
- Those tested did so at private facilities
- People are not likely to go get tested unless they are sick
- They were not aware of public testing centres, VCT services and where to get tested apart from private facilities
- They would not go to a public health centre or hospital to be tested or have a pap smear as they quoted 'people in Saint Kitts farse'. They felt that there was a lack of confidentiality in the public system among nursing staff particularly. The structure and layout of the centres did not lend itself to confidential conversations and it was possible to be overheard even if the staff did not disclose information.
- They believe that if there were legal implications for breaching trust, such as medical staff losing their jobs, being fined or serving jail time, then people might be more disposed to going to public facilities. Private doctors, they felt, could be sued.

Misconceptions about Young People

The respondents felt that they should highlight some common misconceptions about young people and sex:

- There are myths about children not having sex, yet in fact, they begin as young as 8 or 9 years old.
- There are misconceptions that talking about sex and condom use translates into knowledge and awareness of HIV and STDs or into use. This is not the reality.

- One respondent shared from his experiences that there is a misconception that only some 'type' of youth are engaging in sexual activity. Not all youth are involved in risky behaviour, but neither are only those that are labelled 'uneducated' and 'trouble maker'. Often students that study technical skills are treated as less and made to feel that they are worthless. This is evidenced by the unequal distribution of resources to trade departments in schools.

- Opportunities do exist for young people, but they often do not take them and prefer instant gratification, something that influences their engagement in risky behaviour.

3.5.3 SAINT KITTS HIGHLIGHTS

While it was informative to get the perspective of these young people, further research is needed with young people who may not be within organised youth groups and who may be engaged in risky behaviour to understand additional influences driving these behaviours.

3.5.4 NEVIS HIGHLIGHTS

Although no young people were interviewed in Nevis for the assessment, the issues coming out of this discussion group are useful in providing a platform for a more critical look at young people and sexual behaviour and beliefs in both Saint Kitts and Nevis. The issues of cell phone top ups and multiple sex partnerships are the same in both islands and is evident in the responses to informal interviews on local sex work in Nevis and women at risk.

Places particular to Nevis such as areas where young people congregate should be targeted for intervention, and given the strong presence and work programme of the Nevis HIV/AIDS Coordinating Unit (highlights in government and NGO section) it should be possible to widen these linkages to include youth groups and to develop youth-friendly services.

3.5.5 INTERVIEWER COMMENTS

When asked about the popular places that young people go to socialise and meet sexual partners, respondents suggested:

- The Frigate bay, which is the most popular and largest meeting place

- 'Jiggy' clubs on 'jiggy' Fridays. 'Jiggy' clubs are dance clubs and are described as places to free up, drink and smoke and where girls will be scantily clad. At these clubs dance competitions are often held. Often, it was said, young people would hang out at places furthest away from police stations.

Respondents felt that condom vending machines should be placed in public bathrooms and bars and other places where people 'top up'. It may not work in schools because the principal would "mark yuh face" and call your parents, creating another barrier to accessing them, and because condoms may be wasted, as they won't be used for the right purpose.

Respondents felt that phone companies should offer incentives to uses for forwarding texts on prevention messages. Young people want to perceive a tangible benefit.

Other thought and suggestions from respondents included—

- Having companies such as Cable and Wireless involve education in their strategies, possible offering a prize or incentive in the form of cell phone packages to school children for academic performance
- Using drama and videos in presentations (young people don't want to read)
- Using peer counsellors—other young people as outreach counsellors, not 40- and 50-something-year-olds
- Having interventions that target men specifically to address the issue of sexual relationships with school-aged girls
- Exposing youth to PLWHAs so that the reality of HIV and AIDS would be known to them
- Finding and highlighting more strong role models for young men
- Having DJs sending awareness messages at clubs
- Starting strong sex education sessions in primary schools

3.5.6 RECOMMENDATIONS

- Have greater outreach programmes at popular hang outs and social meeting places such as at the Frigate Bay and 'jiggy' Clubs. Relationships should be forged with bar owners, club workers and other proprietors so they can gain ownership of this effort.
- Condom distribution should be targeted at these places during and outside of major events such as Culturama, Easterama and Villagerama festivals and Christmas carnival for interventions
- Increase number of peer outreach workers at these locations
- Engage private telecommunications companies in HIV prevention campaigns
- Develop youth-friendly presentations and other media to engage youth in dialogue and disseminate prevention messages

3.6 PEOPLE LIVING WITH HIV AND AIDS (PLWHA)

3.6.1 OVERVIEW

The team conducting this project for Saint Kitts and Nevis was frankly not optimistic about being able to reach and include the perspective of people living with HIV and AIDS. The International HIV/AIDS Alliance program admittedly documents that this is the hardest community to outreach to and gain access to provide services. They are extremely underground and private. The fear of stigma from living and working within a small island culture has driven many of those with HIV and AIDS to make decisions such as not accessing services in their own environment- there is a preference for some to get medical care and medications on other islands, where no one ill know who they are. The support groups that have been established to provide peer support and safe spaces for those whose lives are changed by becoming diagnosed are under-utilized and not attended regularly for fear of being "outed" as being HIV-positive.

As the project did not initially plan to be able to access HIV-positive individuals, there were not specific questionnaires developed as a part of the protocol. The faith-based, at-risk women, youth questionnaire was used as a guide to ask basic questions—the interviewers assigned to conducting these had previous experience working with and interviewing HIV-positive individuals.

The interviewers were able to speak with four people in Saint Kitts who are HIV-positive. One of the interviewers had the unique opportunity to talk with a married couple who were both living and supporting each other. These individuals were asked to participate in the interviewers through working with the clinical providers in Saint Kitts that provide their primary care services. Once they agreed with the request and set up a time, the interviews we conducted in an environment that was comfortable and safe for the participant. Admittedly, no HIV-positive individuals were spoken to in Nevis. The interviewers will discuss this further in the "Limitations" section, but admit to this being a gap in the research. However, the perspectives and recommendations of those accessed from Saint Kitts are shared below.

3.6.2 FINDINGS

Testing Positive For HIV

We interviewed three women and one man (the husband of one of the female participants) as a part of the sample. The four HIV-positive individuals included in this sample have been diagnosed within the last 8 years: Two tested positive in 1999, and the couple tested positive in 2003. Each found out about their status in various ways: Two individuals found out their status off the island. One person was admitted to the hospital with fevers and was tested to confirm the possibility. Another was tested when she discovered that her partner had tested positive. Two individuals specifically spoke of accessing their initial care and medications overseas—many of the clinicians we spoke with also spoke of patients either getting medications off the island, or

even having to refer people off the island to access medications that are not yet available in Saint Kitts. Although ARV treatment is free in Saint Kitts and Nevis, because of the stigma associated with even picking up HIV medications at the pharmacist, the PLWHA interviewed said they felt more comfortable sending someone across to another island to get meds, or travelling themselves out of the country to pick up their supplies.

Disclosure of Status and Risk Perceptions

Depression was the first response that all provided when asked what their reaction was to becoming positive. They closed off from family and friends—three of the four indicated that there was one person in their family they trusted enough to tell about their status—a sister or a brother. Three of them had not shared their status with their children, mother, father, or any other relatives other than the one they trusted and confided in. They indicated, "I feel like they must suspect by now" or "I've never said it directly to my brother, but he must know…it's just not spoken about." Another stated, "My mother was present when the health care worker told us the news of my result, and we haven't spoken of it all since then."

Again, the issue of stigma was raised here. Those who had not disclosed to their families have mentioned that they felt their family and friends would not understand. When asked about their social involvement, three of them mentioned being active in their churches. Despite this, they felt that even this would not be a supportive environment. "Chatty Kittitians does talk about everything." says one individual. Another says, "I want to be open to others about it, but it's too hard…. I hear statements like people not wanting to drink from my glass…" One person flat out refused; he is going to "keep to himself."

The discussion of disclosure with the married couple brought out issues and challenges unique to being in a relationship and working together to deal with these challenges. They discussed openly of using protection in their sexual relations and talked about being faithful to one another in their marriage. The husband had discovered his status first, and then the wife; although they did not talk about whether they knew how they became infected or who infected whom. In their discussions with each other as an HIV-positive couple, the main concern expressed especially by the wife was, "Is this person going to be here for the long haul, through thick and thin….?" They have a child and are interested in having another someday. They also said that one day, they hoped they could be open with their family and community about their positive HIV status, but they have a "…real fear in society and confidentiality…."

When the discussions turned to "what puts a person at risk of becoming HIV-positive" and the respondents were asked, "Who do you think are at risk?" the response was that "ignorance" puts one at risk. One respondent said, "I didn't think it would happen to me, and I still don't believe it." One woman in particular was very emotional about her status; 8 years into finding out, she was very upset, crying, and worried about her children and what they would face if others became aware of her HIV infection. She "had no idea" that this would happen to her. "I just didn't have enough information…people don't have enough information. That why was at risk, and why others are too."

Support Needs

Two of the individuals have been active to some extent in the HIV positive support group that exists in Saint Kitts, Facilitating Access to Confidential Testing, Treatment and Support (FACTTS), a peer support group that is for "affected and infected persons," but that people are "still afraid to disclose and that regular participation in the group is very low. Meetings sometimes go months at a time without being held because "people won't come out." One person articulated a sentiment that was also echoed by a few of the clinicians we spoke to; there is a need for professional, psychosocial support and trained counsellors in both the private and public sector.

One individual specifically stated that he/she would "never" go to a support meeting and said, "Yes, I know it's available, but I don't want people fishing for information…or talking badly about me." But when asked if he/she would talk with someone on a one-on-one basis, this person indicated that he/she would be open to this option.

Clinical Care and Working with PLWHA

Medical providers also gave us some insight into the issues they face with working with HIV-positive individuals in Saint Kitts. Some providers talked of having to go and pick up medications at the pharmacy to provide to their patient—for the dual reason of protecting the confidentiality of the patient from both the health care workers and the general society. Two of the doctors we spoke with about their work with HIV-positive patients described some of the more "clandestine" movements of having to go provide medications to their patients—even as far as making sure that no other health care provider other than those assigned to the team were aware of the status of the individuals. These doctors also discussed the risk of lack of confidentiality from within the systems and that they fear this may end up in losing contact with their patients who may stop accessing care. In other words, they "do what they have to do" in order to provide the best care possible.

Some clinicians also expressed that they feel that are not adequately addressing the emotional support needs of their patients. 'Sometimes I am counsellor, physician, pharmacist, social worker…." Because of the issues of providing as confidential as possible a setting for their patients to access care, the clinicians use such methods as opening their offices during hours that will allow patients not to be seen by others, and administering medications to patients in a way that no one else will know what the medications are for. These present stressful situations for the clinicians to negotiate.

A few of the providers spoke about the issue of disclosure as well, and how in some cases they might have HIV-positive patients who have not disclosed their status to their spouse.

All four of those interviewed are currently accessing private care on Saint Kitts, and three of the four indicated that they are taking medications. One spoke specifically about private care being expensive, but said, "my medications are free…[and] "my doctor helps with funding for viral load and CD4 testing…." (The interviewer took this to mean that there is support to cover the cost of these tests at their private facility).

All four interviewees expressed their satisfaction and comfort with their clinicians. They felt as though they can "talk about anything" and that they have good relationships with their doctor; one said, "All my questions are answered any time I come for check ups." They also spoke of not wanting to go any place else for care. There is a high level of faith in their providers' ability to be supportive and provide them necessary care, but all did express that if given a choice, they would only go to a private doctor.

Challenges

Again, the issue of confidentiality has come up as a theme amongst all the groups that we have spoken to—and it is especially pressing to understand and develop key recommendations for working with HIV-positive people. The four PLWHA interviewed were very clear about only accessing private clinicians for their care. Two would have preferred to access care off the island.

Many of the discussions around confidentiality seem to be about past breeches in the system that may have occurred some time ago, leading the research team to ask the question: Is it more the fear and feeling of the culture in Saint Kitts that "people does talk" that leads one to have lack of faith in the system, or is it is that confidentiality is not being protected by the health care workers? One comment was "I have heard that the health care workers talk to others outside about patients that come in and out of the hospital." But when we asked when this had happened, not one of the four could give us a range other than perhaps "10 years ago". The team could not document and verify any recent breeches in confidentiality at the health care system level. There seems to be a perceived notion, based on past experiences and issues with confidentiality, that deter people from wanting to access care on the island and/or in public settings.

Yet confidentiality is a very real issue, which is felt by both clinical care providers and their patients. There is a general lack of trust in the health care working environment by both parties; leading clinicians to take steps toward protecting their patients (see section on clinicians).

Another issue that three of those we interviewed spoke clear about was the challenge of maintaining adequate nutritional and dietary needs. The couple spoke about the high cost of food in Saint Kitts: "The kind of food I (we) need to eat is very expensive here" said the couple. Another individual spoke of receiving food distributions for her and her children, but that there is no help from the government and it hard to "…keep on a proper diet…everything is expensive in Saint Kitts….it cost 3 dollars for an apple!"

3.6.3 RECOMMENDATIONS

Although the sample size for this population in this assessment is small, there are a few key recommendations with regards to services that the team would like to point out that are apparent from these discussions, as well as were mirrored in discussions with clinical care providers:

- **Psychological Support—**There is a great need for professional psychosocial support and one-one on counselling services. A trained psychologist/psychiatrist should be recruited and included on the clinical care team in Saint Kitts and Nevis. This person could have the dual role of supporting the HIV positive clients in providing confidential, one-on-one therapeutic support, but can also serve to provide support to the clinicians who are working with patients in advising, referrals, and addressing mental health issues of disclosure and depression.

- **Nutritional Support—**A dietician and/or increased supplemental food support, food vouchers, etc can be incredible useful to HIV-positive individuals trying to maintain healthy life styles but who may not have enough knowledge or enough resources to maintain a proper diet. Such a position may also need to be a member of the clinical care team. These vouchers should be accessible through private care facilities for PLWHAs who do not want to access public facilities.

- **Stigma and discrimination—**While a human rights desk and a formal complaint procedure has been established to address occurrences of discrimination against PLWHA, there is a need to make these processes widely known in St Kitts and Nevis. This process can be disseminated through the media (TV/radio, billboards, posters, etc.). In addition, there is a need to conduct a broad sweeping sensitization campaign addressing stigma and discrimination of PLWHA and perhaps other vulnerable groups in workplaces, schools, health care facilities and churches. This campaign can be implemented through outreach workers or through a media campaign.

CHAPTER 4: PROVIDERS—GOVERNMENTAL AND NON-GOVERNMENTAL ORGANISATIONS: FINDINGS AND ANALYSIS

4.1 CLINICAL SERVICE PROVIDERS

4.1.1 OVERVIEW

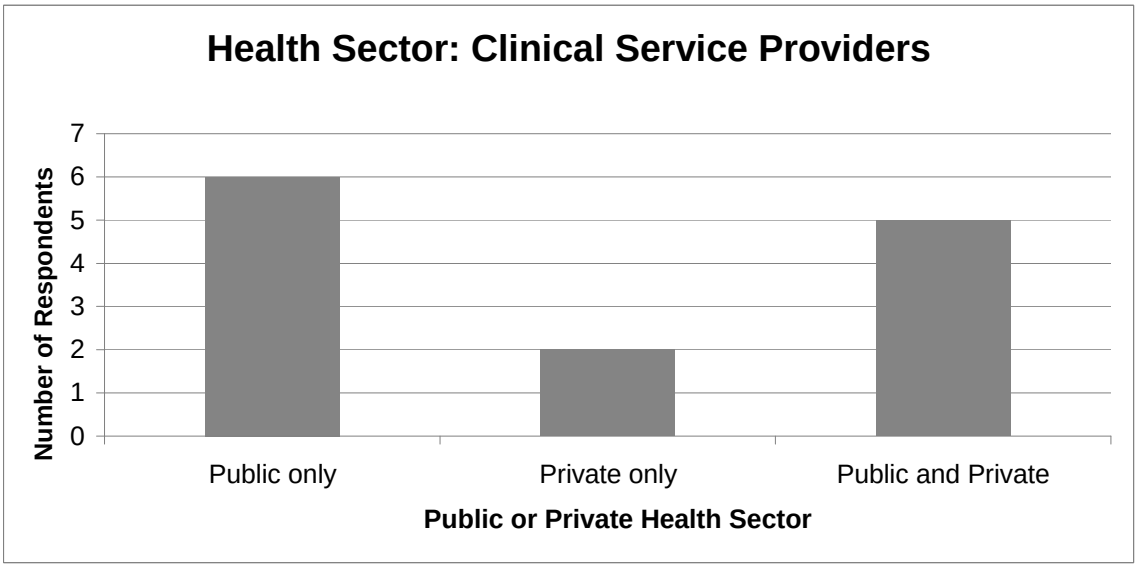
This assessment defined a clinical service provider as an individual who provides clinical and pharmaceutical services in the public and private health sector. The clinical service providers who participated in the assessment were contacted via recommendations of the in-country team and word of mouth. Out of 13 interviews, 10 took place in Saint Kitts and 3 took place in Nevis. More than half (8 out of 13) of the clinical service providers interviewed were over the age of 46. The average number of years working as a provider was 21 years.

4.1.2 FINDINGS

Type of Facility

The clinical service providers interviewed worked in a variety of health care institutions, including hospitals, clinics, private offices or "other" facilities. Many of the clinical service providers interviewed worked in both the public and private sectors, as demonstrated in Figure 4.1.2a.

Figure 4.1.2a: Health Sector: Clinical Service Providers



Differences between patients in private versus public facilities were discussed by many of the interviewees. There were differences of opinion on the demographic of patients who attend public versus private facilities. Some of the providers felt that patients accessing private facilities have a higher income versus those that go to public facilities. A few clinicians also note that the original reasoning for the public clinics was to provide free care to the old and young, with an emphasis on immunizations for children and care and access to medications for the elderly, and therefore others may be less inclined to participate in seeking care at these facilities. Others felt that economic status was not a factor and that rather socio-cultural factors were more influential in one's decision to choose public versus private facilities. Two respondents explained that there is a perceived notion that private services are more confidential and of better quality than public services.

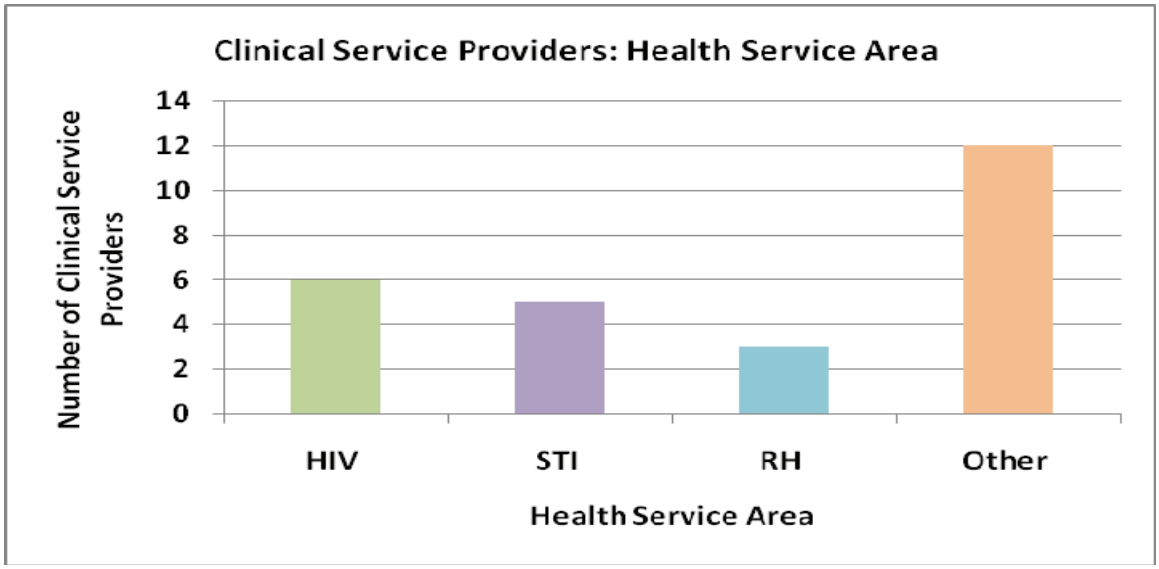
Accessing Care and Treatment Services Off Island

It was mentioned that patients from other countries, including HIV-positive individuals, access health facilities in Saint Kitts. One provider mentioned that he/she provides services to patients from the Virgin Islands, Saint Marten, and Tortola. The interviewer's notes and the clinicians working with HIV-positive individuals documented an example where a patient who needed access to a class of medications not available on Saint Kitts relocated to another island in order to access the needed medications. It was mentioned that PLWHA from other countries also access public services but go to their home countries when they are in the later stages of AIDS. Many of these instances are related to issues of confidentiality and patient fear around being exposed to the public about their HIV status.

Services Related To HIV and AIDS

Many of the clinical service providers interviewed had experience in HIV service delivery (Figure 4.1.2b); however, almost all of them indicated that they worked in an "other" health service area, which included practice in general health delivery or a specialized field.

Figure 4.1.2b: Health Service Area: Clinical Service Providers



Providers discussed services that either they personally provide or the facility provides specifically in relation to HIV and AIDS. These services included HIV pre- and post-test counselling, ARV provision, STI treatment/screening, distribution of HIV prevention materials, condom distribution for HIV prevention and family planning, referrals for PLWHA and psychological counselling for vulnerable groups. In regards to condom distribution, it was mentioned that health centres distribute condoms primarily as part of family planning, however all adults can request condoms from nurses. It was also mentioned that generally nurses do not provide schoolchildren with condoms.

In addition to existing services, many respondents discussed services that they would like to provide or services that are lacking within the current health infrastructure. Some of the services mentioned were:

- A rehabilitation centre for alcohol and drug abuse, since drug abusers are a high-risk group for HIV and AIDS.
- Condom provision in "non-traditional" sites where vulnerable groups seek help—such as psychiatrist or social work offices
- A regular distribution and supply of HIV communication materials (brochures, pamphlets and posters) at health centres, private offices and schools—some providers mentioned that on occasion they ran out of these materials in their offices
- Opening a clinic and/or holding clinics hours that specializes in men's health issues and "youth clinic hours"

- HIV rapid testing at health fairs
- Comprehensive VCT services at all clinics
- Increased psycho-social support services for PLWHA; increased training for providers to give psychosocial support
- Increased availability of ARVs in private pharmacies
- Greater collaboration with groups working in other health sectors that may also be targeting groups vulnerable to HIV
- Increased funding for STI screening and testing
- Better coordination with CAREC to decrease the number of false positives and to decrease the time to receive test results. One provider mentioned that private labs are faster and he/she prefers to go through the private system
- Coordinating with private cell phone companies to relay behavioural messages to youth
- Improve the coding system for HIV tests to increase confidentiality
- Provide one on one interventions for youth that are identified early as 'at-risk' through the schools

HIV- and AIDS- related training

About half (7 out of 13 respondents) indicated that they had received training in the past 3 years in STI or HIV and AIDS service delivery as demonstrated in Table 4.1.2.

Table 4.1.2 STI/HIV/AIDS Training Received in Last 3 Years

STI/HIV/AIDS Training Received in Last 3 Years			
	Training	No Training	Missing
Saint Kitts	6	4	0
Nevis	1	1	1
Total	7	5	1

In regards to VCT training specifically, it was mentioned that nurses and doctors were more likely to receive VCT training rather than other health facility personnel. Even though there are a limited number of dedicated individuals trained in VCT, there is a need for increased human resources in VCT. A consistent message that emerged from discussions with clinical care providers, especially doctors and nurses, was their inability to provide VCT services consistently, and the need for dedicated staff to provide VCT. One provider says, "The process takes a long time…. I'd like to offer more regular, but if I have 20 or 30 people waiting to see me (public setting), then I can't take 45 minutes to counsel someone…. It would be good to have someone here all the time, or set hours with someone here all the time who only does VCT." Another clinician in a public setting talk about the same issue, "….I am the only trained VCT person here, and if I get sent to another facility one day and someone comes in to get a test, there is no one here to do it." Many health centres only have one VCT counsellor. When that counsellor is not available or out of the area, VCT services become unavailable as well. It was suggested that a possible solution for the current VCT shortage is to provide a stipend to compensate for additional duties not related to VCT.

Perception of Vulnerable Groups

Respondents were variable in their perceptions of groups that are vulnerable to HIV and AIDS. Groups cited included commercial sex workers, MSM, youth, drug abusers, low-income women, immigrants, people with multiple sex partners, and people who engage in unprotected sex. One respondent said, "HIV/AIDS is a women's problem." Another respondent explained that youth often seek care for STDs at the facility and that is why youth are vulnerable to HIV and AIDS.

It was mentioned that most clinical care providers feel comfortable providing services to vulnerable groups and that doctors recommend testing to patients and their partners who they feel are at high risk for HIV. Many providers mentioned that women are more open to getting tested than men. On the other hand, interviewees said that it is difficult to identify who is vulnerable to HIV. For example, providers mentioned that few men (including married men) would admit to homosexuality; they are more likely to admit to infidelity or multiple partnerships. In addition, another respondent said that Spanish-speaking sex workers do not self-identify as sex workers. Many providers said that there is simply not enough information on vulnerable groups in Saint Kitts and Nevis to identify individuals as vulnerable to HIV. As a result of this difficulty in identifying vulnerable groups, some of the providers felt that it is better to give equal care to everyone regardless of their perceived vulnerability.

Barriers to Providing HIV and AIDS Services

Clinical care providers like many other individuals who participated in this assessment, discussed issues relating to confidentiality in the health care system and the general problem with stigma surrounding HIV and AIDS. Providers were aware of the public's fear of lack of confidentiality in facilities. It was mentioned that people do not want to go to the hospital to be tested for HIV because of the perceived lack of confidentiality.

Even though providers were aware of perceived lack of confidentiality, few providers could cite past breaches in confidentiality. Despite this, providers take extra precaution to protect the status of their patients. Some of the extra precautions mentioned included "personal services" such as delivering blood samples to labs in person, dispensing ARVs to PLWHA in private places and taking extra care not to disclose a patient's HIV status to nurses and other staff. One provider mentioned that he/she advises to patients not to get an HIV test on the same day as other health tests, since the lab technicians will see the name of the person receiving the tests. Another respondent mentioned that private facilities do not report to the National AIDS Program because patients do not want to disclose their status.

The providers also discussed problems relating to the physical space of the health facilities. Interviewees mentioned that the layout of the majority of health facilities is not conducive to privacy. One respondent recommended that separate buildings should exist for HIV and AIDS-related services in order to protect privacy. In regards to VCT, it was recommended that dedicated VCT rooms with secure filing cabinets should exist to ensure records are protected. Increased laboratory monitoring is needed as well with regards to returning of HIV testing results. One provider quotes an example where the lab test results for all clients come in the same envelope as the HIV test results, so any provider/worker at the clinic can open and receive them.

Many providers explained that most patients are not open about HIV because of the stigma surrounding the disease. To cope with this, some providers explained creative methods utilized when they think that a person has come to the facility for a sensitive health problem. For example, one provider mentioned that if a person arrives at a health facility in Basseterre from a rural area, it might be because the patient does not want the community to know about the reasons for accessing treatment. When this occurs, a provider should make an extra effort to probe why the individual has travelled a long distance to access care.

Providers also mentioned that there are language barriers in providing care to Spanish speakers, although one provider mentioned that many Kittitian doctors have been trained in Cuba and therefore do speak Spanish. It was mentioned that the "Spanish girls" tend to see Cuban doctors in the public system, not English-speaking doctors. Spanish translated prevention materials need to me made available to these providers to encourage also their provisions of HIV messages to this population.

4.1.3 SAINT KITTS HIGHLIGHTS

Throughout this assessment, participants were asked whether they were satisfied with their clinical care provider. One major highlight in Saint Kitts was that the overwhelming majority of respondents felt that they had a good relationship with their doctor (note that the response was in relation with their doctor, not nurse or pharmacist) and were satisfied with their quality of care. This indicates that respondents do have a level of trust in their doctors. Despite this,

there is a general mistrust in the health care staff. Doctors themselves do not trust health care staff, taking measures in their daily practice to ensure the confidentiality of their patients.

4.1.4 NEVIS HIGHLIGHTS

A highlight from the Nevis service provider interviews to point out is the innovative social marketing that has been used in the past to encourage HIV testing. One provider spoke about a series of vignettes that were shown on a local television station for a week that depicted the step-by-step process of counselling and testing and receiving one's results. The provider indicated that this was so successful that several individuals the following week came in to get tested. Creative social marketing campaigns to encourage testing such as these should be encouraged.

4.1.5 RECOMMENDATIONS

The perceived lack of confidentiality in health care services is a major barrier in HIV and AIDS service provision in Saint Kitts and Nevis. All health care staff, including those not providing treatment (administrative staff, support staff, medical assistants, nurses), should be trained in basic measures of protecting privacy of patients. Sensitization campaigns for health staff regarding the realities of PLWHA could be launched. Policies outlining penalization of health care staff for breaching confidentiality and procedures, including a rating system for clinics with confidential policies in effect, should be visible in both public and private clinical settings.

A key recommendation is for increased laboratory monitoring in making sure that HIV testing results are only addressed to the providers and or VCT counsellor designated to provide the results—results should be in a secure envelope only addressed to the VCT counsellor, rather than sending VCT results with all other lab results. With regard to physical infrastructure, implementing sound proofing measures should be considered within designated rooms to protect confidential discussions. HIV testing and counselling should be implemented in designated spaces and results should be kept in locked cabinets.

A social marketing campaign and or media campaigns addressing the "Kittitians does talk" issue perhaps would be appropriate as an intervention in the community. This would reinforce the notion that although "people does talk", the health care providers and other health facility staff are committed to protecting confidentiality.

There is a need for HIV and AIDS activities to be integrated in other health issues that also work with vulnerable populations. Drug abuse, domestic violence and teenage pregnancy are all issues that affect vulnerable populations and linkages should be made with organizations that work in those realms.

There is a large gap in HIV and AIDS information as the private health sector is not very well integrated into the overall health system. Even though most respondents prefer the private

health sector and many health professionals work in both the private and public sectors, reporting is focused on the public sector. Mandatory HIV reporting is not enforced within the private sector, thus resulting in not as accurate a picture of the epidemic. Policies to integrate private health care fully into participating with communicable disease reporting should be encouraged.

4.2 GOVERNMENTAL AND NON-GOVERNMENTAL ORGANIZATIONS

4.2.1 OVERVIEW

Discussions with personnel of governmental and NGOs were held to get a better sense of the roles that governmental and NGOs play in HIV and AIDS. Interviewing civil servants and individuals working for NGOs gives insight into where the strongest institutional linkages lie, stakeholder definitions of vulnerable groups, programmatic considerations based on these definitions and recommendations for a strengthened multisectoral approach.

Formal interviews were held with 10 governmental and 3 non-governmental organizations in both Saint Kitts and Nevis. Two informal interviews were held as well. Of all respondents, 4 out of 10 government personnel not working in a health service area had received training in HIV or STI service provision in the last 3 years. Two respondents had received training in HIV and AIDS, with a focus on behaviour change (prevention and awareness).

4.2.2 FINDINGS

Organisational Linkages to HIV- and AIDS-Related Activities

Below is a list of activities related to HIV and AIDS that are sponsored by governmental and non-governmental organizations. The purpose of this list to identify gaps in the response to HIV and AIDS by government and civil society. This list is not exhaustive and represents the mandated work of the organisation as opposed to the mandated work of the respondents themselves.

- HIV prevention activities (esp. life skills training) with primary and secondary school students
- General HIV prevention activities with in-school and out of school youth
- Parent counselling in schools to address HIV and AIDS related issues
- General psycho-social support to the community through outreach centres
- Condom and HIV prevention materials distribution
- Development of policies to protect PLWHA from discrimination

- Promoting recreational activities for at risk youth
- Sponsoring camps for at risk youth where guest speakers come discuss HIV and AIDS
- Development of workplace policies for PLWHA
- NACHA representation
- Policy development and implementation for immigration and HIV and AIDS (i.e., testing of immigrants)
- Implementing HIV and AIDS workshops
- Sponsoring peer support groups for PLWHA
- Collaborating with NAP to implement HIV and AIDS campaigns on World AIDS Day
- Development and implementation of policies regarding prisons

There seems to be strong programmatic focus on prevention programs with youth, condom distribution and establishing policies to protect PLWHA against discrimination in the workplace and in the general community. However, it is important that those developing and implementing programs and partnering in their efforts for HIV prevention be aware that prevention must move beyond the dissemination of condoms and investing in youth programmes. Poverty reduction strategies and reaching vulnerable groups such as CSWs and MSMs should also be integrated in the multisectoral approach.

Perceptions of Role of Organisation in HIV and Vulnerable Groups

Participants were able to express their opinions on the important role their organisations play in working with vulnerable groups. Their feelings about the importance of working with vulnerable groups and the emotion with which these feelings were expressed indicate a motivation to support further work and collaboration in this area.

Participants working with school-aged children felt that the roles played by their organisations in HIV are important in the following respects:

- Children with special needs are vulnerable to being taken advantage of and must be informed – but subject matter must be tailored to them (visual aids and constant repetition)

- Children on the whole are often emotionally, physically and sexually abused and are sexually active as early as the primary school level

- Children and parents from poor backgrounds need to have one-on-one sessions with counsellors at home. Discussions on HIV and AIDS are currently held with parents and if necessary, referrals are made to a social Outreach centre. Parents are not usually offended at being drawn into these types of discussions as counsellors are trained to read body language, when not to ask a question.

Participants working with young people felt that the roles played by their organisations in HIV are important, as young people need to be targeted early, so that a greater impact on behaviour change can be made. Participants working to implement legislation to protect PLWHA felt that

this work was important because it would ultimately assist in protecting the confidentiality and human rights of PLWHA. Those working in workplace policies were concerned that HIV infection rates could affect the workforce/labour force negatively.

Knowledge and Perceptions of Vulnerable Groups

Respondents' definitions of vulnerable groups indicate that they not only are familiar with the terminology but that a) they have a good grasp of what makes people vulnerable and b) understand that what makes people vulnerable is not only risky behaviour, but the circumstances that often drive or influence risky behaviour, with an emphasis on poverty. Most respondents have heard and claim to be familiar with the term 'vulnerable groups, 'high-risk groups' and 'most at risk populations'. When asked what defines a vulnerable group, participants responded in the following ways:

- Groups of persons who are most likely or most at risk of becoming infected with HIV through lack of condom use and multiple partnerships
- Those who do not have ready access to different health services due to income or services not being offered in their geographic locale.
- Persons due to social constraints or by choice who put in precarious situations where they have to fend for themselves
- Those who are financially and morally poor

When asked to cite groups that would be vulnerable to HIV, responses were variable. The groups most frequently cited were homosexuals/MSM, commercial sex workers, youth, people engaging in multiple partnerships and no condom use, drug users and women. Many respondents made a strong correlation between vulnerability to HIV and AIDS and economic instability. A strong emphasis was also made on multiple partnerships and low condom use. This could suggest that messages citing lack of condoms usage and multiple partnerships as a risky behaviour have been internalized, but that attention needs to be paid now to the influencing factors in risky behaviour.

In Saint Kitts, many respondents had contact with the vulnerable groups in the past and felt it was important to work with these groups. Difficulties and constraints to working with these groups included—

- Behavioural messages received in the school setting are not being reinforced in the home setting
- Limited school counselling staff in Saint Kitts. In Nevis there is one life skills counsellor/per primary school. In Saint Kitts there are three counsellors for all schools

- Inadequate funding for HIV programmes for external ministries results in lessened integration of efforts. Ministries and agencies outside of the Ministry of Health need to be viewed as primary actors in the fight against HIV and AIDS

- Programs implemented outside of the Ministry of Health have weak monitoring and evaluation systems to analyze the impacts of programmes on behaviour change

- Partnership with the National AIDS Programme is often a challenge since the latter often approaches partnership with other agencies from a perspective that HIV and AIDS work supersedes everything else and is more important than mandate of other agency

- Transactional sex is informal and underground therefore it is hard to target these individuals.

- There are few mechanisms to target vulnerable groups with messages. Currently, the only way to reach vulnerable groups with behavioural messages may be to target everyone through advocacy and communication.

- The greatest barrier to providing services to vulnerable groups is the lack of information about their demographics, behaviours and practices.

In Nevis, most respondents had reported contact with the vulnerable groups and all felt it was important to work with these groups. The difficulties/constraints cited by Nevis in working with these groups were—

- Denial among vulnerable groups of risky behaviour because of a perceived lack of confidentiality in whomever they must confide, whether health or other programme personnel

- Parents and school officials screen HIV prevention programmes, therefore making them difficult to implement

- Lack of information and access to vulnerable groups

Support for a Multisectoral Approach

Since the National AIDS Programme may not have the adequate resources (human and financial) to fully implement desired HIV and AIDS related activities, a greater emphasis on programming within other Ministries and civil society should be considered. Multisectoral approaches to developing and supporting public health programmes already exist in the form of initiatives such as NACHA, which includes representation from various governmental and NGOs. Organizational linkages also already exist on the ground with each agency targeting specific groups and issues within their purview. However, these linkages need to be strengthened and a more systematic approach needs to be adopted to minimize duplication and increase impact. There is a substantial role that organizations can play in promoting HIV and AIDS activities that go far beyond what is currently being implemented, such as one-time condom distribution

campaigns. In addition, organizations need guidance on the most effective and appropriate strategies in combating the HIV and AIDS epidemic. Current initiatives outside of the Ministry of Health need to be monitored, evaluated, and reported into the NAPs so that the impact of these initiatives can be tracked.

4.2.3 SAINT KITTS HIGHLIGHTS

Interviewer observation and informal discussions suggest that the National AIDS Programme may need a stronger presence among governmental and non-governmental organisations. While there are linkages, respondents will identify these linkages as linkages with the Ministry of Health as opposed to the NAP. It is possible that further research with a larger sample of participants in each area of work will provide a more accurate picture of how the NAP is perceived in Saint Kitts.

4.2.4 NEVIS HIGHLIGHTS

It is possible to detect, through interviewer observation and informal discussions that the Nevis HIV/AIDS Coordinating Unit is highly visible and has a strong presence among governmental and non-governmental organisations, not only because of the linkages it has formed, but also because of its proactivity in establishing these linkages. Respondents will often attribute HIV/AIDS efforts to the Unit as opposed to the Ministry of Health.

4.2.4 RECOMMENDATIONS

Many recommendations emerge that might be useful in supporting the strengthening of the multisectoral response to HIV and AIDS by forging linkages between Health and other areas of the public sector, and develop more programs that go beyond condom dissemination. They are as follows:

- There was a notable absence of Ministries collaborating with faith-based organisations. There is a need for integration of faith-based organizations into the multisectoral response.
- There is a need to integrate monitoring and evaluation systems so data from HIV and AIDS-related activities outside of the Ministry of Health is captured.
- Encourage each government department to develop a policy statement on HIV and AIDS.
- As mentioned above, expand the purview of the multisectoral approach so more Ministries and NGOs can be involved in programs specifically targeting vulnerable groups.
- In Saint Kitts, strengthen funding, human resource capacity and administrative mechanisms for programming outside of the Ministry of Health.

CHAPTER 5: LIMITATIONS AND GAPS

Many factors and considerations, often unanticipated, influenced the recruitment for and execution of the interview process as well as decisions made by the research team throughout the research period. These factors and considerations led to some limitations to the assessment and gaps in the information collected.

Some of the biggest influencing factors included—

- Not having an on-the-ground Coordinator to recruit and coordinate interviews in Nevis, and specifically for vulnerable groups, as was the case with Saint Kitts. This is reflected in the fewer numbers of vulnerable groups recruited in Nevis as compared to Saint Kitts.

  Three things point to the need for on-the-ground support in this area from someone who not only resides in the respective island, but who works closely with and is trusted by the specific vulnerable groups there.

  One, the Alliance Programme Officer, who resides in Saint Kitts, and who was assigned to recruit and coordinate in Saint Kitts, was able to recruit a higher than expected number of MSM in Saint Kitts within a relatively short time, using his experience and skill working within the MSM community. However, this was not the case with Nevis where even using the same recruiting officer, there were lower than expected numbers of MSM recruited in Nevis. Similarly, managing to recruit participants for the discussion group on Spanish-speaking sex workers was only possible through an Alliance Outreach worker familiar with and trusted by these groups in Saint Kitts.

  Two, although there was invaluable assistance with coordination and recruitment of government and clinical service providers received from the NAP in Saint Kitts and the HIV/AIDS Coordinating Unit in Nevis, as well as the in-country teams in both islands, it was difficult locating the vulnerable groups through these same contacts. Recruitment of at-risk women at the industrial sites in Saint Kitts was only possible through a member of the in-country team and key community leaders working with these women.

  Three, the vulnerable groups such as the English-speaking sex workers in both islands and Spanish-speaking workers in Nevis, for which there was no recruiter or coordinator, were impossible to reach. Although part of the challenge of recruiting local sex workers was the inability to identify them, of those for whom the research team got leads, recruitment was unsuccessful. The interviewers attempted in both islands and came close in Saint Kitts to reaching local girls through taxi drivers and bar managers. In the end, both women refused.

- Scheduling and time constraints. Although the research team, during each visit to Saint Kitts and Nevis comprised of a five-member interview team, and was available for early morning and late evening interviews, it was still often a challenge to accommodate the schedules of all participants and to work within their available time preferences. Sometimes participants would cancel or reschedule interviews to times when the team was out doing others.

Sometimes the inability of the team to be ready at short notice or to be able to schedule multiple interviews at one time was a function of geographic location. Discussion groups also required the attendance of more than one member of the team.

- The preparation for and hosting of the Music Festival during the second trip to Saint Kitts and Nevis meant that many ministry personnel were busy and not available for interviews, had to cut interviews short or had to delegate other staff members at the last minute.

- Immigration sweeps of illegal residents following the Cricket World Cup which made it difficult to locate and convince the Spanish-speaking sex workers to talk to the research team, and which may have later influenced their decision to deny doing sex work

The following are resulting limitations to the assessment and gaps in information:

- No English-speaking CSWs were interviewed in either Saint Kitts or Nevis. The team had to question taxi drivers and bar owners about local girls involved in sex exchange and then rely on them to contact these girls and set up the appointments. Unfortunately, they were unsuccessful due to multiple reasons including the girls' schedules and unwillingness to talk about it or admit to it to the team. What was known about these local girls was discovered through these informal interviews with these drivers and bar owners.

- No Spanish-speaking CSWs were interviewed in Nevis and those that came to the discussion group in Saint Kitts denied engagement in sex work. Therefore questions on exchanges with clients and condom use during transactions, as well as any other habits and behaviours surrounding sex work is still unknown. What is known about these women and their lifestyle is the result of an informal interview with their outreach worker.

- Regarding Christian clergy, only members of one denomination were interviewed (in Saint Kitts) and none in Nevis, despite several attempts to reach other denominations due to their unavailability during the research period in both islands. Therefore, it is not possible to compare religious influences across both islands and neither is it possible across religions to be able to make general inferences about religion and its influences on HIV awareness, vulnerability and risky behaviour. There is also need to have more discussions with the church leaderships to be able to knit together the key religious doctrines that are being taught to and influencing the behaviours of the population.

- There was limited recruitment of CSPs in rural areas in Saint Kitts due to conflicts with scheduled interviews in the urban area and the late establishment of contact with personnel from rural areas. Conducting interviews often provides investigators with further leads. Unfortunately, timeframe did not allow for follow up on additional leads. These interviews also took time to be scheduled given the hectic demands of the medical personnel.

Other gaps in information are the result of research design—

- In hindsight, taxi drivers should have been identified as a target group given their role in facilitating the transaction of commercial sex workers and their clients, either by providing transport or by liaising between the client and the sex worker. However, until we began the interview process and began talking to taxi drivers and bar owners during informal conversations, it was not apparent the role they played in these transactions or to how much they were privy.

CHAPTER 6: CONCLUSION

The findings from "An HIV and AIDS situational assessment: Barriers to access to services in Saint Kitts and Nevis" present a broad picture of the opinions of different communities in Saint Kitts and Nevis on HIV and AIDS; from who they think is at risk for HIV and AIDS to their understanding of the factors placing them at risk and the best ways to provide services. The emergence of themes across the participant groups is significant in the development of key recommendations for guiding strategic planning and programming with vulnerable groups. The objectives of the assessment are—

- To develop stakeholder-driven definitions and profile of the groups at high risk for HIV infection (vulnerable groups) in both Saint Kitts and Nevis.
- To understand the barriers to providing HIV and AIDS services to vulnerable groups from three key perspectives: clinicians/health care workers, program managers and implementers, as well as clients who are accessing services.
- To determine the needs for services and provide concrete recommendations for programming targeting vulnerable groups.
- To provide concrete recommendations for strengthening and implementation of programs for inclusion to the revised National Strategic Plan.

Defining Vulnerable Groups

One of the objectives of the assessment was "to develop stakeholder-driven definitions and profiles of the groups that are at high risk for HIV infection (vulnerable groups) in both St Kitts and Nevis." It is well known that high-risk behaviour (lack of condom use, multiple partners, injection drug use) as well as other social or economic determinants (poverty, access to health care, unfaithful partners) puts one at greater risk for HIV transmission. Programmatically, in low-prevalence settings such as Saint Kitts and Nevis, it is important to define the groups that might be most exposed to behaviours/determinants for HIV infection. This allows for programming to be targeted, as opposed to a more general population approach. Based on the findings of this assessment, the following vulnerable group categories (either because of individual behaviours or because of other determinants) emerged as priority populations for targeted programming:

- Men who have sex with men (MSM) and Men who have sex with men who also have sex with women (MSM/W)
- Heterosexual women ("at-risk" women) who fall within the following categories:
    - Younger women (between the ages of 15-35), who are engaging in multiple concurrent sexual partnerships in exchange for goods (transactional sex, "top-up" sex, etc.) and/or who engage in sex with older men.

- Women who have male partners engaging in multiple sex partnerships
- Commercial sex workers (CSW) including migrant women, venue-based sex workers (hotels, bars, etc.)

To mitigate the impact of HIV and AIDS, programming efforts should target—

- People Living with HIV and AIDS: HIV-positive individuals who do not have access to regular care or who have difficulty maintaining levels of care.

MSM and MSM/W

The MSM or MSM/W interviewed had complex ways of defining themselves. Many were currently having sex with women or had sex with women in the past. Some of them also reported engaging in multiple sex partnerships and/or transactional sex. Even though many of the men were aware of the risk factors for HIV, this was not necessarily translated in behaviours, such as consistent condom use with regular and non-regular partners. Fear of stigma and discrimination was a major concern of the men and prevented them from disclosing their sexuality to their clinical care providers.

Key Recommendations for programming targeting MSM include the following:

- As a result of the fear of stigma and discrimination, programming efforts should be focused on peer outreach and social networking programs (such as those established by the Alliance) to gain access into the MSM community. Outreach workers can provide regular one-on-one messages and distribute condoms.
- Communication messages for MSM/MSMW need to be focused on increasing the use of condoms with both regular and non-regular partners. Condom negotiation skills, consistent condom use with both male/female and regular/non-regular partners, as well as increasing the knowledge of the "window period" with respect to HIV test results are all appropriate messages for this vulnerable population.
- Identifying bisexual men is particularly problematic, as many are on the "down low". Although controversial, the need to develop messages regarding safe sex behaviours for bisexual men should be considered a part of a national prevention campaign.
- Clinical care providers need training on how to engage their male patients sensitively in discussions about sexuality and sexual practices. If these men admit to male partnerships, providers should be educated on active listening, asking questions without judgment, and providing appropriate behavioural messages targeting this population. In addition, there needs to be more of a focus on the importance of messages targeting men's health (whether MSM or heterosexual) at the national level.
- Workplace tolerance and sensitization messages and training might also be needed as a method in national-level programming targeting MSM.

"At-risk" Women

This assessment found that there are key groups of women especially vulnerable to HIV as a result of high-risk behaviour among themselves or among their partners. There are local and foreign commercial sex workers in Saint Kitts. The population is difficult to target, since these women do not consider themselves sex workers and do not congregate in "traditional" venues for sex work such as brothels or on the street. There is also a population of women (especially young women) who exchange sex for favours or material goods (transactional sex) and/or engage in sex with older men. This assessment also interviewed women who have regular partners and are faithful, but consider themselves at risk for HIV as a result of multiple partnerships among the men (who might also be having sex with younger women accepting favours).

Key recommendations for programming efforts for "at-risk" women:

- For local women engaging in sex work, there needs to be a greater effort to distribute condoms and other materials in "hot spots" such as Frigate Bay. Also, taxicab drivers and hotel workers are potential "gate keepers" who could be considered for interventions for English-speaking sex workers. Stronger linkages need to be forged with taxicab associations and with the tourism industry.

- Because of the underground nature of the sex work among Spanish-speaking women, a particular effort needs to be made with groups that have contact with Spanish-speaking sex workers. For example, owners of Spanish bars and Spanish-speaking clinical care providers can be given condoms and prevention materials translated into Spanish to distribute to the women.

- There is a need to target young women and/or women engaging in transactional sex. Intensified peer outreach is a method to gain access to these women in places where they congregate such as bars, restaurants, beauty salons, and clothing shops, especially on Fridays (pay day). Outreach can be focused on distributing condoms and prevention literature to both the women and the "gate keepers" (shop owners and bar managers) at these sites. A special effort needs to be made to work with private cell phone companies to promote condom distribution, and to sensitize company managers to the "top-up" phenomena.

- There is a need to address issues of gender dynamics and economic empowerment with women—especially young women—encouraging the management of finances and being in healthy relationships with men. Session/group-based interventions for young women might be an appropriate form of intervention for these types of issues.

- There is a need to promote greater communication between parents and children in regards to sex. Since parents can influence children's sexual decisions, campaigns that focus on parent-child discussions about healthy relationships and sexuality can be implemented at a national level.

- Cross-generational sex is also a problem that was cited by many of the women interviewed. Possible recommendations include education campaigns for young women regarding the risks of having sex with older men and promotion of the female condom, since it is woman-initiated.

- Multiple partnerships among men constitute a high-risk behaviour that requires special attention in Saint Kitts and Nevis. One recommendation to combat this complex issue is to implement educational workshops and/or social marketing campaigns targeting young men. These programs can focus on such themes as questioning traditional gender norms, women's equality, fatherhood, being faithful and wearing condoms and promoting positive male role models.

- For this assessment, older women from faith-based communities were interviewed. There might be a need to promote educational campaigns or peer outreach with older married women, as they might not be thoroughly educated about HIV transmission and the risk factors involved.

People Living With HIV and AIDS (PLWHA)

While the biggest vulnerability faced by PLWHAs is their susceptibility to developing AIDS, PLWHAs must face additional challenges in their ability to sustain themselves physically, emotionally and nutritionally through social and psychosocial support networks, accessing adequate and timely care and treatment, and being able to nourish themselves in order stay healthy. The factors that most affect their ability to deal with these challenges include fear of stigma and discrimination, exacerbated by a lack of faith in the public health care system to maintain confidentiality, as well as the availability of appropriate treatment and access to proper nutrition. For PLWHAs on their own, the expense of adequate nutrition and some medications not available in Saint Kitts and Nevis makes it difficult for them to maintain a proper health regime.

Specific programming recommendations include—

- Psychological Support—There is a great need for professional psychosocial support and one-on-one counselling services. A trained psychologist/psychiatrist should be recruited and included in the clinical care team in Saint Kitts and Nevis. This person can have the dual role of supporting the HIV-positive clients in providing confidential, one-on-one therapeutic support and can also provide support to the clinicians who are working with patients in advising, referrals, and addressing mental health issues of disclosure and depression.

- Nutritional support—A dietician and/or increased supplemental food support, food vouchers, etc. can be incredible useful to HIV-positive individuals trying to maintain healthy life styles, but who might not have enough knowledge or resources to maintain a proper diet. Such a person might also need to be a member of the clinical care team. The vouchers should be accessible through private care facilities for PLWHAs who do not want to access public facilities.

For programmatic recommendations to address issues of confidentiality, stigma, and discrimination for PLWHA see the following sections.

Understanding Barriers to Access and Service Delivery Needs

In understanding barriers to accessing services in Saint Kitts and Nevis, the following are specific issues that emerged from the assessment requiring programmatic focus:

Confidentiality

The issue of confidentiality is the major theme that has emerged amongst all groups interviewed. It is important to note that both the vulnerable groups and the service providers discussed flaws in the confidentiality systems in Saint Kitts and Nevis. There is a general lack of trust in the health care system, and that is often translated into a fear of accessing HIV testing services.

Despite the work done the last 5 years to strengthen confidentiality systems, the community's perceptions and fear of a weak system of confidentiality must be treated as a very real issue. In a small community, what might be perceived as regular or normal in terms of talking about other people's "business" ultimately has an impact on whether people feel comfortable accessing such sensitive services as HIV testing. Apart from the people sharing information, participants feel that the structure and layout of the public health centres did not lend to confidential conversations, and that it was possible to be overheard, even if the staff did not disclose information.

Key recommendations for addressing issues of confidentiality include the following:

- Reinforcing established guidelines and practices for confidentiality. This includes providing consistent messages to staff at health care facilities (doctors, nurses, administrative staff, housekeeping staff) about the rules on confidentiality.

- A social marketing campaign and or media campaigns addressing the saying, "Kittitians does talk," would be an appropriate intervention in the community to reinforce the notion that although "people does talk," the health care providers and other health facility staff are committed to protecting confidentiality.

- Policies outlining the penalization of health care staff for breaching confidentiality and procedures, including a rating system for clinics with confidential policies in effect, should be visible in both public and private clinical settings.

- With regard to physical infrastructure, implementing soundproofing measures should be considered within designated rooms to protect confidential discussions. HIV testing and counselling should be implemented in designated spaces, and results should be kept in locked cabinets. HIV lab results should be sent in a separate envelope from other test results and should only be addressed to designated staff.

Stigma and Discrimination

The crippling effects of stigma and discrimination in preventing vulnerable groups and the general population from accessing HIV and AIDS services cannot be underestimated. This was an issue cited consistently throughout this assessment, and it should be the primary focus of the strategic planning process. Unfortunately, vulnerable groups are susceptible to experiencing stigma and discrimination in Saint Kitts and Nevis. Issues of disclosure of sexuality (in the case of MSMs), disclosure of status (in the case of PLWHAs), or sexual conduct (in the case of commercial sex workers) limits access to these groups, therefore making it difficult to provide targeted programming.

Fear of stigma and discrimination has led many PLWHAs to refuse to reveal who they are—even to friends, partners and families—often leading to isolation and severe depression. Often a people's private health care professional are the only person who knows their HIV status and can provide emotional support. This fear of stigma and discrimination has affected virtually all aspects of the PLWHAs' lives. It has affected their willingness to be more visible champions for change and advocates for human rights; it has limited their ability to provide peer support to each other; and it has made it difficult to conduct effective prevention, care and treatment programmes, as they will not self-identify or engage in activities that disclose their status such as collecting medications at the pharmacy.

Key Recommendations

While a human rights desk and a formal complaint procedure have been established to address occurrences of discrimination against PLWHA, there is a need to make these processes widely known in Saint Kitts and Nevis. This process can be disseminated through the media (TV/radio, billboards, posters, etc.)

There is a need to conduct a broad sweeping sensitization campaign addressing stigma and discrimination against PLWHAs and perhaps other vulnerable groups in workplaces, schools, health care facilities and churches. This campaign can be implemented through outreach workers or with a media campaign.

OTHER RECOMMENDATIONS

Engaging "Gate Keepers" and Accessing "Hot Spots"

This assessment was not able to state definitively where all the "hot spots" are for meeting sexual partners and engaging in high-risk behaviours. However, there was some insight gained from young people and from interviewer observations about the places where people meet sexual partners. Friday nights tend to be the central "hang out" evening, and places such as Frigate Bay and "Jiggy" clubs (which mostly operate outside of Basseterre), Carnival, as well as other seasonal events are venues where ongoing targeted interventions need to occur. One interviewer noted that drug transactions seem to be taking place in bars around Newtown. Other hot spots are noted above, especially for targeting high-risk young women.

Recommendations for targeting hot spots and engaging "gate keepers" are inclusive of using peer outreach models. Outreach workers should be distributing condoms and providing dissemination materials to youth and other vulnerable people. Relationships should be forged with bar owners, club workers and other proprietors, so they can gain ownership of this effort.

Also of note is the need to work closely with private enterprises, such as BMobile and Digicel, in developing campaigns linked to the "top-up" phenomenon. A concentrated effort should be made to address this issue, as it especially can become key in accessing young people.

Working With Faith-Based Communities

There is a need for increased outreach to the Rasta community. Including them in community forums and trainings, reaching out to non-traditional health care providers, and providing culturally appropriate prevention materials will be central in restoring the links between these communities and HIV and AIDS program efforts. There is also a need to work with faith-based leaders to plan activities such as monthly/quarterly sermons on HIV for churchgoers, implementing session-based interventions for couples attending baptism and marriage counselling classes (i.e., providing HIV testing messages for those getting married or for young people coming to get children baptized). Also key here is supporting the faith-based organizations in implementing basic process monitoring and evaluation tools to help strengthen abstinence-based programs (such as developing pre-/post-testing tools for group activities).

Increasing Institutional Capacity for Monitoring and Evaluation (M&E)

There is a need to strengthen M&E systems and capacity in community-level programs and in programs sponsored by ministries other than the Ministry of Health. These programs should be given the training, tools, and human resources to document their work and report to the National AIDS Program (i.e., submission of quarterly reporting forms, documentation of workshops, pre-and post-test measures, etc). Thus, these activities can be documented, strengthened, and ultimately contribute more fully to the overall AIDS programming efforts.

There is a large gap in HIV and AIDS information, as the private health sector is not very well integrated into the overall health system. Even though most respondents prefer the private health sector and many health professionals work in both the private and public sectors, reporting is focused on the public sector. Mandatory HIV reporting is not enforced within the private sector, thus resulting in not-as-accurate a picture of the epidemic. Policies to integrate private health care fully into participating with communicable disease reporting should be encouraged.

Finally, the information in this assessment should not be used in isolation, but rather in conjunction with relevant behavioural and program data such as the BSS, the HSPA, STD rate data, prison serosurveillance study, and program monitoring data. These data sources should be used to make informed decisions for the direction and continued improvement of programs targeting those at highest risk for contracting HIV and AIDS.

REFERENCES

Ameen, A., Lloyd. E. 2004. Assessment of the National HIV/AIDS Programme (NAP) of the Federation of St. Kitts and Nevis. Caribbean Health Research Council: Trinidad.

Caribbean Epidemiology Center (CAREC). 2007. Behavioural Surveillance Surveys (BSS) in Six Countries of the Organisation of Eastern Caribbean States (OECS) 2005-2006 Final Report. CAREC-SPSTI, Port of Spain.

Central Intelligence Agency (CIA). 2007. CIA World Factbook. Washington DC: Central Intelligence Agency. Available at http://www.cia.gov/cia/publications/factbook/geos/do.html.

MEASURE Evaluation. 2006. Nevis Caribbean Region HIV and AIDS Service Provision Assessment. Calverton, MD: Macro International Inc.

MEASURE Evaluation. 2006. Saint Kitts Caribbean Region HIV and AIDS Service Provision Assessement. Calverton, MD: Macro International Inc.

Pan American Health Organization. Saint Kitts and Nevis Country Profile. Available at http://www.paho.org/English/DD/AIS/cp_659.htm.

Poverty Reduction Strategy for Saint Kitts and Nevis draft.

Saint Kitts and Nevis Ministry of Finance, Development and Planning: Statistics Division. 2004. Saint Kitts and Nevis Statistical Review. Basseterre, Saint Kitts.

Saint Kitts and Nevis Strategic Plan 2001-2005.

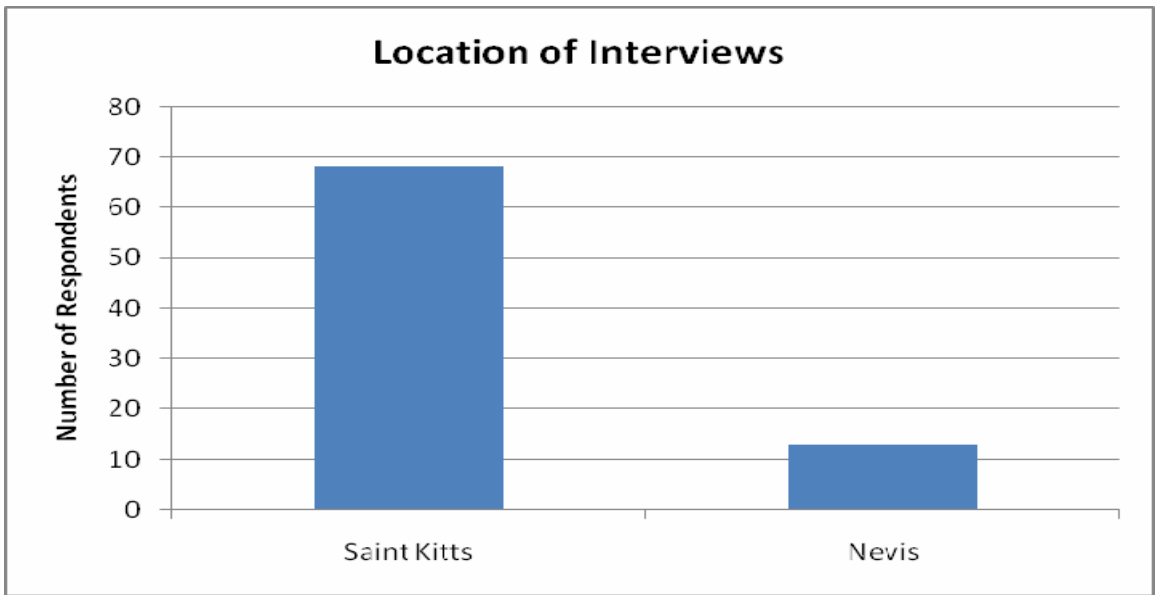
The World Bank, 2002. Project Appraisal Document on a proposed Loan in the Amount of US$ 4.045 Million to St. Kitts/Nevis for a HIV/AIDS Prevention and Control Project . Available at http://wwwwds.worldbank.org/servlet/WDSContentServer/IW3P/IB/2003/01/17/000094946_0301090401388 2/Rendered/PDF/multi0page.pdf (Accessed August 22, 2007)

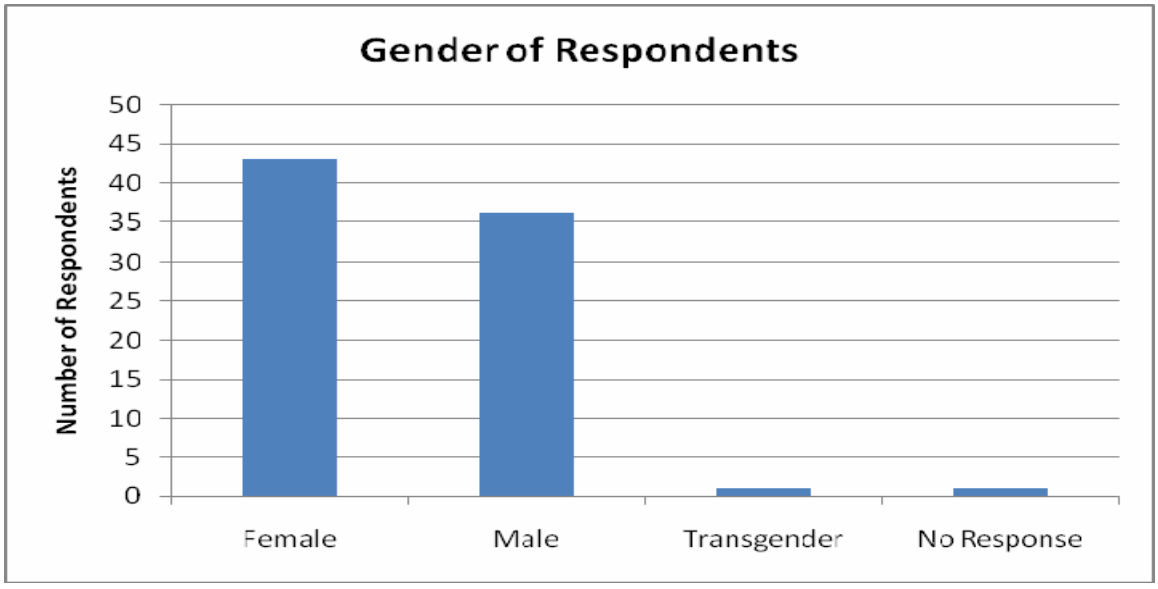
United Nations General Assembly Special Session on HIV/AIDS (UNGASS). 2006. Country Report—St. Christopher and Nevis. Available at http://data.unaids.org/pub/Report/2006/2006_country_progress_report_st_kitts_nevis_en.pdf. (Accessed August 22, 2007).

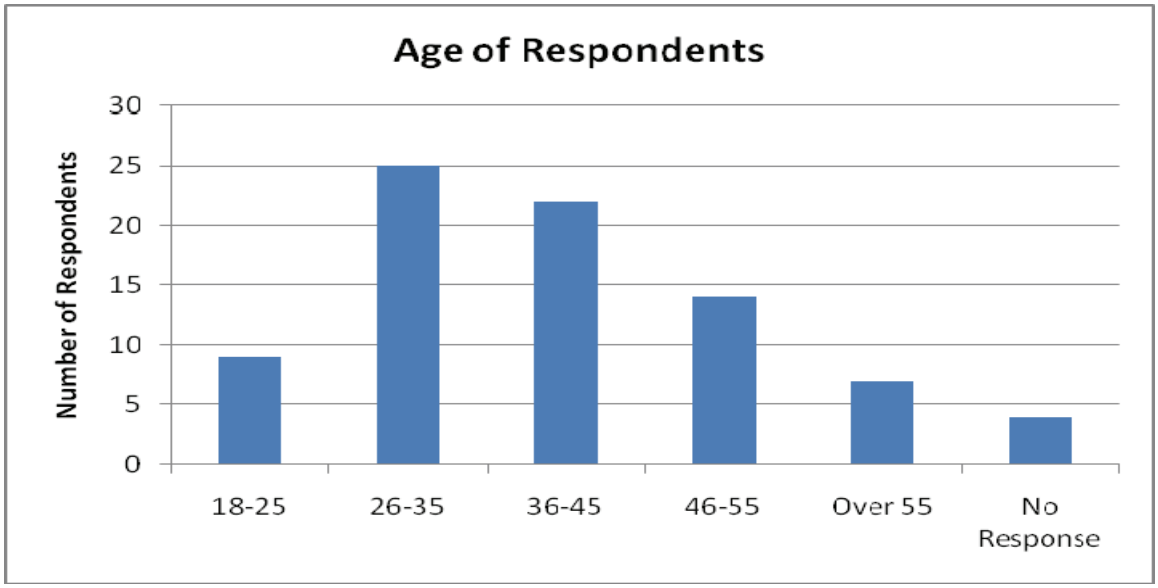
World Health Organization. Core Health Indicators: Saint Kitts and Nevis. Available at http://www.who.int/whosis/database/core/core_select_process.cfm?country=kna&indicators=selected&language=en.

APPENDIX A: AGGREGATED FIGURES FOR SITUATIONAL ASSESSMENT

The following are figures displaying aggregate data from the demographic forms that gathered basic quantitative data from participants






Age of Respondents
Number of Respondents
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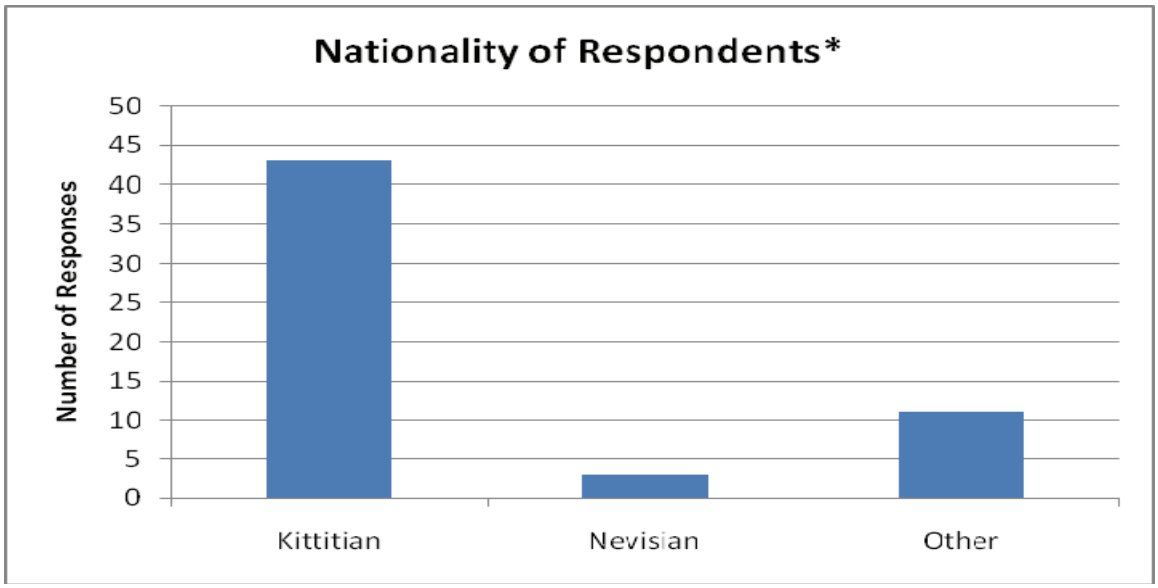
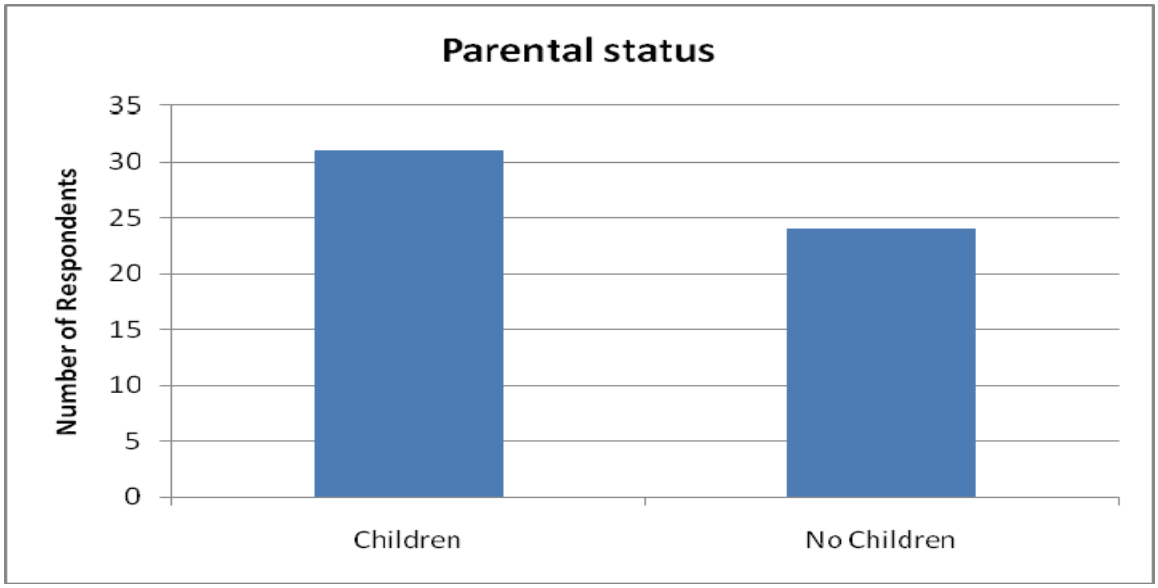
25
20
15
10
5
0
18-25
26-35
36-45
46-55
Over 55
No Response


Nationality of Respondents*
Number of Responses
50
45
40
35
30
25
20
15
10
5
0
Kittitian
Nevisian
Other


Parental status
Number of Respondents
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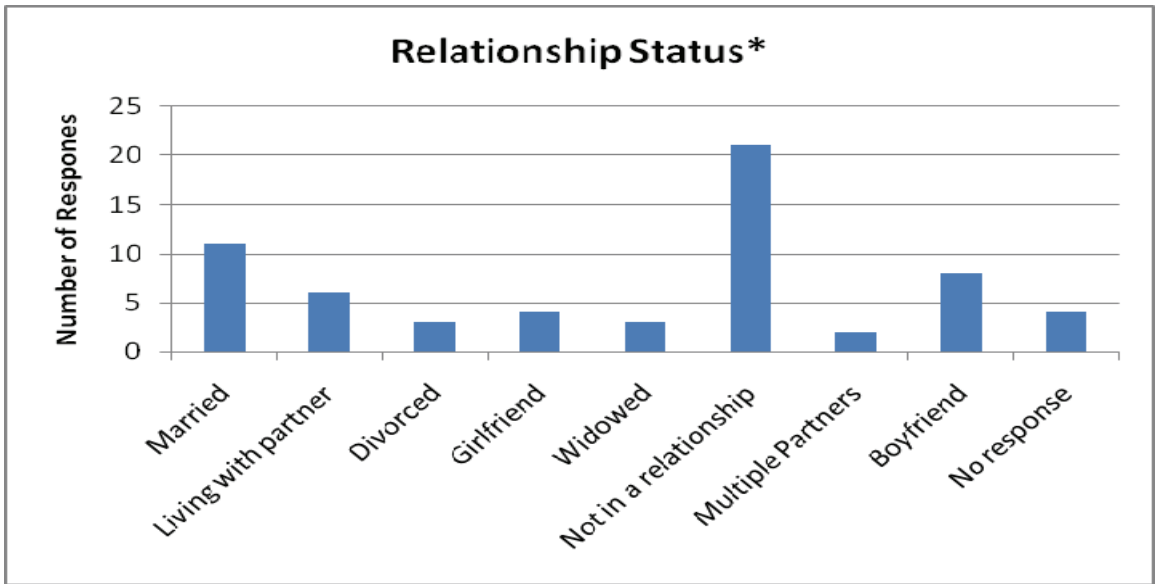
30
25
20
15
10
5
0
Children
No Children


Relationship Status*
Number of Respones
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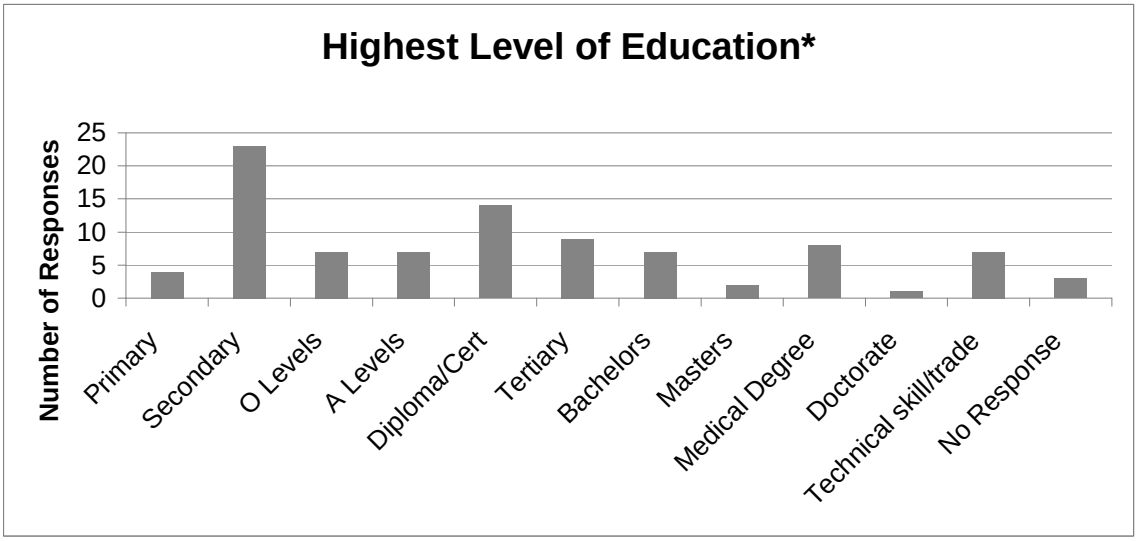
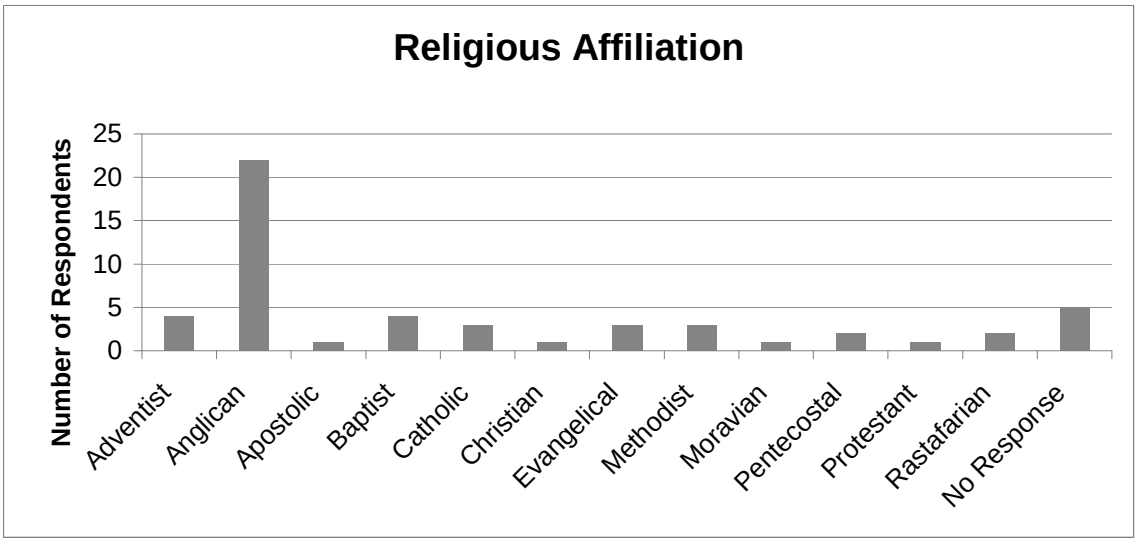
20
15
10
5
0
Married
Living with partner
Divorced
Girlfriend
Widowed
Not in a relationship
Multiple Partners
Boyfriend
No response





***For these questions, respondents could answer more than one category

APPENDIX B: RESOURCES FOR PROGRAMME AND INTERVENTION PLANNING

There are many different sources of information to learn about the variety of HIV and AIDS interventions that have been implemented throughout the world. The assessment team would like to highlight three that may be useful resources with regards to the information provided in this report to generate ideas for interventions targeting specific groups:

www.effectiveinterventions.org- listing of interventions being implemented in the United States and internationally supported by the Centres for Disease Control and Prevention. This website offers resources and intervention packages for group and community level interventions, as well refers to sites where training can be accessed to implement these interventions.

http://www.promundo.org.br- is a program whose mission is to prevent gender inequity and violence among children, youth and women. It is a project that has been successfully implemented in Brazil and perhaps can be a resource for working in St Kitts and Nevis.

www.balmingilead.org- a resource for faith-based organizations implementing HIV and AIDS programming providing recommendations on how faith based communities can actively engage in the response to HIV and AIDS

APPENDIX C: RESULTS FROM SELECTED BSS INDICATORS

Results for selected BSS Key Indicators	All 6 countries	Saint Kitts & Nevis General pop.		All 6 countries
INDICATOR	In-school youth 10-14 years	15 - 24 years	25 - 49 years	Taxi drivers, 15 to 49
Percent of respondents who correctly identified the 'ABC' of HIV prevention (Denominator: All people surveyed)	55%	70%	67%	73%
Percent of respondents who both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions around HIV transmission (Denominator: All people surveyed)	27%	52%	50%	44%
Percent of respondents who knew of HIV mother-to-child transmission during pregnancy (Denominator: All people surveyed)	NA	89%	88%	87%
Percent of respondents who knew that medication can reduce the risk of mother-to-child transmission (Denominator: All people surveyed)	NA	36%	35%	31%
Percent of respondents with accepting attitudes towards people living with HIV and AIDS (Denominator: All people surveyed)	40%	1%	5%	5%
Percent of respondents reporting an STI in the last 12 months (Denominator: People who had sex in the last 12 months)	NA	5%	10%	4%
Percent of respondents who had sex2 before the age of 15 (Denominator: All people surveyed)	NA	22%	32%	40%

Results for selected BSS Key Indicators	All 6 countries	Saint Kitts & Nevis General pop.		All 6 countries
Percent of respondents who have had sex with a non-marital non-cohabiting3 partner in the last 12 months (Denominator: People who had sex in the last 12 months)	NA	98%	56%	48%
Percent of respondents with multiple5 non-marital non-cohabiting sexual partners in the last 12 months (Denominator: People who had sex in the last 12 months)	NA	46%	23%	20%
Percent of respondents with multiple5 non-marital non-cohabiting sexual partners in the last 12 months (Denominator: People who had sex in the last 12 months)	NA	46%	23%	20%
Percent of respondents reporting the use of a condom the last time they had sex with a non-marital non-cohabiting sexual partner (Denominator: People with non-regular non-commercial partners in the last 12 months)	39%	56%	52%	59%
Percent of respondents reporting consistent condom use with non-marital non-cohabiting sexual partner (Denominator: People with non-regular non-commercial partners in the last 12 months)	NA	16%	29%	42%
Percent of males who had sex with a sex worker in the last 12 months (Denominator: All males surveyed)6	NA	7%	18%	9%
Percent of respondents who think it is possible to get a confidential HIV test in their community (Denominator: All people surveyed)	NA	60%	62%	73%
Percent of respondents who ever had an HIV test (Denominator: All people surveyed)	NA	20%	61%	48%

APPENDIX D: RESULTS FROM SELECTED HSPA INDICATORS

Indicator	Saint Kitts	Nevis
Of the public facilities sampled, percent of providers with an accepting attitude towards PLHIV (Denominator: Total number of providers interviewed)	63% of 30 providers interviewed	47% of 17 providers interviewed
Of the number of public facilities offering ART, number ever offering ART services to residents of other countries (Denominator: Number of public facilities offering ART)	The HSPA showed that 2 public facilities offer ART and of those, neither offer ART to residents of other countries	The HSPA showed that 1 public facility offers ART services and that facility does not offer ART services to residents of other countries
Of the number of public facilities offering PMTCT, number ever offering PMTCT services to residents of other countries (Denominator: Number of public facilities offering PMTCT)	The HSPA showed that 11 public facilities offer PMTCT services and of those, none offer PMTCT to residents of other countries	The HSPA showed that 7 public facilities offer PMTCT services and all of those have offered PMTCT services to residents of other countries
Percent of public facilities with an HIV testing system that has an observed informed consent policy for VCT in all relevant service sites (Denominator: Number of public facilities with an HIV testing system)	9% of 11 facilities	57% of 7 facilities
Percent of public facilities with an HIV testing system that has an observed register with test results in all relevant service sites (Denominator: Number of public facilities with an HIV testing system)	55% of 11 facilities	86% of 7 facilities

Indicator	Saint Kitts	Nevis
Percent of public facilities with an HIV testing system that has an observed record of clients receiving test results in all relevant service sites (Denominator: Number of public facilities with an HIV testing system)	36% of 11 facilities	71% of 7 facilities
Percent of public facilities with an HIV testing system with visual and auditory privacy in all counselling areas (Denominator: Number of public facilities with an HIV testing system)	46% of 11 facilities	71% of 7 facilities
Percent of public facilities with an HIV testing system with an observed policy or guideline on confidentiality of HIV test results in all relevant service sites (Denominator: Number of public facilities with an HIV testing system)	18% of 11 facilities	57% of 7 facilities
Percent of public facilities with an HIV testing system with at least one counsellor trained in pre and post test counselling (Denominator: Number of public facilities with an HIV testing system)	100% of 11 facilities	86% of 7 facilities
Percent of public facilities offering STI services (Denominator: Total number of public facilities)	100% of 13 facilities	100% of 7 facilities
Of the public facilities offering STI services, percentage with condoms in any site (Denominator: Number of public facilities offering STI services)	100% of 13 facilities	100% of 7 facilities

Indicator	Saint Kitts	Nevis
Percent of public facilities with an HIV testing system that offer nutritional rehabilitation services (Denominator: Number of public facilities with an HIV testing system)	18% of 11 facilities	14% of 7 facilities
Percent of public facilities with an HIV testing system that offer fortified protein supplement (Denominator: Number of public facilities with an HIV testing system)	9% of 11 facilities	14% of 7 facilities
Percent of public facilities that offer care and support services with an observed confidentiality guideline in all relevant sites (Denominator: Number of public facilities offering care and support services)	0% of 3 facilities	0% of 1 facility
Percent of public facilities with HIV testing system that offer youth-friendly services (Denominator: Number of public facilities with an HIV testing system)	36% of 11 facilities	0% of 7 facilities