SAINT LUCIA

STATEMENT BY

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TO THE

HIGH-LEVEL MEETING OF THE GENERAL ASSEMBLY AND COMPREHENSIVE REVIEW OF THE PROGRESS ACHIEVED IN REALIZING THE TARGETS SET OUT IN THE 2001 DECLARATION OF COMMITMENT ON HIV/AIDS

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Background

The Government of Saint Lucia is committed and has an unflinching obligation to reverse the spread and mitigate the impact of HIV/AIDS on the entire population of Saint Lucia. This goal is eloquently promulgated in the National HIV/AIDS Strategic Plan for 2005-2009, which the Cabinet of Ministers endorsed as the blueprint for the national response to the HIV/AIDS pandemic in 2004. This goal is also consistent with the goal of universal access to HIV prevention, treatment, care and support – that is, providing access to the information and services to all those who need it by 2010.

In response to the HIV/AIDS pandemic and on the basis of the National Strategic Plan, the government is dedicated to the development and implementation of a comprehensive and integrated package of prevention, treatment, care and support programs and initiatives to reach all citizens of Saint Lucia who need them.

This process involves the participation of a wide range of stakeholders including Civil Society Organizations and particularly persons living with HIV/AIDS. This broad-based participation is at all levels from the planning to implementation stages and at community to sub-national to national levels.

The government is receiving additional support for this process from international agencies, bilateral institutions and donors such as the World Bank, the Global Fund, UNAIDS, DFID, PAHO, CAREC, CARICOM/PANCAP, FHI, UWI, friendly governments, and other agencies and institutions.

Situation and Response Analysis

Saint Lucia faces special development challenges due to its small size and vulnerability to natural disasters (particularly due to storms and hurricanes) and other external shocks. Our country has witnessed several fluctuations in economic growth since its independence in 1979. Negative growth in the early 1980s was followed by annual growth rates averaging 3 percent in the 1990s. The economy experienced major structural transformation between 1997 and 2006 with the growing importance of services, especially tourism, and the reduction of the contribution of the agriculture and manufacturing sectors to overall GDP. The country faces institutional capacity weaknesses in a number of areas and per capita costs of basic social and infrastructure services are high due to the small size of the population (just over 160,000 in 2005).

The first case of AIDS in Saint Lucia was reported in 1985. By the end of 2005 the total number of reported cases of HIV infection climbed to 546. About 51 percent of reported cases have advanced to AIDS, and 48% have succumbed to AIDS-related conditions. Surveillance data from official sources indicate that from 1990 to 2001, HIV prevalence among women attending antenatal clinics has ranged from 0.6 percent to 4.0 percent, suggesting that the epidemic in St. Lucia is still at a low level. Saint Lucia, therefore, is well poised to prevent the epidemic from

escalating and posing a significant problem to its current and future socio-economic development.

Gross underreporting of cases is suspected due to inadequate monitoring, poor surveillance systems and a reluctance of persons to come forward for HIV testing because of high levels of stigma and discrimination. These factors have resulted in a poor understanding of recent trends of the epidemic, particularly with respect to important vulnerable groups such as commercial sex workers (CSWs), men who have sex with men (MSMs), sexually transmitted infection (STI) clients, pregnant women and other sub-populations.

Like most countries in our region, the HIV epidemic in Saint Lucia is propelled by heterosexual intercourse – with transactional sex as a significant component – within a milieu of poverty, unemployment and gender inequalities. Bisexual transmission occurs among 10 percent of reported cases. However, strong cultural and social taboos that stigmatize homosexual relations, including the criminalization of buggery, connote that the true attributed proportion may be reasonably higher. Mother-to-child transmission accounts for about 4 percent of reported cases.

About 70 percent of reported cases occurred during the last decade ending in 2005 – in spite of all our efforts at prevention for almost two decades.

The findings of a Situation and Response Analysis conducted in 2003 surmised the following to provide some explanation for this phenomenon:

- Poor and incomplete surveillance systems
- Lack of resources
- Low levels of buy-in from policy-makers
- High levels of staff turnover

- Malaise to plan, monitor and manage the epidemic in a sustainable manner
- Limited focus on treatment, care and support for persons infected or affected by HIV AIDS

The apparent need to intensify and expand the national response to be more multi-sectoral, multi-dimensional and coordinated has now became clear and urgent.

Expanding the Response using "Three Ones" Principles

At the 26th session of the United nations General Assembly (UNGASS) in June of 2001, the world acknowledged the threat and challenges of HIV/AIDS and pledged to take action through the adoption of the Declaration of Commitment on HIV/AIDS. This Declaration of Commitment provided a strong foundation for important developments which occurred subsequently at the global level, and which I believe will make significant contributions toward the goal of universal access by 2010 and beyond. These major developments include:

- The establishment of the Global Fund to fight AIDS, Tuberculosis and Malaria to provide additional funds to low and middle-income countries;
- The significant reduction in prices of some important AIDS medicines;
- The 3 by 5 initiative which has served as a catalyst to quickly move countries and regions to increase the number of people on antiretroviral treatment; and
- The "three ones" principles which have been endorsed globally and implemented by many countries to achieve effective and efficient use of resources.

In order to intensify its response to the HIV/AIDS pandemic to provide easy access to HIV prevention, treatment, care and support for all who need it, the Government of Saint Lucia produced and endorsed the National HIV/AIDS Strategic Plan 2005-2009. This first critical step was taken early in 2004. The plan is based on a situation and response analysis of HIV/AIDS in the country and broad consultation with all major stakeholders. This ambitious plan proposes four main strategies:

1. Advocacy, policy, legislation and socio-economic development;
2. Comprehensive HIV/AIDS care for all people living with HIV/AIDS;
3. Prevention of further transmission of HIV; and
4. Strengthening national capacity to deliver an effective, coordinated, multisectoral response.

Consequently, the Government sought and received assistance from the World Bank for the HIV/AIDS Prevention and Control Project to support the implementation of the National HIV/AIDS Strategic Plan. This project is part of the third phase of the Bank's Caribbean Multi-Country HIV/AIDS Prevention and Control Adaptable Program Lending (APL) instrument approved in June 2001. The Saint Lucia HIV/AIDS Prevention and Control Project articulates four components:

1. Community and Civil society HIV/AIDS Initiatives;
2. Line (non-health) Ministries HIV/AIDS responses;
3. Strengthening the health sector response to HIV/AIDS; and
4. Strengthening institutional capacity for program management, monitoring and evaluation, and legal technical assistance.

The National AIDS Coordinating Council (NACC) was established in 2005. This body is the authority charged with the responsibility for overseeing and coordinating the national response. The Prime Minister is the chairman of the

NACC. Its membership is broad-based and comprises representatives from public and private sector stakeholder groups including government ministries, Civil Society Organizations, the private sector, support groups for persons living with HIV/AIDS and other relevant organizations and institutions. The NACC meets every quarter to discuss and make important decisions about the national HIV/AIDS response. The establishment of the NACC marks the second important step towards a coordinated national response to HIV/AIDS.

The National AIDS Program Secretariat (NAPS) - which became fully operational in January 2006 - is in-charge of coordinating the national response and serves as the administrative and operating arm of the NACC. The NAPS bears direct responsibility for monitoring and evaluating the national response. A monitoring and Evaluation framework for the national response was developed in 2005. This framework is based on indicators from the National Strategic Plan, UNAIDS, the Global Fund, UNGASS and other sources. The NAPS is working with implementing agencies and other regional and international partners to establish and/or strengthen the requisite surveillance and information-generation systems for continued and systematic monitoring and evaluation at programmatic, sub-national and national levels.

Saint Lucia has now established the three pillars required to facilitate the unity of coordinating entities, partnerships and funding mechanisms for concerted and collaborative action against the HIV/AIDS pandemic.

Key Issues for Achieving Universal Access

HIV prevention and HIV treatment must both be given top priority and equal focus. It will be impossible to provide antiretroviral therapy to all who need it if HIV prevention fails and new infections continue to increase year after year.

We can not even dream of getting close to universal access without placing children and young people at the centre. The full range of HIV programs and services must reach these two very important groups - otherwise the conditions that fuel this epidemic will persist and HIV/AIDS will prevail. Top priority must be given to children and young people who are most at risk, most vulnerable and most disadvantaged.

We must also acknowledge that we need to address the needs of our women. With the growing feminization of the epidemic many more women in all our countries are becoming infected. As more and more women become infected, more and more children will become infected through mother-to-child transmission.

It is quite distressing to find out that only 10 percent of pregnant women worldwide have access to programs and services that address mother-to-child prevention. This statistic is even lower in some countries, including severely affected countries. This is really appalling because it is about 10 years since research has convincingly demonstrated that this seemingly simple and straightforward intervention can save all babies from being born infected with HIV.

This experience with mother-to-child interventions provides important lessons for universal access in particular and what we are trying to achieve in general. It tells us that solid scientific evidence, a straightforward intervention and money

are not enough. For all these to work we must also mobilize and involve the community, we must address the stigma, we must garner political support in the community and at the highest levels, and we must associate them with education and counseling. We must also shake and modify some of our established conventions, traditions and taboos. For example it may no longer be true that "breast is best" for infants in all circumstances.

In closing I will look to the future and posit the question: What about the next twenty, thirty or even forty years?

In my humble view, the movement towards universal access must be supported by a social movement. This means that we must approach the epidemic in a very comprehensive manner. We must also address the long-term agenda even as we deal with the crisis of the epidemic on a daily basis.

I must mention five critical points which ~~must~~ have to be addressed from now to realize the goal of universal access by 2010 and to maintain it in the future:

1. Sustainable, predictable, guaranteed long term funding - We must start and keep talking about where the money will continue to come from in five, ten, twenty or thirty years from now. We must maintain and increase the political momentum to keep the money flowing. Thirty or forty years from today the people who started treatment now will still need antiretroviral therapy.
2. Human resources capacity is absolutely critical for small resource-constrained countries such as mine - not only in health services but also in social services as well. We must also move speedily to strengthen the health and social service delivery systems. We are now paying the price for decades of not making the requisite investments in the public and private services and staff. We have seen a professional "brain drain" with

key professionals in the health and social sectors, and a "brain hemorrhage" in the case of qualified nurses. The public sector delivery systems must be given priority for support and strengthening because in many countries this is the only place that the poor could afford to go to.

3. Availability of and access to medicines and diagnostics needs to be enhanced and accelerated to reach all who need them in the shortest possible time. We also need concerted efforts to discuss and resolve the issues around generics versus patents within the context of fundamental and basic human rights.
4. The broader determinants which drive the epidemic: stigma and discrimination in all forms, gender inequality, poverty, illiteracy. We need to take concrete actions against these drivers of the epidemic – particularly AIDS-related stigma and the inferior position of women – if we are to have any hope of ending the pandemic.
5. Sustained leadership and political support, not only from heads of state and other political leaders, but also from leaders in all walks of life. This is critical for continued political engagement, support in public opinion and normalizing of the epidemic.

I thank you very much for listening.