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HIV/AIDS Country Progress Report**



ST. VINCENT & THE GRENADINES

UNGASS COUNTRY PROGRESS REPORT

St. Vincent and the Grenadines



Ministry of Health and the Environment

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TABLE OF CONTENTS

ACKNOWLEDGEMENT	3
ACRONYMS AND ABBREVIATIONS	4
STATUS AT A GLANCE.....	5
OVERVIEW OF THE UNGASS INDICATORS DATA.....	6
OVERVIEW OF THE EPIDEMIC.....	11
NATIONAL RESPONSE TO THE AIDS EPIDEMIC	13
BEST PRACTICES	28
MAJOR CHALLENGES AND REMEDIAL ACTIONS	29
SUPPORT FROM COUNTRY’S DEVELOPMENTAL PARTNERS	32
MONITORING AND EVALUATION ENVIRONMENT	33
ANNEXES	36
1. Consultation/preparation process for the country report.....	36
2. National Composite Policy Index	
3. CRIS Database	

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
BSS	Behavioural Sero-prevalence Survey
CARE SVG	Care to Assist by Reaching out to Empower SVG
CAREC	Caribbean Epidemiology Centre
CDC	US Centers for Disease Control and Prevention
CHRC	Caribbean Health Research Council
CRIS	Country Response Information System
DFID	United Kingdom Department for International Development
DNA PCR	Deoxyribonucleic Acid / Polymerase Chain Reaction
EC\$	Eastern Caribbean Dollars
FSW	Female Sex Worker
GAP	Global AIDS Program
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HTLV-1	Human T-cell Lymphotropic Virus
IEC	Information, Education and Communication
MARP	Most At Risk Populations
MBTD	Minibus and Taxi Drivers
MERG	Monitoring and Evaluation Reference Group
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NAC	National HIV/AIDS Council
NAS	National HIV/AIDS Secretariat
NCPI	National Composite Policy Index
NGOs	Non Governmental Organizations
OECS	Organization of Eastern Caribbean States
OVC	Orphans and Vulnerable Children
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PCU	Project Coordinating Unit
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child Transmission
PSI	Population Services International
RDS	Respondent Driven Sampling
SVG	St. Vincent and the Grenadines
SVG +	St. Vincent and the Grenadines' Network of Persons living with and affected by HIV/AIDS
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counselling and Testing
VDRL	Venereal Disease Research Laboratory Test
YOB	Youth on the Block

STATUS AT A GLANCE

HIV/AIDS remains a serious health challenge in St. Vincent and the Grenadines affecting primarily those who are often socially and economically vulnerable. The epidemic is still being driven by cultural, behavioural and socio-economic factors.

Based on the cumulative reported cases at the end of 2006, the prevalence in the general population was computed at 0.4 % (472 reported cases). This prevalence was computed using the total population of 106,253 persons based on the 2001 Population Census. In order to be consistent with the reporting age groups of this document, the population distribution of 15-24 year olds in SVG is 21,008 persons and that of 25-49 year olds is 35,680 persons.

Although the incidence of HIV infection is steadily increasing in women, men continue to bear the major burden of the disease. This is depicted by simply analysing the current ratio of men to women with HIV infection which is averaging 1.3 to 1 over the last five years, compared to the previous ratio of about 2 to 1.

A revised National Strategic Plan which covers the period 2004 - 2009 was prepared with specific emphasis on care services and high risk vulnerable groups. The National HIV/AIDS Secretariat as the coordinating body for national HIV/AIDS responses, interacts and collaborates with key stakeholders and institutions, internal and external partners to ensure that appropriate mechanisms are implemented to address HIV/AIDS in the country. It has been proven that Vincentians are highly knowledgeable and experienced with HIV/AIDS. In fact, the Behavioural Surveillance Survey (BSS) conducted in 2005/2006 which comprised 979 participants (a representative sample) supported this fact with 99% of respondents demonstrating such knowledge. The challenge however, is translating that knowledge into action to achieve a positive impact in respect of HIV transmission.

There is no doubt that substantial progress has been made over the years in sensitizing the general public on the various facets of HIV through information, education and communication. However, it is crucial that the level of information dissemination be maintained to consolidate the advances that would have been made. In addition, there's need to sustain the excellent collaboration that has developed with internal and external partners.

The Government of St. Vincent and the Grenadines has remained committed to the prevention and control of the spread of HIV along with the care and support of people already infected in the country. Interventions have strengthened as a result of the influx of funds from the World Bank and Global Fund. A significant number of programmes have been successfully implemented among them: the Mother to Child Transmission (MTCT), Voluntary Counselling and Testing (VCT), Condom Promotion, Care and Treatment, Stigma and Discrimination and Orphans and Vulnerable Children. Resources have been allocated to Line Ministries and Civil Society Organizations to implement HIV/AIDS activities. The country as a Nation, has now achieved the three guiding principles of national responses "the three ones" in order to combat the HIV/AIDS epidemic in St. Vincent and the Grenadines.

Several stakeholder meetings and discussion sessions have been convened to prepare this comprehensive and balanced report on the existing HIV/AIDS situation in the country.

Table 1: Overview of the UNGASS indicators data

INDICATOR	CALCULATED INDICATOR		
<p>1: AIDS spending, by financing source for reporting period January 2006 to December 2007.</p> <p>(Source: Ministry of Finance, Planning and Development; Ministry of Health and the Environment Accounts Department)</p>	<p>Project Coordinating Unit (World Bank)</p>	<p>EC\$ 7,398,331.08 US\$ 2,740,122.62</p>	
	<p>Salaries and Allowances</p>	<p>EC\$ 6 70,811.00 US\$ 248,448.52</p>	
	<p>Global Fund</p>	<p>EC\$ 345,173.04 US\$ 127,841.87</p>	
	<p>Pan Caribbean Partnership</p>	<p>EC\$ 79,047.62 US\$ 29,276.90</p>	
	<p>DFID</p>	<p>EC\$ 92,266.06 US\$ 34,172.61</p>	
	<p>TOTAL</p>	<p>EC\$ 8,585,628.80 US\$ 3,179,862.52</p>	
<p>2 : National Composite Policy Index (Source: See NCPI)</p>	<p>See NCPI data, Part A and Part B</p>		
<p>3 – Percentage of donated blood units screened for HIV in a quality-assured manner</p> <p>(Source: Ministry of Health and the Environment, Milton Cato Memorial Hospital)</p>	<p>884 units (100%)</p>		
<p>4 – Percentage of adults and children with advanced HIV infection receiving antiretroviral combination therapy</p> <p>(Source: Ministry of Health and the Environment, Milton Cato Memorial Hospital)</p>	<p>Age group (years)</p>	<p>Males (%)</p>	<p>Females (%)</p>
	<p><15</p>	<p>5 (60)</p>	<p>5 (80)</p>
	<p>15 +</p>	<p>69 (82.6)</p>	<p>91 (56)</p>
	<p>Total</p>	<p>74 (81.1)</p>	<p>96 (57.3)</p>
<p>5 – Percentage of HIV-positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission</p> <p>(Source: Ministry of Health and the Environment, Milton Cato Memorial Hospital)</p>	<p>2006: 85% (n=20) 2007: 100% (n=18)</p>		

INDICATOR	CALCULATED INDICATOR			
<p>6 – Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV</p> <p>(Source: Ministry of Health and the Environment, Milton Cato Memorial Hospital)</p>	<p>2006: 100 % (2 males 2 females)</p>			
<p>7 – Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results</p> <p>(Source: Ministry of Health and the Environment, OECS, BSS 2005)</p>	<p>Age group (years)</p>	<p>Males (%)</p>	<p>Females (%)</p>	<p>Both sexes (%)</p>
	<p>15-19</p>	<p>n=256 (4)</p>	<p>n=288 (8)</p>	<p>6</p>
	<p>20-24</p>	<p>n=195 (12)</p>	<p>n=240 (12)</p>	<p>12</p>
	<p>25-49</p>	<p>n=291 (9)</p>	<p>n=256 (16)</p>	<p>12</p>
<p>8 – Percentage (of most-at-risk populations) who received an HIV test in the last 12 months and who know their results</p> <p>(Source: Ministry of Health and the Environment, OECS, BSS 2005)</p>	<p>Minibus & Taxi Drivers (MBTD) n= 338 (17%)</p> <p>MSM: Data not available Sex workers: Data not available Prisoners: Data not available YO B¹: Data not available</p>			
<p>9 – Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes</p>	<p>Data not available</p>			
<p>10 - Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child</p>	<p>Data not available</p>			
<p>11 - Percentage of schools that provided life-skills-based HIV/AIDS education within the last academic year, 2006/2007</p> <p>(Source: Ministry of Education)</p>	<p>School level</p>		<p>Percentage (%)</p>	
	<p>Primary</p>		<p>n=66 (91)</p>	
	<p>Secondary</p>		<p>n=26 (77)</p>	
	<p>Total</p>		<p>n=92 (87)</p>	
<p>12 - Current school attendance among orphans and non-orphans aged 10–14</p>	<p>Data not available</p>			

¹ Youth-on-the-block

INDICATOR	CALCULATED INDICATOR			
<p>13 - Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</p> <p>(Source: Ministry of Health and the Environment, OECS, BSS 2005)</p>	Age group (years)	Males (%)	Females (%)	Both Sexes (%)
	15-19	n=256 (59)	n=288 (40)	49
	20-24	n=195 (58)	n=240 (41)	49
<p>14 - Percentage of (most-at-risk populations) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</p> <p>(Source: Ministry of Health and the Environment, OECS, BSS 2005)</p>	<p>YOB: 53% (n= 388) MSM: Data not available Sex workers: Data not available Prisoners: Data not available</p>			
<p>15 - Percentage of young women and men aged 15-24 who have had sex before the age of 15</p> <p>(Source: Ministry of Health and the Environment, OECS, BSS 2005)</p>	Age group (years)	Males (%)	Females (%)	Both Sexes (%)
	15-19	n=256 (29)	n=288 (17)	23
	20-24	n=195 (33)	n=240 (10)	20.4
<p>16 - Percentage of women and men aged 15-49 who have had sex with more than one partner in the last 12 months</p> <p>(Source: Ministry of Health and the Environment, OECS, BSS 2005)</p>	Age group (years)	Males (%)	Females (%)	Both Sexes (%)
	15-19	n=256 (16)	n=288 (10)	13
	20-24	n=195 (52)	n=240 (15)	32
	25-49	n=291 (13)	n=298 (5)	9
<p>17 - Percentage of women and men aged 15-49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse</p> <p>(Source: Ministry of Health and the Environment, OECS, BSS 2005)</p>	Age group (years)	Males (%)	Females (%)	Both Sexes (%)
	15-19	n=42 (62)	n=29 (55)	59
	20-24	n=102 (62)	n=36 (50)	59
	25-49	Not available		

INDICATOR	CALCULATED INDICATOR		
18 - Percentage of female and male sex workers reporting the use of a condom with their most recent client	Data not available		
19 - Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Data not available		
20 - Percentage of injecting drug users who report using a condom the last time they had sex	Not applicable to St. Vincent and the Grenadines		
21 - Percentage of injecting drug users who report using sterile injecting equipment the last time they injected	Not applicable to St. Vincent and the Grenadines		
22 - Percentage of young women and men aged 15-24 who are HIV infected (Source: Ministry of Health and the Environment, Milton Cato Memorial Hospital and Caribbean Reference Laboratory)	2006: 1.36% (n=731)		
23 - Percentage of most-at-risk populations who are HIV infected (Source: Ministry of Health and the Environment, Prison Seroprevalence Survey CAREC)	Prisoners² (n=344) 4.1% HIV positive MSM: Data not available Sex workers: Data not available MBTD: Data not available YOB: Data not available		
24 - Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (Source: Ministry of Health and the Environment, Milton Cato Memorial Hospital)	Children (< 15 years old)		
	Cohort	Males % (n=1)	Females % (n)
	2003	---	---
	2004	100	---
	2005	---	100 (2)
2006	---	100 (1)	

² Report on an HIV seroprevalence survey among male inmates in Her Majesty's Prison in St. Vincent and the Grenadines conducted on April 12-13, 2005. CAREC, July 2005.

INDICATOR	CALCULATED INDICATOR		
<p>24 (continued) - Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy</p> <p>(Source: Ministry of Health and the Environment, Milton Cato Memorial Hospital)</p>	Adults (15 years and older)		
	Cohort	Males n (%)	Females n (%)
	2003	11 (82)	10 (50)
	2004	17 (41)	1 (100)
	2005	17 (47)	16 (50)
	2006	13 (46)	14 (79)
<p>25 - Percentage of infants born to HIV infected mothers who are infected</p>			

OVERVIEW OF THE AIDS EPIDEMIC

St. Vincent and the Grenadines remains a low HIV-Prevalence country with an estimated 0.4% prevalence in the general population. Apart from an HIV seroprevalence survey that was conducted among male prison inmates (n=344) in 2005 revealing a prevalence rate of 4.1 %, very little or no data are available for other vulnerable groups. It has been 23 years since the first case of HIV was reported in St. Vincent and the Grenadines and at the end of 2007 the cumulative number of persons identified as HIV positive was 1012 (preliminary) Nationally, there is a reported number of 509 (2007) persons living with HIV, 265 (52%) being males and 230 (45.2%) being females; 14 (2.8%) were categorised as being of unknown sex.

The male to female ratio stands at 1.6 : 1 with heterosexual contact being the most common form of transmission and accounts for approximately 70% of total infection. Homo/bisexual transmission accounts for 10% and Vertical transmission 4% of cases. Sixteen percent (16%) of all cases is reported as Unknown. AIDS – related deaths which account for approximately 4% of total deaths attributed its main causes to Pneumonia, Wasting Syndrome, Toxoplasmosis, Renal Failure and Meningitis in order of rank.

The spread of the HIV virus, as shown in graphs 1 and 2, was slow during the early years of the epidemic, recording approximately fifteen (15) cases annually. However in 1996, a sharp acceleration was observed with 60 cases reported that year. Since then, the annual incidence had been ranging between 50 to 108 cases with the year 2004 experiencing the highest peak. According to the data from year 2005, the epidemic curve appears to be lowering; however data must be interpreted with much prudence due to possible underreporting.

For the UNGASS current reporting period, (2006-2007) a total of 154 new cases of HIV were recorded. Of these, 84 (54.5%) were males and 69 (44.8%) were females. One (1) case was recorded as unknown sex. Seventy-four (74) persons progressed to AIDS with 68 deaths. The age group 20-49 accounted for 74% of the total new case identified in the period, with the 50 years and over accounting for 8%, the under 15 years 3% and the age group 15-19 : 1%.

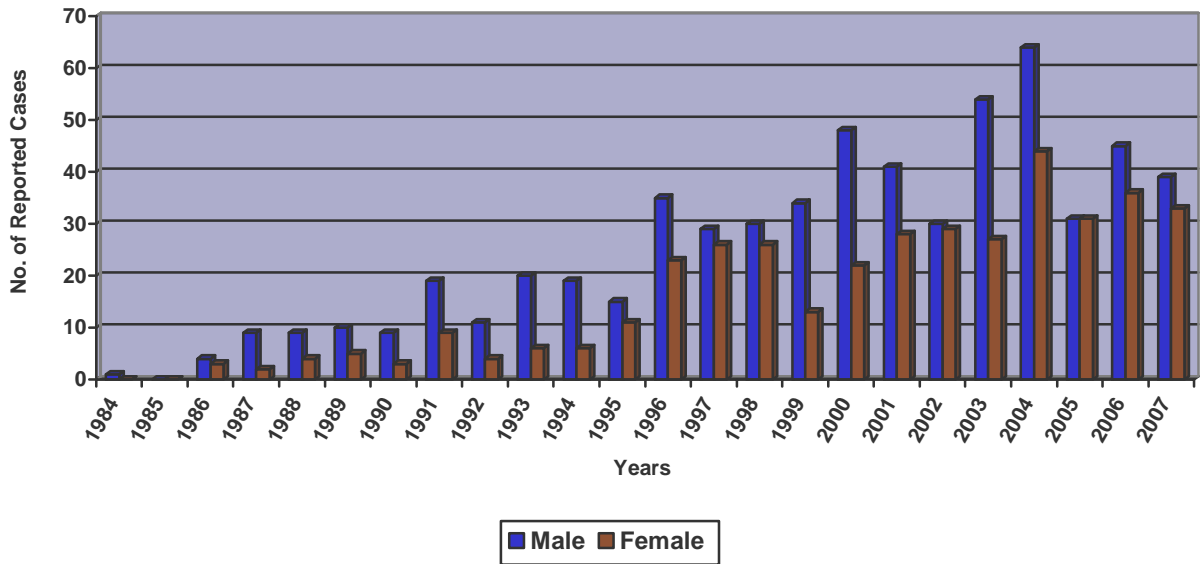
The HIV/AIDS Prevention and Control Programme continue to make notable progress in a number of programme areas. Of significance, is the steady advancement of the Mother-to-Child Transmission Programme providing voluntary counselling and testing to pregnant women and achieving coverage of 85-100%. The provision of antiretroviral coverage to all HIV positive mothers to reduce the risk of vertical transmission is also worthy of mention in this regard.

The Care and Treatment Programme is another component where considerable advancement was made. This programme which was formalized in 2003 with a clientele of 55 had an enrolment of 252 as of December 2007. The structure possesses an effective patient monitoring system integrated with care, prevention and treatment, as well as a clinical care team comprising highly trained professionals.

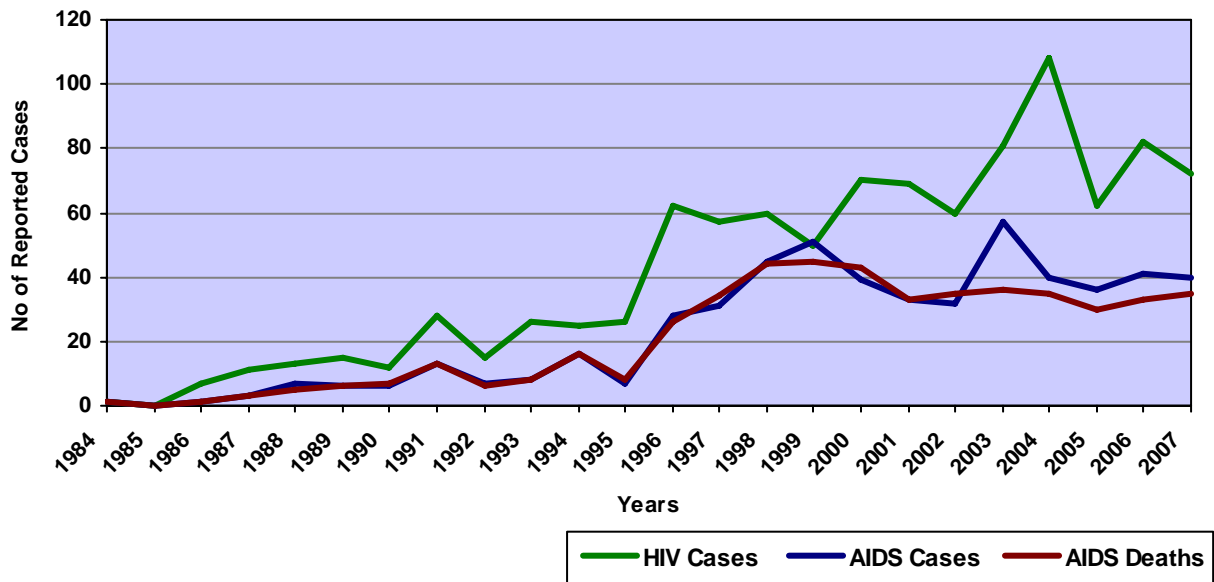
While progress has been made in a number of areas, the “most at risk populations” such as men who have sex with men and female sex workers still pose a huge limitation in the studies of the HIV/AIDS epidemic. There is still no readily nor accessible data on these groups. Nonetheless, in St. Vincent and the Grenadines, other most at risk populations such as minibus and taxi drivers, prison inmates, and youth on the block offer significant data inferences.

The line and bar graphs below depict HIV AIDS and Deaths for the period 1984-2007 and sex distribution of HIV for the same time period.

Graph 1: Reported HIV Cases by Sex from 1984 - 2007



Graph 2: Cases of HIV, AIDS and Deaths in SVG, 1984-2007



NATIONAL RESPONSE TO THE AIDS EPIDEMIC

DOMESTIC AIDS SPENDING

Spending on HIV/AIDS increased significantly over the reporting period January 2006 to December 2007. It must be noted that the actual spending is more than the EC\$ 8.5 million presented in the overview table. The unaccountable expenditure includes hospitalization of people infected with HIV; laboratory and other investigations; and additional human resources.

AIDS spending occurred in all categories including prevention, care and treatment, orphans and vulnerable children, programme management and administration, incentives for human resource at the care and treatment clinic, social protection and social services, human rights and research.

The major expenditures included networking of the Milton Cato Memorial Hospital for the patient management information system; extensive refurbishment of VCT Centres and National AIDS Secretariat (NAS) building; training of Health Care Personnel; information, education and communication materials and Civil Society Organizations (CSOs) sub-projects.

POLICY ENVIRONMENT

The policy environment addressing gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation has shown considerable improvement over the reporting period. Our major target populations are young people including Youth on the Block (YOB), Men who have Sex with Men (MSM), Female Sex Workers (FSW), PLHIV, prisoners, minibuses and taxi drivers and uniformed officers.

The national strategic plan was developed in collaboration with CSOs and other stakeholders through National Consultations and Focus Group Discussions and is a multisectoral strategy/action framework which addresses the major target groups outlined above.

In this current reporting period, several programme areas made noteworthy improvement. For example,

- The area of Stigma & Discrimination was given particular attention. A human rights desk where complaints of stigma and discrimination from HIV positive clients can be lodged and recourse sought, was established in the first quarter of 2007. The national assessment of law ethics and human rights was also completed.
- Two (2) HIV/AIDS Support Groups were formed, namely SVG +, Friends for Life (St. Vincent and the Grenadines' Network of Persons living with and affected by

HIV/AIDS) and CARE SVG (Care to Assist by Reaching out to Empower SVG). Their total membership to date is 46.

- There was greater involvement of Line Ministries quantitatively and qualitatively. A total of ten (83%) out of 12 targeted Line Ministries are now involved in the multisectoral strategy and action plan to address the epidemic. These include Health, Education, Labour, Tourism, Youth and Sport, Finance and Planning, National Security, Housing, Telecommunications, and Social Development. Each Line Ministry has a selected Focal Point. Ministerial Committee and HIV/AIDS Work plans have been developed and implemented.

The political commitment has remained strong over the two year period. The government intends to evaluate the socio-economic impact of HIV on the country and plans are at an advanced stage to conduct this research. The government continued to promote and support the delivery of comprehensive treatment, care and support services for PLHIV. A communications strategy, which was recently completed, addresses the various target audiences in different settings.

PREVENTION

Voluntary Counselling and Testing

Voluntary Counselling and Testing (VCT) is one of the intervention strategies used to control the spread of HIV in St. Vincent and the Grenadines. The VCT programme which began in 2003, intensified in 2006/2007. A number of measures were undertaken to ensure adequate functioning of this programme. These included:

- Training of personnel at different levels in different areas of VCT
- Identification and refurbishing of sites to be used for VCT
- Procurement and distribution of VCT equipment and supplies
- Preparation of VCT data collection tools
- Establishment of a data base to input VCT data
- Social marketing for VCT
- Piloting of VCT (HIV rapid test) sites
- Preparation of a VCT Policy Manual

During the period 2006 and 2007, eighteen (18: 46%) Health Centres throughout the country have had civil works done on the physical structure in preparation for the delivery of VCT services. Additionally, a total of 114 stakeholders including health care providers have so far received VCT training and 41 persons have been trained in HIV rapid testing. Seven HIV rapid test sites became operational from June 2007. A 'parallel' algorithm is utilized to perform the test, where two different test kits are used. Confirmation of positive results is done at the Milton Cato Memorial Hospital Clinical Laboratory.

A VCT community outreach programme offering HIV rapid testing commenced in September 2007 and continued until December 2007. A total of 10 communities were

visited and 1,221 persons were counselled and tested with two (2) new HIV positive cases identified. This VCT outreach programme will continue throughout 2008 with the expectation of reaching every community in the country. A total of 1846 persons have been counselled and tested through the VCT programme for the period January 2006 to December 2007.

VCT services are provided through a network involving primary health care workers, other health care providers, community based individuals and persons from non governmental organizations.

National Policy Guidelines for Voluntary Counselling and Testing were developed in June 2005 using a multisectoral approach and included key Stakeholders such as Line Ministries, Non Governmental Organizations, PLHIV and Community Based Organizations. The document was developed with 3 objectives in mind. Namely: (1) providing a framework for VCT services and the training of health providers and counsellors, (2) incorporating VCT as part of the comprehensive health care system and (3) to bring about positive behaviour change. This document was widely disseminated to Health Care providers and other HIV Stakeholders.

Efforts to promote and sustain the VCT programme will continue in the future as this provides the opportunity for persons to know their HIV status and be in a better position to access care and treatment early for a longer and better quality of life.

Prevention Mother to Child Transmission

The PMTCT Programme which was initiated in year 2000 is now fully integrated into the Primary Health Care System. Pregnant women are offered the HIV test as part of the antenatal screen and antenatal mothers who are HIV positive are referred to the care and treatment programme and provided with highly active anti-retroviral therapy (HAART). The treatment management for both HIV positive mother and baby are standardized according to WHO Guidelines. There are several treatment options available which are easily accessible.

The babies of HIV positive women are closely monitored for the first 18 months of life by a paediatrician. Mothers are counselled regarding the risk of breastfeeding and informed of infant feeding options. A regular supply of replacement feed is provided for all children up to 6 months old. The PMTCT programme is managed by a steering committee headed by the HIV/AIDS Nurse Manager and guided by a PMTCT policy manual.

The expectation is that all pregnant women will be counselled and tested for HIV. The data revealed that pregnant women counselled and tested for HIV in 2006 was 88 % as compared to 58% during the period 1999-2000.

St. Vincent and the Grenadines is one of the OECS countries involved in early infant diagnosis for HIV, using DNA PCR through the Dry Blood Spot method. This intervention was initiated by the Clinton Foundation and will be supported for the next three years. A training programme on the Dry Blood Spot methodology was conducted in early December 2007 for Laboratory Technologists, Medical and Nursing personnel.

Blood Safety

Laboratory support for HIV prevention and care continues to be a major strength of the HIV/AIDS Programme in St. Vincent and the Grenadines. The Pathology Laboratory of the Milton Cato Memorial Hospital has maintained an excellent record with regard to safety of blood for transfusion. There have been no documented cases of HIV transmission through blood transfusion, since the HIV epidemic began in 1984. The Laboratory ensures that each unit of blood for transfusion is screened for HIV, Hepatitis B and C, HTLV 1 and 2 and VDRL. A standardized set of procedures have been documented to allow for uniformity, reliability and consistency in blood screening. Additionally, laboratory staff members have been trained to use the required standard operating system.

The Pathology Laboratory participates in an External Quality Assurance Scheme; this implies that the quality of HIV screening performed is assessed at regular intervals.

The HIV Prevalence among blood donors remains low at about 0.2%. Table 2 shows the prevalence of HIV among blood donors from 2002 to 2007.

Table 2: Prevalence of HIV among blood donors from 2002-2007

Year	No. tested	No. HIV positive	HIV seroprevalence (%)
2002	987	4	0.4
2003	994	3	0.3
2004	950	0	0.0
2005	823	0	0.0
2006	884	1	0.1
2007	1,144	5	0.4

Condom Promotion and Distribution

The vast majority of adults and young people in St. Vincent and the Grenadines acquire the HIV infection through unprotected sexual intercourse. Therefore the condom as a line of defence against the infection is considered a relatively safe sex practice and is promoted as a prevention strategy.

The BSS survey done in SVG in 2005/2006 designed questions to test knowledge on HIV prevention strategies (abstinence from sex, having one faithful uninfected partner, consistent condom use) and found that the identification by females of condom use as an HIV prevention method was low (females 66 %, males 91%). This indicated a lack of knowledge of “consistent condom use” for HIV prevention and highlights the fact that there is still

work to be done. The female condom is now being promoted at the community level as an alternative to the male condom.

According to the data on condom distribution; in 2006 the number of condoms distributed in that year almost doubled when compared with that of 2005. There were 472,014 condoms distributed in 2006 compared with 240,000 in 2005.

Social marketing for condoms has increased considerably over the last two years with assistance from external partners such as Population Services International (PSI) and the United Nations Population Fund. Population Services International in partnership with the St. Vincent Planned Parenthood Association has created traditional and non-traditional condom outlets throughout the country. For the period January 2006 to July 2007, 135 outlets were created of which 99% were non-traditional sites. During the same period 244 service deliverers (retailers) were trained. The social marketing programme included the development of a regional logo (GOT IT? GET IT!); mass media campaigns including TV spots, posters and promotional items; production of educational materials; training in social marketing and BCC as well as research.

Prevention Programmes Addressing Most-At-Risk Populations

Men Who Have Sex with Men (MSW) and Female Sex Workers (FSW)

The International HIV/AIDS Alliance Caribbean Regional Programme, whose overall goal is to reduce the incidence of HIV in the Caribbean, has been working closely with the MSM and FSW populations in St. Vincent and the Grenadines.

A group of individuals who self identify and belong to the beneficiary populations, have previous experience with HIV/AIDS programming and are well networked with wide population catchments were selected as Animators. These Animators are responsible for (a) supporting most-at-risk populations with primary prevention interventions such as the promotion and distribution of condoms and lubricants and (b) supporting persons living with HIV and AIDS with secondary prevention interventions including the encouragement of compassion and tolerance.

The entry points used to locate most-at risk populations (MARPs) in St. Vincent and the Grenadines included bars, clubs, private homes, on the street and communities. During a 15 month period (April 2006 to June 2007) Animators were successful in reaching 368 PLHIV. This represents more than three quarters of persons living with HIV/AIDS in the country.

The work of the Alliance has impacted directly on the National Strategic Plan through (1) The development and implementation of a national IEC programme targeting the general and at-risk populations, (2) the promotion of safer sex practises, (3) the provision of support to PLHIV support network, (4) provision of opportunity for HIV/AIDS voluntary counselling and testing (VCT).

HIV Education in Schools

The current reporting period has shown a quadrupling of the indicator ‘Percentage of schools that provided life-skills-based HIV/AIDS education within the last academic year’. In 2005, 22% was reported compared to 87% for this reporting period. It must be borne in mind that a perfect score of 100% was obtained for the Public Secondary and Primary Schools, however, the Private schools were not assessed (Table 3). The quality of the information and skills imparted to students has also improved.

The Ministry of Education is one of the proactive Ministries that has selected an HIV Focal Point and has formed a Ministerial HIV/AIDS Committee. Annual work plans and budgets were developed and implemented over the reporting period. The Ministry has also developed a draft policy document which will soon be reviewed and adopted. The Focal Point is also a member of the Caribbean Regional HIV Education Coordinators network.

Table 3: HIV education provided in schools in St. Vincent and the Grenadines during the academic year 2006/2007

School type and number	Was HIV education provided in school?	Was the HIV education based on life-skills?	If yes, was the life skills-based education provided to each grade?	No. hours of life skills-based education
Public Primary: 52 in St. Vincent 8 in Grenadines	Yes Yes	Yes Yes	Yes Yes	Two 40 minute periods per week in all grades including Kindergarten grade.
Private Primary: 5 in St. Vincent 1 in Grenadines	Unknown Unknown			
Public Secondary: 18 in St. Vincent 2 in Grenadines	Yes Yes	Yes Yes	Yes Yes	At least two 40 minute periods per week; some provide more.
Private Secondary: 5 in St. Vincent 1 in Grenadines	Unknown Unknown			

Source: Ministry of Education programme review

CARE TREATMENT AND SUPPORT

Antiretroviral Therapy Coverage Including Survival/Adherence

Treatment with Highly Active Antiretroviral Therapy commenced in St. Vincent and the Grenadines in August 2003. Care, treatment and support to people infected and affected by HIV/AIDS is currently being provided at one medical facility located at the main Hospital in the capital Kingstown. The plan is to increase the number of ARV sites by June 2009. Decentralization of the services is necessary to increase access to high quality care at health facilities within the Health Districts and to ensure sustainability when the World Bank project terminates. To ensure access to treatment and ARV, the Government provides treatment free of charge to all clients.

The number of people on ARV increased from 21 in 2003 to 115 in 2007. According to the spectrum generated estimates, 170 people are in need of treatment and 115 are currently on treatment, an overall coverage of 68%. It must be noted that the estimates of people in need of ART used to calculate the indicator, were obtained from the workbook and spectrum estimation software. The estimated values for females are thought to be higher than the actual situation because of the unavailability of valuable MARP data and the use of higher antenatal sero-prevalence data due to the absence of the private laboratories' data regarding antenatal testing. This data is now being collected from private laboratories so future estimations would be more accurate. However, in spite of this limitation, the indicator shows universal ARV coverage (81.1%) among the male PLHIV population and 57% coverage among the female PLHIV population. Although, the national picture shows a greater burden of HIV prevalence on the male population (265 males and 230 females), the estimation models produced higher values for females in need of ART compared to males in need of ART (74 male, 96 females).

From the clinic data, it has been computed that 86 % of all clinic attendees with advanced HIV disease are currently on ART. Of note, all children under 15 years who are in need of ART receive treatment. Compared with the ARV coverage calculated using the estimates generated from spectrum estimates, the coverage was the same for the males (81% from both clinic data and spectrum), whereas for the females the clinic data showed coverage of 93% compared with 57% from spectrum estimates. The following table 4 provides more details.

Age group (years)	Males (%)	Females (%)	TOTAL Both Sexes (%)
< 15	3 (100)	4 (100)	7 (100)
15 +	71 (80)	55 (93)	126 (86)
Total	74 (81)	59 (93)	133 (86)

The national protocols for HIV/AIDS care and treatment are currently being completed and training will be conducted with Health Care Providers. An Adherence protocol and training of trainers programme were completed in December 2007. These are aimed at enhancing adherence to medication and subsequent survival. The early warning indicators have been incorporated into the adherence strategy. The patient tracking and monitoring system is being improved, the ART Journal software was installed at the treatment facility and training was conducted. Nutritional assessment and counselling is currently being offered as part of the treatment services.

The laboratory has provided invaluable service to enhance the treatment of clients with AIDS. Routine services offered include the provision CD4+ T cell, Hb/CBC, Liver Function Tests, Glucose, Cholesterol, BUN/Creatinine and electrolytes. HIV viral load capacity is not yet available at the Pathology Laboratory; however, this service is accessed through the Caribbean Epidemiology Centre located in Trinidad and Tobago. Laboratory training has been completed for the diagnosis of Opportunistic Infections and material and supplies are currently being procured to strengthen the capacity.

HIV survival/adherence has shown some fluctuations over the years (Table 5). All the cohorts in the under 15 years age group had a perfect record of 12 month survival/adherence. Table 5 indicates that the survival/adherence of adult male clients on ARV has remained below 50% for most years, while the female survival/adherence has been improving although it is still not at an acceptable level. The low levels in the males have been attributed to late enrollment in clinic with low CD4 and poor adherence. These two factors are being addressed by development and implementation of an adherence strategy, decentralization of services and addressing stigma and discrimination.

Table 5: Showing survival/adherence rate post-ARV treatment from 2003-2006

Adults (15 years and older) known to be on treatment 12 months after initiation of antiretroviral therapy		
Cohort	Males (%)	Females (%)
2003	11 (82)	10 (50)
2004	17 (41)	1 (100)
2005	17 (47)	16 (50)
2006	13 (46)	14 (79)

Co-Management of HIV and TB Treatment

Tuberculosis which has been reported as the most common opportunistic infection affecting HIV/AIDS clients world wide has been given considerable national attention over the years. With appropriate drugs and diagnostic technology available in country, the diagnosis and management of TB are done efficiently. All patients diagnosed with Tuberculosis are

routinely tested for HIV and all symptomatic HIV infected persons who access medical services are tested for Tuberculosis.

The national records illustrate a low incidence of Tuberculosis over the last decade with approximately 13 cases reported annually. Up to year 2005, Tuberculosis / HIV Co-infection documented just 2 cases annually. However in 2006, there were twenty (20) Tuberculosis cases diagnosed with five (5: 25%) co-infected with HIV and in 2007, 16 Tuberculosis cases were recorded with seven (7: 44%) cases co-infection with HIV. Of the 12 co-infected clients, diagnosed over the reporting period, two died shortly after diagnosis and two were defaulters who were previously diagnosed.

The Ministry of Health and the Environment has committed itself to continue its efforts to enhance prevention measures, treatment and identification of the two diseases as well as the continuous provision of effective treatment options.

Indicator 6 reflected 100% coverage for TB/HIV co-infected clients who received treatment for both tuberculosis and HIV. The reporting period for this data was September 2006 to September 2007.

Services for Orphans and Vulnerable Children (OVC)

The National AIDS Secretariat is aware of 66 HIV/AIDS related orphans and vulnerable children. The definition used here is: “Children aged 0 to 18 years who have lost one or both parents to HIV/AIDS–related causes, or who have at least one parent who suffers chronic illness due to HIV/AIDS”.

Approximately 15% are themselves HIV-infected; five of the HIV-infected children are double orphans. Most of the children (63 or 95%) are of school age. Of these, 92% attend school. Six (6) children reside at an orphanage while the remaining children reside with family.

In terms of support, all persons with HIV infection who attend the public clinic for care and treatment are assessed regarding their social and economic situation. Financial assistance is provided via disbursement through the Ministry of National Mobilization Family Services Department. Priority for financial assistance is given to orphans and the elderly. Assistance provided takes various forms, e.g. school lunches, monthly stipends, monthly food packages (mostly for pregnant and post-natal mothers), school supplies and school fees. In 2007, 100 children infected and affected by HIV/AIDS received school-related assistance. Separate and apart from school-related assistance, financial support is provided to the Bread of Life orphanage for general care of the children under their control. Seventy-five percent (75%) of the non-institutionalized OVC also receive financial assistance from the programme.

KNOWLEDGE AND BEHAVIOUR

General Population

In 2005, the first round of the Behavioural Surveillance Surveys³ was conducted in six countries of the OECS. These surveys collected data on knowledge, attitudes, beliefs and practices related to HIV/AIDS and other sexually transmitted infections. A second round of surveys is necessary in order to ascertain any changes in knowledge and behaviour. BSS round 2 is planned for 2009/2010. Some key findings from the baseline surveys are listed as follows:

- Approximately one in ten or less of the general population had been tested for HIV in the 12 months preceding and knew their results.
- Approximately half of the young people surveyed correctly identified the ways of preventing sexual transmission of HIV and rejected common HIV/AIDS-related myths.
- Approximately one in five young people reported having initiated sexual intercourse before the age of 15 years.
- Approximately one-third (32%) of respondents aged 20 to 24 years had more than one sexual partner in the 12 months preceding their interview compared to 13% of respondents 15 to 19 years old and 9% of respondents 25 to 49 years old.
- More males than females in all age-groups reported more than one sexual partner in the 12 months preceding their interview
- Approximately six out of ten young people aged 15 to 24 years old who reported more than one sexual partner in the 12 months preceding their interview had used a condom at last sex.⁴

General Population 15 to 24 years old

The survey showed that 71% of the respondents in the 15 to 24 age group had a comprehensive knowledge of the “A,B,C” HIV prevention strategies. The proportion of males with overall correct knowledge was higher than females, which was influenced by the low identification by females of consistent condom use. During the reporting period, the female condom was introduced within the population. Condom vending machines to facilitate easy access to condoms will be placed at strategic locations during the first quarter

³ Behavioural Surveillance Surveys conducted in six countries of the Organization of Eastern Caribbean States. CAREC, June 2007.

⁴ Amongst the general population aged 25 to 49 years old, data was collected on condom use however these data were specific to the type of sex partner (i.e. regular (marital) partners, non-regular (non-commercial) partners, and commercial partners). As such, it was not possible to calculate the indicator on condom use at last sex for respondents who had more than one sex partner in the past 12 months.

of 2008. The table below (Table 6) provides the information on knowledge on HIV prevention strategies for the 15-24 year olds in the general population.

Table 6: Respondents with knowledge of HIV prevention strategies, General Population 15-24 year old

Sex of Respondents	Total No. surveyed (%)	Percentage of respondents with correct answers		
		Abstinence (%)	One faithful uninfected partner (%)	Consistent condom use (%)
Male	451	92	92	91
Female	528	95	92	66
Both Sexes	979	94	92	77

According to the survey, most people (97%) knew that a healthy-looking person could have HIV. The composite indicator showed that only 64% of this surveyed age group was able to reject all three myths. In order to address and correct the societal myths surrounding HIV, the Communication Consultant has launched a media campaign which includes television and radio advertisements. The table below provides information about HIV transmission myths rejection in the 15-24 age group.

Table 7: Respondents who rejected myths about HIV transmission General Population 15-24 year old

Sex of Respondents	Total No. surveyed (%)	Percent who knew that ...		
		Infection from mosquito bite is not possible (%)	Infection from sharing a meal is not possible (%)	Healthy looking person can have HIV/AIDS (%)
Male	451	84	71	93
Female	528	83	76	99
Both Sexes	979	84	74	97

Concerning sexual debut, the survey revealed that the median age at first sex was 15 years (Female 16, Male 15) in the 15 to 24 years age group. In relation to higher risk sex and condom use among youth; a total of 40 percent in the age group 15-24 years self-reported having higher risk sexual behaviour with regard to condom use at last sexual intercourse with a non commercial partner. Approximately 80 percent of the respondents admitted that they did not use condoms at every sexual intercourse with a non commercial partner.

Most-at-risk Populations

The Ministry of Health and the Environment, through programme activities and epidemiological data, has identified the following as ‘most-at-risk populations’: men who have sex with men (MSM), persons who engage in transactional sex, prisoners, and ‘youth-on-the-block’.

Men who have sex with men and female sex workers

The baseline BSS conducted in 2005 did not have an HIV seroprevalence component. Although questions regarding male-to-male sex, commercial sex and transactional sex were included in the survey questionnaire for the general population sample, the findings did not yield statistically useful information on the proportion of the general population who engage in these activities nor their condom use practices. Under-reporting is assumed and was most likely due to the face-to-face interview methodology used where persons are less likely to report highly sensitive and stigmatizing information, especially about an activity that is illegal in St. Vincent and the Grenadines.

In an effort to obtain behavioural and seroprevalence data on two hidden populations namely, MSM and FSW, the Ministry of Health and the Environment worked in collaboration with the Caribbean Epidemiology Centre (CAREC), the International HIV/AIDS Alliance (Caribbean Office), the Caribbean Health Research Council (CHRC) and the Global AIDS Program (GAP) of the US Centers for Disease Prevention and Control (CDC) to implement a Behavioural and Seroprevalence Surveillance Survey in 2006/2007⁵. These surveys, conducted from November 2, 2006 to January 31, 2007, used the Respondent Driven Sampling (RDS) methodology which has been used successfully in many countries for sampling hard-to-reach populations. By the end of the survey period, a total of 7 males and 4 females had been interviewed out of the planned samples of 175 males and 218 females. Information obtained from monitoring visits, survey evaluation and field-worker debriefing interviews indicated the following key reasons for the failure of the surveys:

- issues relating to networking between MSM cliques that are affected by mistrust, fear of disclosure, etc

⁵ Report of the Pilot Behavioural and HIV Seroprevalence Surveillance Surveys of Men who have sex with men (MSM) and Female Sex Workers (FSW) in Antigua and Barbuda and St. Vincent and the Grenadines November 2006 to January 2007. CAREC, March 2007

- the network of female sex workers appeared not dense enough for use of the RDS methodology;
- potential female participants were not willing to identify themselves as being sex workers;
- fear of disclosure and fear of a lack of confidentiality were also cited as barriers
- incentives offered were reportedly not worth the risk of disclosure.

These issues require further exploration before the implementation of subsequent surveys. There are efforts underway to reach these hidden populations with the assistance of the Caribbean office of the International HIV/AIDS Alliance.

Prison inmates

In April 2005, 344 male inmates (92% of inmates on the survey days) of Her Majesty's Prison in St. Vincent and the Grenadines were surveyed⁶ for their HIV serological status. The seroprevalence rate for all inmates tested 4.1%; half of these HIV positive inmates were between the ages of 20 to 29 years.

Subsequent to these surveys, the NAS increased their prevention and VCT activities in the prisons. A counsellor with the Secretariat makes regular visits to the prison to conduct HIV education sessions, counselling and voluntary HIV testing for inmates and prison officers. NAS programme data showed that a total of 320 inmates participated in HIV education and/counselling sessions between January and August, 2007. The documented results of such sessions were requests by 97 inmates for HIV testing. Between January and June, 2007, a total of 47 prison officers and/or new recruits attended HIV education/counselling sessions.

Minibus and Taxi drivers

The analysis of the data for the minibus and taxi drivers' population (15-49 years) was done on a collective basis (as an OECS region), not by individual countries. The data revealed that almost all MBTD interviewed had heard of HIV/AIDS (n=388 : 99%). With regard to the ABC of HIV prevention, 73% (n=388) of the respondents mentioned all prevention strategies. Almost all MBTD surveyed (98%) knew that a healthy looking person can be HIV positive, however, only 40% of the respondents rejected all three myths (HIV transmission by a mosquito and sharing a meal, as well as, a healthy looking person can be HIV positive). Approximately 40% of respondents had initiated sexual activity before the age of 15 years. Forty eight percent of the respondents reported that they ever had an HIV test, whereas 17% received HIV test and results in the last 12 months.

⁶ Report on an HIV seroprevalence survey among male inmates in Her Majesty's Prison in St. Vincent and the Grenadines conducted on April 12-13, 2005. CAREC, July 2005.

Youth on the block

A total of 388 youths (aged 10 to 19 years) were surveyed in the BSS conducted in St. Vincent and the Grenadines in 2005. Most (86%) were males and the median age was 16 years. Almost all (97%) of respondents had heard of HIV or the disease called AIDS. Of those respondents who had heard of HIV or AIDS, almost all (98%) knew of transmission via sexual intercourse and almost two-thirds (61%) knew of transmission via blood. By contrast, 32% and 36% knew of mother-to-child transmission and injecting drug use, respectively. Only thirty-three respondents (9%) knew all four routes.

More than nine of ten respondents were aware that a healthy looking person can be infected with HIV. Approximately one-fifth (19%) of the youths believed that HIV can be transmitted by mosquitoes, and one-third (31%) believed that HIV can be transmitted by sitting on a toilet seat previously used by an HIV infected person, indicating persisting fears of HIV transmission through body fluids. Overall, only 39% of respondents correctly rejected the two myths and knew that a healthy looking person could be infected with HIV, indicating that three out of five youths aged 10 to 19 in St. Vincent and the Grenadines still have misconceptions about HIV transmission.

In terms of HIV prevention, abstinence and faithfulness between uninfected partners were the most identified methods (89% and 90%, respectively). Condom use was identified by 76% of respondents. Approximately seven out of ten respondents correctly identified all three HIV prevention methods. Roughly half of the youths (53%) surveyed correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions about HIV transmission⁷.

Through a list of different questions, willingness of the respondents to interact with persons with HIV was assessed. Eight out of ten (80%) respondents indicated being willing to care for an HIV infected relative in their own household. Empathy was less for HIV infected students and teachers, with 63% being willing to allow an HIV infected student to attend school and just over half (54%) being willing to allow an HIV infected teacher to teach. Overall, half of all respondents gave answers that indicate an accepting or supporting attitude towards persons with HIV infection.

In the area of sexual behaviour, almost half (47%) of all respondents reported ever having had sexual intercourse. Forty-four percent (44%) of the sexually active youths reported sexual debut before the age of 15 years. The age range at sexual debut was as early as 6 years old for at least one respondent. For the majority (86%) of respondents who had ever had sex, their first sexual partner was older by ten years or less. Among those who had ever had sex, almost one-fifth indicated that they had been forced during the act that resulted in their loss of virginity. See the table 8 below for a summary of these findings. All but one

⁷ UNGASS indicator 14: Percent of survey respondents who correctly identified faithfulness to one HIV uninfected partner and condom use as HIV risk reduction practices, and who knew that a healthy looking person can have HIV, a person cannot be infected from mosquito bites and a person cannot be infected by sitting on a toilet seat after someone who is infected.

respondent had ever heard of a male condom, however, of the 182 sexually active youths, only 40% had used a condom the last time they engaged in sexual intercourse.

Table 8: Experiences at sexual debut; OECS BSS 2005, Youth on the block surveyed in St. Vincent and the Grenadines.

Questions related to first sexual intercourse		Statistics (n=183)
% who had had sex before age 15 years		44%
Age at first sex		Range: 6 to 19 years
Partner's age at sexual debut	Older than respondent by more than 10yrs	1%
	Older than respondent by 10yrs or less	86%
	Don't Know	7%
	No response	2%
Forced at first sex		17%

IMPACT ALLEVIATION

Youth-on-the-block

A total of six (6) Peer Communicators/Educators have been employed to specifically work with Youth on the Block. These Peer Communicators/Educators visit the various communities on a daily basis for approximately 14 hours per week and work by means of convenience sessions with individuals or groups, as well as through organized sessions at schools. The content of their sessions can range from basic HIV education, myth reduction, risk reduction behaviours (e.g. condom use, partner reduction), HIV treatment availability, the importance of knowing one's HIV status, etc. Referrals are also given for Voluntary Counselling and Testing (VCT) services. The Programme data estimates approximately 300 youths reached each month on mainland St. Vincent.

This programme, like other programmes, has its challenges. Some of the immediate challenges include the need for additional Peer Communicators/Educators both on mainland St. Vincent and on the islands of the Grenadines. There is also a need for the development of a formalized training curriculum to educate new and existing peer communicators/ educators.

BEST PRACTICES

The following is being put forward as a best practice in St. Vincent and the Grenadines by Civil Society who form part of a network established approximately five years ago. Civil Society Organisations affiliated with the HIV NGO Network in St. Vincent and the Grenadines are of the view that the amalgamation of the respective groups provides:

- a) a forum for all the groups concerned to strategically address HIV ,
- b) an opportunity for groups to work together collectively, focusing on specific interests/target, as well as areas that they are comfortable with,
- c) a medium for sharing information and efforts of each group,
- d) a means for building capacities collectively and individually through mutually agreed programmes and methods,
- e) greater lobbying and advocacy skills, and
- f) individual and collective recognition for the work and worth of individual affiliates, as well as, the Network.

MAJOR CHALLENGES AND REMEDIAL ACTIONS

STIGMA AND DISCRIMINATION

Stigma and Discrimination associated with HIV and well-known to impede universal access to HIV prevention, treatment and care remain a major concern. Nevertheless, noteworthy progress has been made towards addressing this challenge in the recent past. A Human Rights Desk was established in January 2007 to provide an opportunity for PLHIV to report instances of discrimination. This desk is managed by an individual who is living positively with HIV and advocates on behalf of that population. National and regional training in Human Rights matters was organized for the Human Rights Desk Manager to enhance knowledge and skills. Close collaboration and cooperation with the Care and Treatment Centre allows for prompt referrals of complaints from clients to the Desk.

With the assistance of the Pan Caribbean Partnership against HIV/AIDS (PANCAP), a law, ethics and human rights national assessment was undertaken in the country and two reports were prepared. The first report was a desk review of the laws and policies as they pertain to HIV/AIDS human rights issues. The second report was prepared following community consultations addressing the findings of the legal consultant. The next steps in the process include discussion with Policy Makers and the Attorney General's Office.

The issue of stigma and discrimination receives attention at the highest level of Government. Several political speeches have addressed this problem in support of the call for termination of stigma and discrimination against PLHIV.

Stigma and discrimination sensitization training sessions were conducted for Health Care Providers and Line Ministries. Additionally, a number of information, education and communication activities were implemented to address this problem. These included: distribution of material from the regional 'Ouch' campaign, public sensitizations and education sessions through radio and television advertisements, carnival mass band and live radio call-in discussions. Activities will continue to address this major issue, as 2008 will see the launching of a major stigma and discrimination campaign.

DATA MANAGEMENT

Data management from collection to analysis remains a major challenge in St. Vincent and the Grenadines. While cognisance must be given to the high cost and complexities of a fully automated data management system, it must be stated that it becomes extremely difficult to provide detailed and comprehensive analyses for different population groups, using the paper-based system.

As a first step to remedial action a patient monitoring and tracking system for HIV was introduced at the care and treatment clinic of the Milton Cato Memorial Hospital in November 2007. This was made possible with assistance from PAHO/CDC and OECS HIV/AIDS Project Unit.

This system allows for the collection of all relevant follow-up information for each client in a systematic and standardized way as well as providing feedback on the patient population and indicators. The system is supported by paper forms capturing the OECS Minimum Dataset and customized to facilitate charting of patient clinical staging information, laboratory results, patient encounters, and clinical histories. Members of staff at the care and treatment clinic have already been trained to operate the patient monitoring and tracking system which is currently functional.

The Ministry of Health and the Environment is moving towards a fully automated patient management information system within the next two years.

Table 9 shows the core indicators selected with targets set for 2010 along with concrete remedial actions that are planned to ensure achievement of targets.

Table 9: Target, core indicators and remedial actions for 2010

Core Indicators of Universal Access to Prevention, Treatment, Care and Support	Baseline (%)	Ambitious targets 2010 (%)	Activities required to ensure attainment of ambitious targets
<p><u>1. Treatment</u></p> <p>Percentage of women, men and children with advanced HIV infection receiving antiretroviral combination therapy</p>	100 (2005)	≥ 80	<ul style="list-style-type: none"> ↳ Expansion of the care and treatment clinics to other Health Districts
<p><u>2. Treatment</u></p> <p>Percentage of adults and children known to be on ART twelve months after initiation of antiretroviral therapy</p>	51.4 (2005)	80	<ul style="list-style-type: none"> ↳ Introduction of an adherence strategy. ↳ Increase community outreach activities to promote HIV treatment availability and early testing.
<p><u>3. Care and Support</u></p> <p>Percentage of OVC (boy/girl) under 18 living in households whose household has received a basic external support package</p>	N/A	80	<ul style="list-style-type: none"> ↳ Development and implementation of appropriate programmes
<p><u>4. Prevention</u></p> <p>Percentage of HIV-positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission</p>	100 (2005)	100	<ul style="list-style-type: none"> ↳ Maintain campaign for PMTCT ↳ Evaluation of the PMTCT programme

Table 9: Target, core indicators and remedial actions for 2010 (continued)			
Core Indicators of Universal Access to Prevention, Treatment, Care and Support	Baseline (%)	Ambitious targets 2010 (%)	Activities required to ensure attainment of ambitious targets
<p><u>5. Prevention</u></p> <p>Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.</p>	<p>10 (OECS BSS 2005)</p>	<p>20</p>	<p>↪ Expansion of HIV rapid test services offered at Health Centres.</p> <p>↪ Evaluation of the VCT programme</p>
<p><u>6. Prevention</u></p> <p>Percentage of young people (15-24) who correctly identify ways of preventing sexual transmission of HIV-including delaying sexual debut, reducing partners, use of condoms and reject major misconceptions (male/female)</p>	<p>49 (OECS BSS 2005)</p>	<p>90</p>	<p>↪ Implementation of youth community outreach programmes</p>
<p><u>7. Prevention</u></p> <p>Percentage of young women and men aged 15-24 who have had sex before the age of 15</p>	<p>22 (OECS BSS 2005)</p>	<p>10</p>	<p>↪ Expansion of BCC campaign targeting youth</p>
<p><u>8. Prevention</u></p> <p>Number of condoms distributed annually by public and private sector</p>	<p>240,000 condoms (2005)</p>	<p>300,000 condoms (Achieved)</p>	<p>↪ Support for personnel to distribute condoms in the community</p>
<p><u>9. National Commitment</u></p> <p>Amount of funds committed by the government</p>	<p>EC\$1.52M (2004)</p>	<p>EC\$ 4M (Achieved)</p>	<p>↪ Ministries to develop and implement annual work plans and budgets</p> <p>↪ Support to conduct National AIDS Spending Assessment</p>

SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

CAPACITY BUILDING

The number of development partners offering technical assistance to HIV/AIDS programmes in the region has been steadily increasing. These Partners have strengthened to a great extent the HIV/AIDS national response in all areas with the provision of capacity building for local Stakeholders.

In order to achieve the UNGASS targets, technical assistance will be required from the country's development partners to assist in ensuring that the following objectives are accomplished:

Decentralization of HIV care and treatment: This process will pose some challenges unless the care and treatment guidelines are completed. These Guidelines provide direction for the training of Health Care Providers so that they can carry out their duties with greater proficiency.

Reaching Most at Risk Populations: Continuous support for the development and implementation of activities to reach the most at risk vulnerable groups in our population, such as MSM and FSW will be most crucial. Data and information regarding these groups have been minimal, hence reporting on indicators relating to vulnerable populations have been difficult.

Orphans & Vulnerable Children: A comprehensive programme to address Orphans and Vulnerable Children in our society is very essential. Therefore technical assistance will be required to provide some concentration in this area.

IEC Strengthening: The development of Information, Education and Communication strategies specifically targeting the age group 15-24 years will be necessary in order to reach the target set for the Indicator "Percentage of young women and men aged 15-24 who have had sex before the age of 15".

Research: The strategic framework has placed emphasis on evidence-based programming and the use of research to guide decisions. Support will be needed from partners to assist in building capacity to carry out good quality relevant research, from the planning, implementation, analysis and through to the publication and presentation stages.

CONTINUED SUPPORT FOR SUSTAINABILITY OF PROGRAMMES

As the country continues to strengthen its response to the epidemic, more and more financial and human resources are required. The financial sustainability will always remain an area of concern and the support of development partners will definitely be vital.

MONITORING AND EVALUATION ENVIRONMENT

OVERVIEW OF THE CURRENT MONITORING AND EVALUATION SYSTEM

The process of designing a Monitoring and Evaluation system for HIV/AIDS programmes commenced in mid 2005 with several activities undertaken towards the development of such a system. Activities included: (a) the development of a monitoring and evaluation framework consisting of 50 programmatic indicators covering output, outcome and impact for 14 service areas; (b) refinement process of the programmatic indicators (c) development of baseline values and agreed targets for indicators to monitor achievements; (d) development of data collection and abstraction forms to collect monitoring and evaluation data; (e) orientation of Stakeholders to the various data collection forms and how to use them; (f) development of a data base to organize and manage M&E data; (g) production of a Newsletter for information sharing; (h) formation of a Monitoring and Evaluation Reference Group (MERG) to provide advice on M&E approaches and practices as well as M&E technical and managerial aspects; (i) production of a Monitoring and Evaluation Plan to improve HIV/AIDS systems and programmes and (j) organizing monitoring and evaluation capacity building workshop for Stakeholders to equip them with the basic concepts of monitoring and evaluation, as well as enhancing their capacity to apply those concepts to real life situations.

The fourteen (14) service areas under the HIV/AIDS programme selected for monitoring and evaluation include national programme impacts, voluntary counselling and testing, prevention of mother to child transmission, care, treatment and support, Non Governmental Organizations, Community Based Organizations, Behaviour Change Communication/ Behaviour Change Mass Media, Orphans and Vulnerable Children, Condom Distribution, Line Ministries, Partnership Programme Management, Monitoring and Evaluation, Post Exposure Prophylaxis, Stigma and Discrimination and Sexually Transmitted Infections.

The completion of the National HIV/AIDS Monitoring and Evaluation Plan was a significant step in the entire M&E Process. The Plan, which consists of 6 chapters, was designed to improve HIV/AIDS systems and programmes with an ultimate goal of controlling the HIV epidemic in St. Vincent and the Grenadines.

The Plan describes the approach for assessing progress toward the overall strategic objectives of the National Strategic Plan for St. Vincent and the Grenadines. It documents how activities contribute to the achievement of the results described in the Monitoring and Evaluation Framework. The Monitoring and Evaluation Framework presents the results that the National Strategic Plan expects to achieve in specified priority areas.

The plan also addresses the needs of several Stakeholders Groups such as Ministry of Health and Environment, National AIDS Council, National AIDS Secretariat, Line Ministries, Non-Governmental Organizations, The Global Fund, UNAIDS and the World Bank. It articulates the linkages, reporting relationships and indicators used to measure inputs, outputs, outcomes and impact of national response to HIV/AIDS.

The National HIV/AIDS Monitoring and Evaluation Plan will be fully implemented in 2008.

Another noteworthy step in the development process of the monitoring and evaluation system was the formation of a technical body called the Monitoring and Evaluation Reference Group (MERG). This body was formed in July 2006 with the primary purpose of providing advice on monitoring and evaluation approaches and practices as well as other technical and managerial aspects of HIV/AIDS Monitoring & Evaluation at all levels.

The MERG comprises a 9 member body with representation from the National HIV/AIDS Secretariat, Public Sector Institutions, Civil Society and Non-Governmental Organizations. MERG meetings are convened on a monthly basis. One of the important activities of the MERG in 2006 was the 1-day work session to critically review the contents of National HIV/AIDS Monitoring and Evaluation Plan.

CHALLENGES FACED IN THE IMPLEMENTATION OF A COMPREHENSIVE M&E SYSTEM

1. The first challenge encountered was the inheritance of a Monitoring and Evaluation Framework template which was pre-designed for the OECS countries in an Excel programme. This presented much frustration during the first year of the programme. When one tried to alter information within the cells, some words remained legible, while others were reduced to illegible fonts. Eventually the Framework template had to be redesigned into a word document which significantly simplified the problem.
2. It was difficult trying to keep track of the specific indicators that were of particular interest to the various donor agencies. An attempt was made to harmonize these indicators across donors by accepting all the indicators as national indicators and designating those that were for external use. Additionally, Donors have been revising, omitting and including indicators from time to time. When this is done, it also requires revising and updating the national indicator set as well as adjusting the required data collection formats.
3. There was a preconceived notion that monitoring and evaluation was established to highlight the deficiencies and inefficiencies of service providers. This made it difficult to convince persons of the importance and necessity of monitoring and evaluation as a management tool that primarily yields information to guide policy decision-making, programme planning and implementation. Several meetings and discussion sessions were undertaken with Stakeholders to enhance relationships and dispel anxiety.
4. The establishment of this new system required that a number of data reporting formats for data collection be developed, tested, refined and introduced to Health Care Providers primarily, who were already overburdened. This hurdle required numerous meetings and orientation sessions at various levels of the health system to convince Stakeholders of the importance of data collection and data used to enhance HIV/AIDS programmes. To ease the burden, existing data collection methods and data flow systems that were already in place were capitalized on. Another challenge that will most likely be on a long term is the system of data flow using the courier

system in the absence of internet service. This most obviously will impede the consistency and timeliness of the data.

5. Another challenge is in the area of data management. There is an urgent need for an appropriate Information Technology Platform to manage HIV related information at the national level. The project currently uses statistical software (SPSS) to input routine data; however the software package cannot fulfill the functions of a management information system. The Ministry of Health and the Environment has expressed the desire to employ the services of a consultant to assess the current infrastructure and to provide advice and services for the provision of a suitable IT Platform.

TECHNICAL ASSISTANCE AND CAPACITY BUILDING

There is urgent need for training at all levels in the following areas:

- Information technology

- Data and its importance in planning and decision making

- Monitoring and Evaluation, (basic concepts and use)

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes	No
b) NAP	Yes	No
c) Others (please specify)	Yes	No

2) With inputs from

Ministries:		
Education	Yes	No
Health	Yes	No
Labour	Yes	No
Foreign Affairs	Yes	No
Others (please specify)	Yes	No
Civil society organizations		
People living with HIV	Yes	No
Private sector	Yes	No
United Nations organizations	Yes	No
Bilateral	Yes	No
International NGOs	Yes	No
Others (please specify)	Yes	No

3) Was the report discussed in a large forum? Yes No

4) Are the survey results stored centrally? Yes No

5) Are data available for public consultation? Yes No

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

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