ST. VINCENT AND THE GRENADINES

HIV AND AIDS NATIONAL STRATEGIC PLAN 2010-2014

Together we can prevent HIV

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Preface

The Government of St. Vincent and the Grenadines began the process of scaling up HIV and AIDS prevention, treatment, care and support services in 2001. Several strategic plans were developed to guide the service delivery process and much has been accomplished since. This third HIV and AIDS National Strategic Plan continues on the path established by the previous two plans and aims to solidify the progress made, by ensuring sustainability.

Over the past five years, there has been an increase in financial resources to combat the epidemic, including an EC$ 23 million World Bank loan/credit/grant, EC 6 million dollars of Government funding, EC$ 1 million through the Organization of Eastern Caribbean States (OECS) Global Fund project, and other technical support. There was also an increase in the number of core staff coordinating the multisectoral response including many stakeholders such as civil society organizations, public sector and private sector entities.

By October 2009 there were 319 People living with HIV (and AIDS) under care with 175 persons on antiretroviral treatment in the country. The emphasis remains on the provision of and adherence to treatment with first line antiretroviral drugs. All HIV positive pregnant women are offered Prevention of mother to child transmission of HIV services during and after pregnancy. This has proven to be very effective resulting in an almost zero percent mother to child transmission of HIV in recent years. Voluntary counselling and testing (VCT) services are integrated in the public health sector system. Health centres have been upgraded to provide VCT services in keeping with the regional quality standards and HIV rapid testing has been introduced at 17 sites. An increase in the number of people tested has been attributed to more sites being available and accessible for testing.

The laboratory capacity has been strengthened with the provision of equipment and supplies as well as human resource. Equipment include CD4 machine. Other laboratory support services not available in country are accessed elsewhere. There is more visibility of educational materials in the community with more HIV/AIDS prevention messages including billboards. Condoms distribution has been enhanced with the introduction of the female condoms and condom vending machines. Health care workers such as Doctors, (private and public) Dentists, Family Nurse Practitioners, Counsellors, Social Workers, Nursing Assistants and Registered Nurses were trained in different aspects of HIV/AIDS. Over the years the response to the epidemic has strengthened the health system with the introduction of health information system and expansion of a more structured monitoring and evaluation system. An HIV/AIDS socio-economic impact assessment is currently being conducted. The findings and recommendations of this study will be used to guide future planning.

A great challenge will be to sustain and manage existing programmes in light of reduced financial resources. This plan intends to address this issue by utilising some proven strategies of decentralization/integration of care and treatment services, strengthening the multisectoral ownership, and implementation and ensuring that the response is more evidenced-based. While decentralization and integration are essential, the ministry is also cognizant that coordination must be maintained to ensure cohesion. We fully endorse this new HIV/AIDS Strategic Plan for St. Vincent and the Grenadines.

Hon. Dr. Douglas Slater
Minister of Health and the Environment

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal clinic
ART	Anti-retroviral treatment
ARV	Antiretroviral (drugs)
ASAP	AIDS Strategy and Action Plan
BCC	Behaviour change communication
BSS	Behaviour and social surveys
BUN	Blood urea nitrogen
CARE SVG	Care, Advocacy Reaching out to Empower SVG
CAREC	Caribbean Epidemiology Centre
CBC	Complete blood count
CBO	Community-based organization
CCH	Caribbean Cooperation in Health
CCM	Country Coordinating Mechanism
CHAA	Caribbean HIV & AIDS Alliance
CHRC	Caribbean Health Research Council
CMS	Central Medical Stores
CRN+	Caribbean Region Network of PLHIV
CRSF	Caribbean Regional Strategic Framework
CSO	Civil society organization
DNA	Deoxyribonucleic acid
EC	East Caribbean
EC$	East Caribbean $
FBO	Faith-based organization
FSW	Female sex workers
GAMET	Global AIDS Monitoring and Evaluation Team
GDP	Gross Domestic Product
HAART	Highly active antiretroviral therapy
HAPU	HIV/AIDS Programme Unit
HBC	Home-based care
HCW	Health care worker
HH	House of Hope
HIV	Human Immunodeficiency Virus
HPIU	Health Planning and Information Unit
HRD	Human Rights Desk
ILO	International Labour Organization
M&E	Monitoring and evaluation
MARP	Most at risk population
MCMH	Milton Cato Memorial Hospital
MDG	Millennium Development Goals
MoE	Ministry of Education
MoHE	Ministry of Health and the Environment
MoL	Ministry of Labour
MoLA	Ministry of Legal Affairs
MoNM	Ministry of National Mobilization
MoT	Ministry of Tourism

MSM	Men who have sex with men
NAC	National AIDS Council
NAS	National AIDS Secretariat
NFPP	National Family Planning Programme
NGO	Non-governmental organization
NNN	National Network of NGOs
NSP	National Strategic Plan
OECS	Organization of Eastern Caribbean States
OI	Opportunistic infections
OVC	Orphans and vulnerable children
PANCAP	Pan Caribbean Partnership on HIV/AIDS
PCR	Polymerase chain reaction
PEP	HIV post exposure prophylaxis
PHC	Primary health care
PITC	Provider initiated testing and counselling
PLHIV	People living with HIV (and AIDS)
PMTCT	Prevention of mother to child transmission of HIV
PSI	Population Services International
S&D	Stigma and discrimination
STI	Sexually transmitted infections
SV PPA	St Vincent Planned Parenthood Association
SVG	St. Vincent and the Grenadines
SW	Sex workers
TB	Tuberculosis
ToR	Terms of reference
TSC	Technical Sub-Committee
UNAIDS	Joint United Nations Program on HIV and AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary counselling and testing (for HIV)
WHO	World Health Organization

EXECUTIVE SUMMARY

Situation assessment

Epidemiological situation

Twenty-four years after the first case of HIV was diagnosed in St. Vincent and the Grenadines, the epidemic is becoming generalized with a prevalence of just over 1% among pregnant women attending antenatal clinic (ANC). There has been a general decrease in the HIV incidence, of approximately 37% at the end of 2008, from the peak of 2004. This decrease may be attributed to the interventions that the country has implemented. The reduction in mortality attributable to AIDS is about 40% over the same period, due to the successful implementation of the PMTCT programme and ART.

As recorded, the main mode of HIV transmission is through heterosexual contact, accounting for approximately 70% of all HIV infections. Recorded homosexual/bisexual and vertical transmissions account for 10% and 4% of cases respectively. HIV risk in St. Vincent and the Grenadines is at the confluence of different but overlapping population segments that interact socially and sexually. The HIV epidemic in St. Vincent and the Grenadines is driven by sexual interactions, including unprotected sex with multiple or concurrent partners; stigma; and economic conditions that fuel the exchange of sex for goods or money.

The population segments at risk for HIV were heterosexual youth (men and women) and men who have sex with men (MSM). A finding shows that while unprotected sex between men may contribute to HIV risk in SVG, the number of those men is probably small enough to only partially drive the HIV epidemic. Data suggest that a larger population segment of heterosexual men and women, young adults, mostly with low economic resources, who may have multiple partners and may engage in periodic or sporadic transactional sex, either to cover basic needs, or have access to other material items they could not otherwise afford, is also at risk for HIV.

The male to female ratio of HIV has, over the past 20 years, been decreasing from a high of 4.5:1 in 1987 to 1.4:1 in 2008. Cumulative cases of HIV from 1984 to 2008 show that there have been more females in the age groups: less than 5 years, 15 – 24 years and 65 - 69 years. The majority of male HIV cases have occurred within the ages of 20-49 years while the female cases have occurred within the ages of 20-39 years. Cumulative AIDS cases, 1984-2008, show a similar sex-specific age distributions to HIV distributions. The majority of male AIDS cases have been in the age range of 25-49 years whereas the female cases have been in the age range of 20-39 years.

National response

The national response to the epidemic has been aggressive with the establishment of a National AIDS Council and its Secretariat (NAS), co-chaired by the Prime Minister and the Minister of Health and the Environment, to provide a multi-sectoral co-ordination. NAS co-ordination of the national response has resulted in the establishment of focal points in 9 non-health line ministries, with work plans and a number of CSO partners actively contributing to the national response.

HIV prevention strategies have been guided by the objective of developing, strengthening and implementing HIV/AIDS/STI prevention and control programmes with priority given to

the youth and high risk vulnerable groups. Most of the available indicators of the prevention interventions are input indicators. Preventive strategies have included:

- Condom distribution with the challenges of :
  - lack of in-depth information on the drivers of the epidemic,
  - lack of behavioural and sero-prevalence information on the "hidden" MARPs of sex workers and MSM (in spite of the number of CSOs and public sector interventions).

- Voluntary counselling and testing for HIV which is being fully integrated in PHC services, especially with the introduction of the provider initiated testing and counselling (PITC). Comprehensive coverage for HIV counselling and testing is, however, compromised by a high transfer of staff trained in rapid HIV testing who are posted at health centres.

- Targeting the youth and key populations at higher HIV risk. Any outcomes of these initiatives with the youth are expected to be identified by the planned behavioural survey.

- Provision of HIV post exposure prophylaxis, with the need to address the issue of fear of stigmatization by false association of accessing the service, and being infected with HIV.

- Prevention of mother-to-child HIV transmission which is being implemented successfully. The services are reaching almost all pregnant women attending antenatal clinics.

- Use of behaviour change communication (BCC) strategies which include mass media interventions. There remains the difficulty of measuring outputs and outcomes of BCC as input indicators alone are not sufficient to assess the impact of the intervention.

The treatment, care and support response includes treatment with highly active antiretroviral therapy services, provided since August 2003, at the care and treatment clinic of the Milton Cato Memorial Hospital (MCMH). There are plans to establish three additional ART accredited sites within the next two years and three more eventually. The number of persons enrolled annually for care and treatment has been fairly uniform at about 60 per year. By the end of 2008 there were 259 persons enrolled. From 2003 to the end of 2008, of the 177 clients enrolled for ART, only 9 were children under 15 years, 82 (46.3%) were women and 95 (53.7%) men. These statistics do not include PLHIV treated in private clinics who may include individuals from other Caribbean islands, seeking anonymity, and have decided to seek treatment in St. Vincent and the Grenadines

All PLHIV diagnosed with tuberculosis are routinely tested for HIV, and all symptomatic HIV positive persons who access medical services are expected to be tested for tuberculosis. The Ministry of Health and the Environment has committed itself to enhancing prevention measures, treatment and identification of the two diseases (HIV and tuberculosis), as well as the continuous provision of effective treatment options.

The care and support response is primarily addressing orphans and vulnerable children (OVC) but all persons with HIV infection who attend a public clinic for care and treatment are assessed regarding their social, economic and psychological situation. Financial assistance is provided through the Ministry of National Mobilization, Family Services Department. Priority for financial assistance is given to orphans, the physically impaired and

the elderly. A psychological programme provides assistance with psychological issues relating to coping with the HIV/AIDS diagnosis. Stigma and discrimination had been monitored by HIV/AIDS monitoring and evaluation programme through data collected by the Community Outreach and HIV Human Rights Advocates until funding stopped in November 2008.

The clinical laboratory at MCMH provides support to the treatment of HIV/AIDS clients. Services that the laboratory cannot provide locally, such as viral load test and DNA PCR for infant diagnosis, are accessed from CAREC and South Africa. Laboratory training has been completed for the diagnosis of opportunistic infections. The Laboratory also trains HCW in HIV rapid test techniques.

Preparation process

The HIV/AIDS National Strategic Plan 2010-2014 was prepared through an intensively interactive and participatory process managed by the National AIDS Secretariat. A Steering Committee of six persons was established to guide the preparation of the strategic plan and its 2-year action plan. The NSP was prepared with contributions of five technical sub-committees (TSC), each chaired by a member of the Steering Committee, involving altogether about 50 persons representing all sectors: public, private, civil society, MSM and PLHIV.

The NSP preparation process was supported by two External Consultants recruited by UNAIDS EC Office in Barbados through the ASAP, a service of UNAIDS hosted by the World Bank in Washington, D.C., USA. One consultant supported the preparation of Parts I-IV and another the preparation of Part V.

Vision and goals

The vision of the National Strategic Plan 2010-2014 is:

To substantially reduce the spread and impact of HIV in St. Vincent and the Grenadines through sustainable systems of Universal Access to HIV prevention, treatment, care and support, and empowerment of the population to prevent HIV infection.

The national goals are:

- ***To reduce the estimated number of new HIV infections by 30% by 2014***
- ***To reduce mortality due to HIV by 30% by 2014.***

Guiding Principles and Strategic Approaches

St. Vincent and the Grenadines endorses the following guiding principles:

- Political leadership for a sustained and effective national response to HIV.
- Gender equity is important for the development, planning and implementation processes
- Good governance that provides leadership that mobilizes and manages resources in an effective, transparent and accountable manner.
- Regional cooperation
- Multisectoral approach that involves not only the health sector but all sectors to address economic, social and cultural issues.
- Inclusiveness and greater involvement of people living with HIV
- Equal access to prevention, treatment, care and support services by all the people.
- Equality before the law and freedom from discrimination
- Evidence-based interventions and international best practices.
- Sustainability of intervention programmes over the long term.

St. Vincent and the Grenadines also endorses the following strategic approaches in the fight against HIV:

- Prevention remains a priority in the absence of a cure for AIDS and with the high lifetime costs associated with treatment.
- Strengthening health and social systems for effective delivery of HIV programmes
- Monitoring and evaluating programmes to improve programme design and management
- Bilateral, regional and international cooperation and collaboration

Priority areas

St. Vincent and the Grenadines intends to continue to address the challenges facing the country as a result of the HIV/AIDS epidemic. Notable progress has been made in the areas of treatment for PLHIV; preventing the transmission of HIV from mother to child; and providing HIV rapid test to the populace. The efforts made so far must be continued and strengthened to reduce the spread and impact of HIV in the country.

The main messages of the epidemic in St. Vincent and the Grenadines have been:

- That the epidemic is becoming generalized. This observation is based on antenatal data (which for the past five years have been slightly over 1%) and limited data on vulnerable groups such as youth and men who have sex with men.
- The need to decentralize the services and integrate them in the primary health care services to ensure sustainability in a small economy and multi-island country such as St. Vincent and the Grenadines.
- That stigma and discrimination associated with HIV must be seriously addressed through continued education of the general public.
- That adherence to ARV therapy and disclosure to sexual partners must be encouraged
- That involvement in the multi-sectoral response must be targeted to the critical stakeholders who are most likely to have an impact on reversing the epidemic.
- A need for operational research to assess the effectiveness of preventive interventions that have been implemented over the last strategic planning period and guide future efforts.

The priorities of this strategic plan are the following.

- Enhancement and expansion of HIV/AIDS prevention programmes.
- Strengthening of HIV/AIDS surveillance especially as it relates to MARPs and other vulnerable groups.
- Increased focus on stigma and discrimination reduction.
- Strengthening the ARV treatment programmes.
- Sustainability through human resource management, decentralization and integration of HIV/AIDS services, and health systems strengthening.
- Conducting further research in relation to the driving factors of the epidemic, core societal issues influencing the disease spread, and the impact of intervention programmes.
- Drafting of legislation and policies to govern the management of HIV/AIDS
- Ensuring greater involvement of critical stakeholder.

Strategic objectives

The following priority areas and strategic objectives for action over the next five years are based on the need to build on programmatic strengths established over the years and address identified weaknesses. The NSP addresses 18 strategic objectives.

Priority Area 1: *Policy development and legislation*

1. Develop policies, programmes and legislation that promote human rights, including gender equality, and reduce socio-cultural barriers in order to achieve Universal Access.
2. Reduce stigma and discrimination associated with HIV and vulnerable groups.

Priority Area 2: *Multisectoral involvement and decentralization*

1. Enhance the ownership of national HIV programmes and the responsibility for the national response to the epidemic.
2. Strengthen the multi-sectoral response to HIV, including involvement of key government organizations, NGOs, CBOs, FBOs, PLHIV networks, the private sector, trade unions and vulnerable groups.
3. Train relevant workers in all sectors to provide HIV prevention, treatment, care and support services.
4. Strengthen health and social systems and improve infrastructure to provide comprehensive and integrated HIV services.
5. Support national, public and private sector organizations to introduce comprehensive workplace policies and programmes.
6. Promote and protect the health of students and staff and mitigate the impact of HIV on the education system.

Priority Area 3: *Prevention services*

1. Establish friendly, comprehensive, gender-sensitive and targeted prevention programmes to prevent sexual transmission of HIV.
2. Provide services for prevention of mother-to-child transmission of HIV to all pregnant women, and their families.
3. Strengthen prevention efforts among PLHIV as part of comprehensive care.
4. Reduce vulnerability to HIV through early identification and treatment of other sexually transmitted infections (STI).

Priority Area 4: *Care, treatment and support services*

1. Increase access to treatment, care and support services, for persons living with HIV.
2. Improve the management of tuberculosis (TB), opportunistic infections (OI) and sexually transmitted infections (STI) by early identification and treatment.
3. Improve access to nutritional and psychosocial services, for persons living with HIV.

Priority Area 5: *Strategic information, M&E and research*

1. Track progress in the implementation of National HIV responses.
2. Maintain and strengthen HIV/AIDS/STI surveillance
3. Develop appropriate evidence-based policies, practices and interventions through the use of research findings and M&E data.

Implementation framework

The implementation framework for the NSP assumes an environment in which:

- The country invests in capacity development through institutional and in-service training for health care providers, develops the human resource and management capacity of the CSO partners, and expands the HIV module in the School of Nursing curriculum and other educational institutions.

- The country has very limited financial resources to meet all the social demands; hence external financing will continue to be vital for an effective implementation of the NSP without losing the momentum established in the various programmes including ART and the need to move beyond mere sensitization for the prevention of HIV infection. The Government is committed to its role in the prevention and control of HIV/AIDS and will contribute more financial resources in its response to the epidemic. The indicative cost of the NSP 2010-2014 is about EC$ 31.0 million or US$ 11.5 million over a period of five years.

- The country will continue to draw on the regional resources and cooperation as a member of OECS and CARICOM. Among such areas is technical and financial support for research in epidemic drivers, including the youth and difficult-to-reach high-risk populations of sex workers (probably “transactional”) and men who have sex with men. The country will also participate in cost-saving regional bulk purchases of commodities, and sharing of information on good practices particularly in connection with monitoring drug resistance.

- The country acknowledges that the fight against HIV/AIDS is a collective responsibility of all sectors of society: public and private. The multi-sectoral coordinating structure will continue to guide the national response in identifying areas of the response best executed by the public or private sector. The Government will continue to deepen existing partnerships with civil society and develop new strategic partnerships that will provide enhancement to the efforts of reaching difficult-to-reach high-risk populations and

addressing certain issues. The research agenda of the NSP will eventually provide information needed for a better understanding of the most cost-effective interventions for a country of the size of St. Vincent and the Grenadines.

- People living with HIV are fully involved in the national response and will continue to be supported in their involvement. Strengthening of PLHIV networks and support groups will increase their contribution in the planning and decision making on prevention and support issues.

- To ensure effective implementation, there will be ongoing monitoring and evaluation.

M&E Environment

Monitoring the national response to the HIV/AIDS epidemic has been a vertical activity, supported financially through grants and other external funding sources. A new monitoring environment is being established under which the monitoring and evaluation of the national response will be under the Health Planning Information Unit (HPIU) in the Ministry of Health and the Environment as part of the overall M&E services of the health sector. The integration will also be in line with the "Three Ones" principle.

In spite of the unified monitoring services, M&E for HIV/AIDS will continue to focus on the key areas:

(i) Helping to create an environment for the system to function well by training stakeholders in the concepts of monitoring and evaluation.
(ii) Ensuring that the kind of data needed for monitoring the HIV response is collected and verified and stored in an organized manner.
(iii) Ensuring that data is analysed, reported and disseminated for use by decision makers and implementing partners.

The national response is monitored by well selected indicators for trends and the collective impact of various interventions. Some of the indicators for national monitoring are also used for global monitoring, for example, UNGASS and MDGs. Twenty seven such indicators are identified based on country relevance, scope of work, ability to collect relative data and usefulness. Among these core indicators; the following will have top priority in monitoring the key areas in the continued national response to the epidemic.

1. Percentage of pregnant women aged 15-24 years that are HIV positive
2. Percentage of MARPs that are HIV positive among:
    a. male prisoners
    b. sex workers
    c. men who have sex with men
3. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results
4. Percentage of PLHIV known to be on treatment 12 months after initiation of ART
5. Number and percentage of women and men with advanced HIV infection receiving ART (Clinic Attendees)
6. Number of health facilities offering PITC

7. Number of health facilities offering ART
8. Amount of national funds spent by the Government on HIV/AIDS

The NSP also includes indicators for monitoring specific interventions, activity by activity, according to the strategic objectives and their expected results. The monitoring framework matrix gives, for each strategic objective, output indicators corresponding to the activities in the NSP implementation framework and targets for the years 2011 and 2014. The National HIV/AIDS M&E Plan will be followed in monitoring the NSP with any necessary amendment when HIV/AIDS monitoring and evaluation is fully integrated with the MoHE HPIU.

PART I: INTRODUCTION

1 Situation assessment

1.1 Epidemiological situation

1.1.1 HIV/AIDS prevalence

St. Vincent and the Grenadines remains a low HIV-prevalence country with a prevalence believed to be about 1% of the population. Results of ANC sero-surveillance show that the HIV prevalence among pregnant women was less than 1% up to 2003. Since 2004 it has ranged from 1.45% to 1.0% as shown in Table 1. The epidemic in St. Vincent and the Grenadines may, therefore, be categorized as *generalized*[1]. It is a quarter of a century since the first case of HIV was reported in St. Vincent and the Grenadines and at the end of 2008 the cumulative number of persons identified as HIV positive was 1093. By the end of 2008 the number of persons who had died of AIDS-related causes since 1984 was 525 (2 males living with HIV died in 2005 of non-AIDS related causes). The number of recorded persons living with HIV in SVG was 555 by the end of 2008 of whom 295 (53.2%) were males and 245 (44.1%) females and 15 (2.7%) were of unknown sex.

Challenge: Lack of definitive prevalence of HIV in SVG. Figures vary widely from 0.4% made in 2005 to 0.9% estimated by CAREC in 2001. The prevalence of 0.4% is based on reported cases of PLHIV and believed by people working in the treatment and care of PLHIV to be an under-estimate.

Table 1: HIV sero-prevalence of ANC clients, 2001-2008

Year	Number of women		HIV prevalence %
	tested	positive	
2001	1902	14	0.74
2002	1746	11	0.63
2003	1648	9	0.55
2004	1726	25	1.45
2005	1495	15	1.00
2006	1653	24	1.45
2007	2061	23	1.12
2008	2188	25	1.14

Source: MoHE Infectious Diseases Clinic

HIV increased gradually up to 1996 when 62 cases were recorded. The highest annual record of HIV cases was 108 cases in 2004. The HIV recorded incidence in 2008 was 68 cases which was lower than the recorded incidences in 2006 and 2007 of 82 and 85 cases respectively. The 2004 spike of HIV cases followed the introduction of antiretroviral treatment in 2003. The peak number of recorded HIV cases could have been due to a general response by people to find out their HIV status when they knew there was a

Achievement: The lowest number of AIDS related deaths since 1995, when 8 deaths were recorded, was in 2008 with 24 deaths. Since 2003 AIDS is no longer synonymous with death

[1] http://unaidstoolkit.s-3.net/support_pages/faq_hiv_prev_epi_setting.aspx

possibility for treatment. The AIDS epidemic curve followed closely the pattern of the HIV incidence curve up to 1999 when the two epidemic curves became slightly divergent. There were progressively fewer AIDS reported and recorded cases in successive years till 2003 when there was a spike with 57 AIDS cases. The HIV spike in 2004 has not been followed with an equivalent spike in AIDS cases in subsequent years. The lowest annual number of AIDS related deaths since 1995, when 8 deaths were recorded, was 24 deaths in 2008. Figure 1 shows the annual distribution of HIV, AIDS and HIV-related deaths from 1984 to 2008. Figure 1 clearly shows that since 2003 AIDS is no longer synonymous with death.

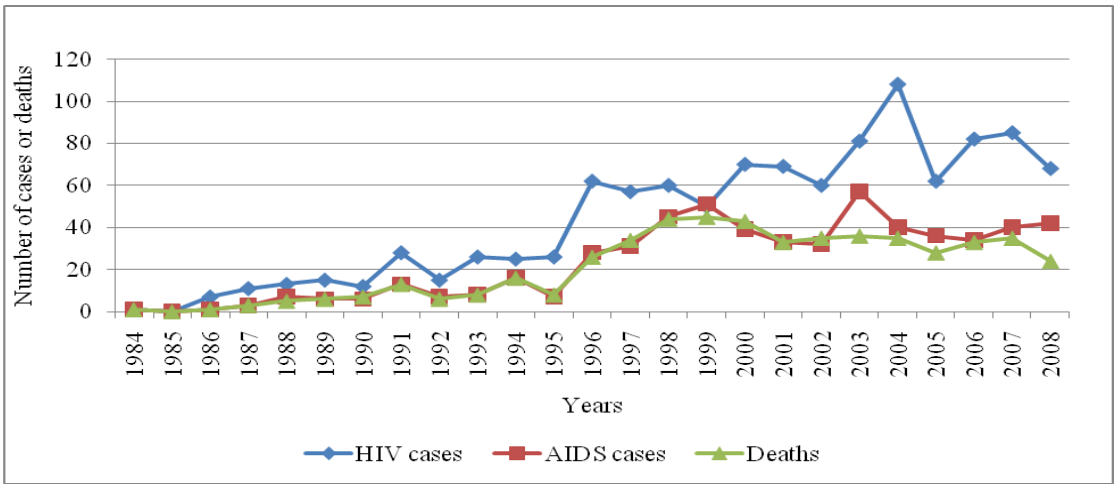

Figure 1: Annual HIV and AIDS incidence and AIDS-related deaths, 1984-2008
Source: NAS Programme reports

From the HIV incidence peak of 2004 there has been a general decrease in the incidence of approximately 37% by the end of 2008. This decrease may be attributed to the interventions that the country has been implementing. The reduction in AIDS-related mortality is about 40% over the same period due to the successful implementation of the PMTCT programme and ART.

Achievement: There has been a general decrease in the incidence of HIV. This decrease may be attributed to the interventions that the country has been implementing. The reduction in mortality attributable to AIDS is due to the successful implementation of the PMTCT programme and ART

1.1.2 Mode of transmission

The main mode of HIV transmission is through heterosexual contact, accounting for approximately 70% of all HIV infections. Recorded homosexual/bisexual and vertical transmissions account for 10% and 4% of cases respectively. Data on homosexual/bisexual men may not be reliable because of the social stigma attached to homosexuality.

Challenge: Lack of data and general information on homosexual or bisexual men probably due to social stigma attached to homosexuality

1.1.3 Sex and age distribution of HIV and AIDS cases

The male to female ratio of HIV has, over the past 20 years, been decreasing from a high of 4.5:1 in 1987 to 1.4:1 in 2008. Figure 2 shows the male to female ratios from 1984 to 2008 in terms of annual specific sex percentage distribution of HIV cases.

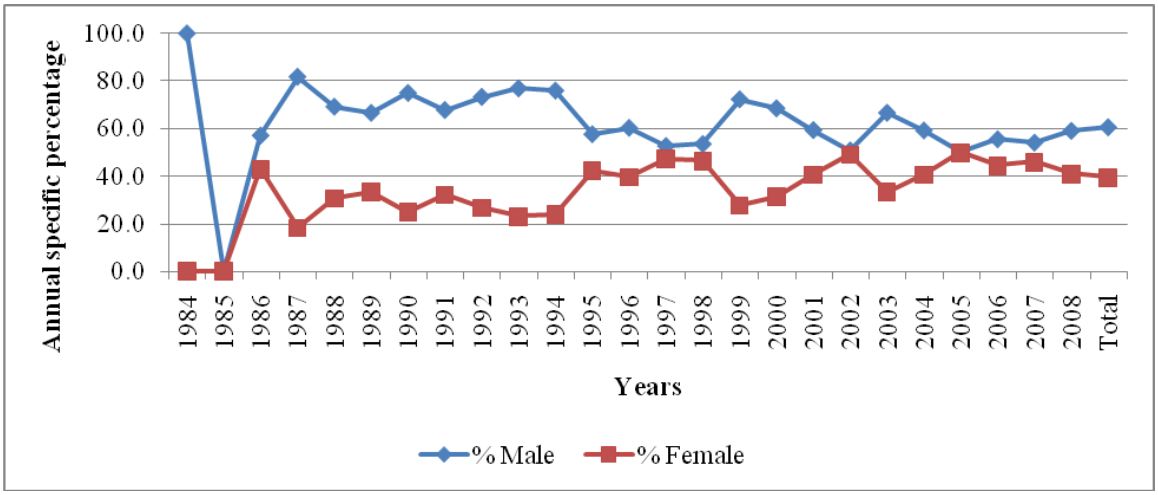

Figure 2: Year-specific sex percentage distribution of HIV cases (1984 to 2008)
Source: NAS Programme reports

Cumulative cases of HIV from 1984 to 2008 show that there have been more females in the age groups: less than 5 years, 15 – 24 years and 65 - 69 years with all the other age group categories dominated by males (Figure 3). The majority of the male HIV cases have occurred within the ages of 20-49 years while the female cases have occurred within the ages of 20-39 years.

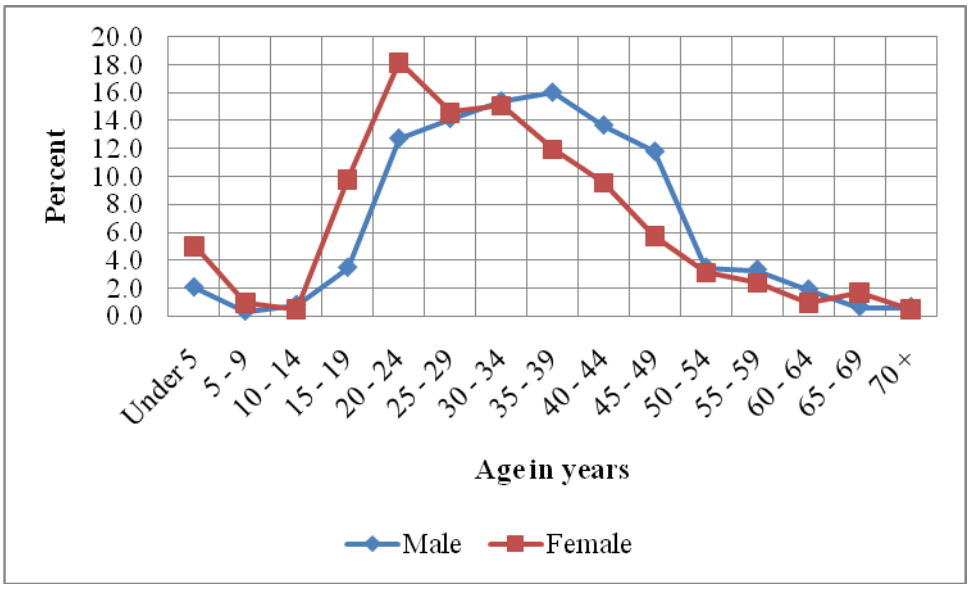

Figure 3: Cumulative 1984-2008 HIV age and sex distribution
Source: NAS Programme reports

Cumulative AIDS cases, 1984-2008, show a similar sex-specific age distribution to HIV distribution (Figure 3). The majority of male AIDS cases have been in the age range of 25-49 whereas the female cases have been in the age range of 20-39 ages.

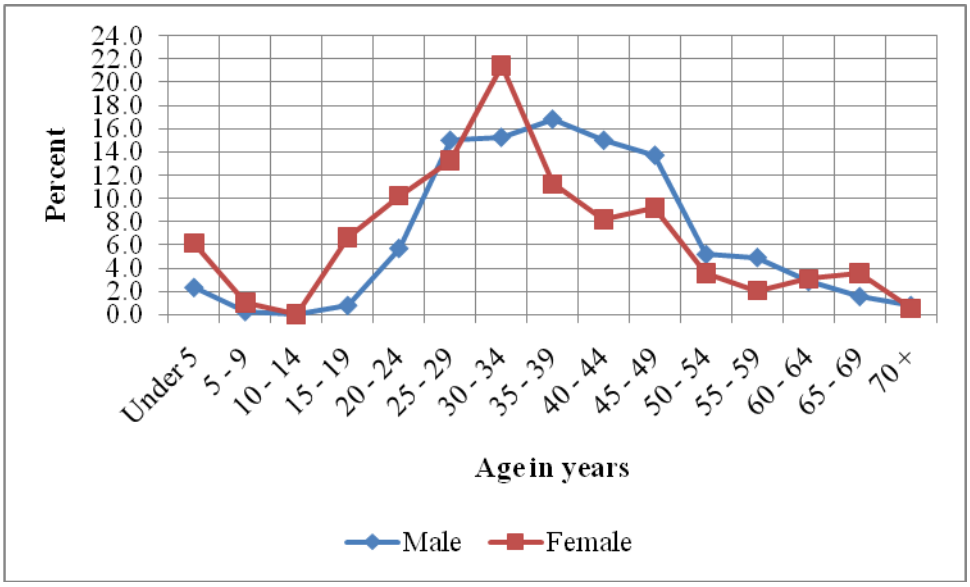

Figure 4: Cumulative 1984-2008 AIDS age and sex distribution
Source: NAS Programme reports

1.1.4 Drivers of the HIV epidemic in St. Vincent and the Grenadines

The findings of the rapid assessment study echo evidence in the Caribbean which shows that both girls and boys are exposed at an early stage of their life to sexual intercourse. This behaviour is influenced by peer pressure as well as other factors. In order to fit in with their peers, youth experiment with alcohol, marijuana and sex. Through those experiences, teenagers build their own identity and gain acceptance and recognition from others but expose themselves to risky situations with regard to HIV infection. The second driver of risky behaviour among youth is through the practice of transactional sex which occurs among both sexes. The current consumerism culture together with poverty can lead to transactional sex in which people have sex in exchange for commodities, clothes, etc. In addition, practices of age-mixing create greater risk with lower condom negotiation skills among the younger partners. Finally, youths are involved with multiple partners (concurrently or subsequently). Access to youth-friendly health services remains inadequate in SVG and it seems that, young girls especially experience challenges in accessing condoms.

The second group identified as 'most at risk' for HIV is MSM (gay or heterosexual). Social norms, stigma and discrimination, together with religious conservatism and buggery laws, encourage MSM to remain a hidden population and as such expose them to a greater risk of getting HIV and limited access to prevention, care and treatment.

The third population group identified as 'most at risk' is PLHIV through the risk of re-infection and transmission of the disease to their sexual partners. Evidence shows that some PLHIV are not able or willing to disclose their HIV status generally or with their sexual partners. When this situation occurs condom introduction is difficult, increasing the risk of HIV infection to their sexual partners and a risk of re-infection if the partner is HIV-infected as well. In addition, some PLHIV are involved in transactional sex due to their low socio-economic status, and this can affect their ability to engage in condom negotiation and result in low condom use.

These are segments of population, sometimes overlapping with youths, whose HIV risk may be influenced by their occupation:

Mini bus drivers: These are young men who work for a fixed and small salary driving the vans that provide public transportation throughout St. Vincent. They are sexually active and likely to interact with school-aged girls on the bus or at bus stops, and then see and socialize with them, on the block or at different places.

Uniformed personnel: Comprised of police, security guards, tourist police responsible for safety and security in tourist areas. Security guards, because of the nature of their job, may have sexual relations during work hours, for instance at night, and HIV can be transmitted in the absence of condom use.

Fisher folk: These are typically men who may stay overnight in some other islands to sell fish, may have ready cash to spend and may be at risk for HIV and STIs through sex. Persons who work in cargo ships were also reported to be at risk for HIV or transmitting HIV themselves by having unprotected sex during their work-related trips.

1.1.5 Knowledge and behaviour

Knowledge of HIV/AIDS among the youth was found to be almost universal in a BSS done in 2005. The survey found that a large majority of male and female youths knew of mother-to-child HIV transmission and that transmission can be through breastfeeding and people reject the most common myths of the spread of HIV. AIDS does not "have a face" in SVG because of the relatively small numbers. Consequently the behaviours survey of 2005 found that personal experience with HIV positive people, or people with AIDS, was quite low particularly among male respondents.

Achievement: The youth are knowledgeable about HIV/AIDS, including mother-to-child HIV transmission and that transmission can be through breastfeeding and reject the most common myths of the spread of HIV

The behavioural survey found evidence that the youths in St. Vincent and the Grenadines have multiple sexual partners (as many as 12) in a year for males and 4 for females. While information on condom use at first sexual intercourse may not be a strong indicator of current condom use, the survey's results were that only 35% of all respondents had used a condom during their first sexual intercourse (whenever that was). Among the respondents in the survey more women had used a condom during their first sexual intercourse than males (42% and 27% respectively). There is currently a dearth of available information on detailed condom use but a survey is planned on the use of male and female condoms.

1.2 National response

1.2.1 Institutional

The HIV/AIDS/STI Prevention and Control Programme was established in 2001 to respond to the HIV epidemic. In 2004 a National AIDS Council was established to provide a multisectoral coordination of the national response as a result of funding from the World Bank. The Council is co-chaired by the Prime Minister and the Minister of Health and the Environment. The Council's Secretariat, the National AIDS Secretariat (NAS) is a department in the Ministry of Health and the Environment. NAS oversees the multisectoral coordination as well as being responsible for the implementation of some of the activities in

the Ministry of Health and the Environment. There is an institutional arrangement for the management of the World Bank-funded project in the Ministry of Finance. The Project Co-ordinating Unit is responsible for fiduciary management (financial management and procurement).

The most informative indicators of the effectiveness of NAS co-ordination of the national response are the establishment of focal points in 9 non-health line ministries with work plans, and the number of CSO partners actively contributing to the national response. As a result of NAS's work there are now nine non-health line ministries with focal points and sectoral work plans. These ministries are: Education, Finance and Economic Planning, Housing, Labour, National Mobilization, National Security, Rural Transformation, Telecommunication and Tourism. All, but the Ministry of Housing, have work plans for 2008/2009. All of the seven ministries with work plans have done some HIV/AIDS-related activities in their work plans. The ministry of Tourism has done more than 75% of the activities it planned to do while the ministries of Finance, Labour and Education have done at least a third of the planned activities as shown in Table 2.

Achievement: NAS's coordination of the national response has resulted in the establishment of focal points in 9 non-health line ministries with work plans and a number of CSO partners actively contributing to the national response

Table 2: Non-health ministries' performance

Ministry	**Activities for 2008/2009**		
	Planned	Completed	Percent of activities completed
Education	22	8	36.4
Finance	20	9	45.0
Labour	13	5	38.5
National Mobilization	22	7	31.8
National Security	28	6	21.4
Rural Transformation	15	3	20.0
Telecommunication	6	1	16.7
Tourism	13	10	76.9

Source: NAS Programme reports

One of the co-ordination challenges is meeting the needs of the sectoral response of the key ministries of Education, Labour, National Mobilization, National Security and Tourism because of their limited HIV/AIDS technical and organizational capacities.

Challenge: Limited HIV/AIDS technical and organizational capacities of the key ministries

The institutional responses for civil society (NGOs, CBOs and FBOs) and the private sector are varied. A National Network of NGOs (NNN) was established in 2002 with 5 members in response to a perceived need by national NGOs for coordination. There are now 15 member organizations in NNN with varied technical and organizational capacities. The private

Achievement: There are now 15 member organizations in NNN and the private sector is addressing HIV/AIDS through the Employers' Federation developing HIV/AIDS work place policies in 16 work places.

sector is addressing HIV/AIDS through the Employers' Federation, developing HIV/AIDS work place policies in 16 work places supported by the ILO. There are also private clinics providing treatment to PLHIV. A major challenge for the country is how to provide the right environment for civil society and private sector to develop their capacities to relieve some of the public sectors that are unlikely to muster the necessary capacity to meet their sectoral obligations.

Challenge: How to provide the right environment for civil society and private sector to develop their capacities to relieve some of the public sectors that are unlikely to muster the necessary capacity to meet their sectoral obligations.

The Government is investing financially in the prevention and control of the spread of HIV/AIDS but there is no information readily available on how a possible impact of HIV/AIDS on the various sectors such as health, education, agricultural activities, security etc. is addressed in national development planning. No assessment has been made on either existing or possible impact of HIV/AIDS on sectors such as health, agriculture, tourism and security. The impact may be "smouldering" in spite of not being perceived due to the small numbers of AIDS cases, because of the small population base. An HIV/AIDS social economic impact study is planned under the World Bank funding.

Challenge: Lack of information on how a possible impact of HIV/AIDS on the various sectors is addressed in national development planning. The impact may be "smouldering" in spite of not being perceived.

1.2.2 Prevention

The national response towards the prevention of HIV infection has been guided by the objective of developing, strengthening and implementing HIV/AIDS/STI prevention and control programmes with priority given to the youth and high risk vulnerable groups. Most of the available indicators of the prevention interventions are *input indicators*. There is need to assess the effectiveness of the various interventions that have been implemented in St. Vincent and the Grenadines over the years against the spread of HIV. It is also important to have information on the core societal issues that may hinder effective implementation of crucial preventive interventions to MARPs or issues that may be fuelling the epidemic.

Challenge: Lack of information on the effectiveness of the prevention interventions and the role of societal issues in the dynamics of the epidemic in St. Vincent and the Grenadines.

The prevention strategies used in St. Vincent and the Grenadines have included:

(i) <u>Condom distribution</u>

Since HIV transmission is mainly through sexual intercourse, male and female condom use is promoted as one of the primary prevention strategies. The target cumulative number of male condoms distributed through public sector, including Line Ministries, since 2004 is 2 million at the end of 2009[2]. From 2004 to 2008, 1.5 million condoms have been distributed.

Challenge: Lack of information on real drivers of the epidemic, the "hidden" MARPs of sex workers (most likely "transactional") and MSM in spite of the involvement of CSOs and the public sector

[2] At the time when the NSP 2004-2009 was prepared, female condoms were not one of the preventive commodities that were being promoted.

A number of CSOs are involved in the distribution of male and female condoms and sexual intercourse lubricants to MARP particularly MSM. Although social marketing for condoms was intensified in 2007 with assistance from external partners such as Population Services International (PSI) and the United Nations Population Fund, the total number of condoms distributed was less than the numbers distributed in 2006 by nearly 170,000 condoms. Challenges for the condom preventive strategy are: lack of information on real drivers of the epidemic, the "hidden" MARPs of sex workers (most likely "transactional") and MSM in spite of the number of CSOs and public sector involvement.

Challenge: Problems of comprehensive coverage for HIV counselling and testing and PLHIV sexual contact tracing, compounded by transfer of staff trained in rapid HIV testing who are posted at health centres

(ii) Voluntary counselling and testing (VCT)

The VCT programme started in 2003 and was intensified in 2006/2007 with refurbishing of the infrastructure, training people and expanding the coverage of the services. 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. VCT services are rapidly being fully integrated in PHC services especially with the introduction of the provider initiated testing and counselling (PITC). However, there are still challenges to providing comprehensive services to the majority of the people including effective PLHIV sexual contact tracing and HIV testing. The target, by the end of 2009, of individuals 15-49 years to be tested for HIV, is 50%. By the end of 2007 only 30% had been tested at least once. One of the drawbacks has been the transfer of staff trained in rapid HIV testing who are posted at health centres. The human resources of the country are such that it is not possible to have staff dedicated to HIV rapid test, posted in all health facilities. Alternative strategies must, therefore be found for either institutionalizing the training in health training institutions or to keep on training health workers as they are posted in health facilities slated to offer VCT.

Achievement: VCT services are rapidly being fully integrated in PHC services especially with the introduction of the provider initiated testing and counselling (PITC).

(iii) Peer education programme

There are programmes specifically designed for the youths (referred to as "youth-on-the-block"), taxi and minibus drivers, using Peer Communicators/Educators. These peer communicators and educators visit the various communities on a daily basis for approximately 14 hours per week working through convenience sessions with individuals or groups, as well as through organized sessions at schools. They cover 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. Approximately 300 youths were reached each month in 2007 on mainland St. Vincent. A challenge for the intervention is lack of information on size, location and behaviour of some of these groups. While it is difficult to measure the true impact of peer education programmes, basic operational research is needed to at least establish key baseline figures that can be used in monitoring outputs and outcomes.

(iv) Community animators programme

Community Animators implement the model of Stages of Behaviour Change with their prevention efforts targeting key populations such as men who have sex with men, women who sell sex for money, goods and services, and people living with HIV. Because these behaviours are highly stigmatized and illegal, MSM and sex workers and their sexual partners are difficult to access through traditional social services. The Community Animators Programme therefore utilizes the services of community outreach workers called "community animators". The outreach is conducted by individuals, drawn from the local community and familiar with the subcultures within these groups, during social events, in private homes, shops, bars, etc.

Since this model was implemented in 2006, specific outreach strategies have included:

- Communicating basic risk-reduction information;
- Presenting a hierarchical framework for understanding the relative effectiveness of different risk-reduction strategies;
- Providing literature, commodities and other materials to support behaviour change; and
- Facilitating access to drug treatment, HIV/AIDS testing and counselling services, and other medical and social services available

(v) HIV prevention among the youth

Several training activities focusing on adolescents were organized in 2007 covering HIV/AIDS, self esteem, domestic violence and capacity building. There are also youth clubs initiated by the HIV/AIDS Secretariat and other government departments and NGOs. Any outcomes of these initiatives with the youth are expected to be identified by the planned behavioural survey in 2009.

(vi) HIV post exposure prophylaxis (PEP)

PEP is provided as part of the Universal Precautions Package that reduces staff exposure to infectious hazards at work. A PEP treatment protocol, outlining the steps to be followed should an injury occur, was developed in May 1991 and revised in June 2001. The target, by the end of 2009, is to have less than 10 health care providers requiring PEP according to National Guidelines. At the end of 2007, twenty one health workers had taken PEP. A challenge to accessing PEP services is fear of stigmatization by false association of accessing the service, and being infected with HIV.

Challenge: fear of stigmatization by false association of accessing the service, and being infected with HIV

Challenge: MSM and sex workers and their sexual partners are difficult to reach because their activities are highly stigmatized and illegal

(vii) Prevention of HIV mother to child transmission (PMTCT)

The prevention strategy against vertical transmission of HIV is being implemented successfully according to the current indicators. The treatment management for both HIV positive mother and baby are standardized according to World Health Organization (WHO) Guidelines. 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 targets set for the end of 2009 were achieved by the end of 2007. There has been a steady increase in the percentage of pregnant women

Achievement: PMTCT is being implemented successfully and data is readily available.

counselled and tested for HIV (58% during 1999-2000, 88% in 2006 and 98% in 2007). The target is to have all pregnant women counselled and tested for HIV. PMTCT data is available through the Health Centres, the Laboratories (public and private) and the Care and Treatment Clinic.

(viii) *HIV prevention among key populations at higher risk*

Some populations are more likely to have higher risks for HIV infection than the general population, either because of their occupation or life-style. Sailors, offshore workers, fishermen, sex workers, guards and uniformed groups are regarded as high HIV infection risk groups in SVG. Men who have sex with men are likely to have a high HIV infection risk because of their life-style. There is very little information about these likely high HIV infection risk groups. Prisoners are another group that is likely to be at high HIV infection risk. The sero-prevalence for all inmates tested in 2005 was 4.1%, with half of the HIV positive inmates between the ages of 20 to 29 years. There are sessions on HIV education, VCT and HIV prevention measures conducted by NAS for prisoners and prison officers.

Challenge: Very little information about these likely high HIV infection risk groups

(ix) *Behaviour change communication (BCC) and mass media communication*

A national behaviour change and strategic communication strategy has been distributed since the beginning of 2008. This Strategy addresses (a) the broad programmatic areas that need to be integrated into the national response, (b) strategic elements including prioritisation of target populations most at risk, (c) a situation analysis and previous BCC, and strategic communication initiatives, and (d) a plan for effective communication response aimed at supporting and advancing the goals of the HIV/AIDS programme.

A weekly radio programme, 'HIV Mirror', is aired by five radio stations, and three weekly newspapers carry print messages/advertorials on a weekly basis. In addition, interactive radio call-in discussions held from time to time are broadcast simultaneously on several radio stations. Other electronic initiatives include television advertisements, radio advertisements and public service announcements, aired on six radio stations on a daily basis. Print BCC materials have also been distributed. These include pamphlets, leaflets and flyers dealing with a range of pertinent issues such as the basics of HIV/AIDS, stigma and discrimination, abstinence and condom usage. A challenge for this preventive strategy is the difficulty of routinely measuring outputs and outcomes. Input indicators are not sufficient to assess the effectiveness of any of the interventions under the strategy. Impact indicators are collected through five-yearly surveys.

Challenge: It is difficult to routinely measure outputs and outcomes of BCC, and input indicators are not sufficient to assess the impact of the intervention.

1.2.3 Treatment care and support

(i) *ART*

Treatment with highly active antiretroviral therapy (HAART) commenced in St. Vincent and the Grenadines in August 2003 and is provided at the Care & Treatment Clinic of the Milton Cato Memorial Hospital. Plans are under way to establish 6 new sites, 3 within the next two years.

The number of persons enrolled annually for care and treatment has been fairly uniform since the introduction of the treatment services in 2003 as shown in Table 3 and Figure 5. At the end of 2008 there were 259 persons enrolled for care and treatment.

Table 3: Enrolment for care and treatment from August 2003 to 2008

Year	Enrolment					Cumulative Total		
	New	Male	Female	Deaths	Transfer Out	Male	Female	Total
Aug-03	56	21	35	2	0	20	34	54
2004	66	43	23	5	0	61	54	115
2005	60	22	38	18	1	72	84	156
2006	42	21	21	17	0	78	103	181
2007	60	25	35	20	1	89	131	220
2008	59	34	25	16	4	113	146	259
Total	343	166	177	78	6			

Source: NAS Programme reports

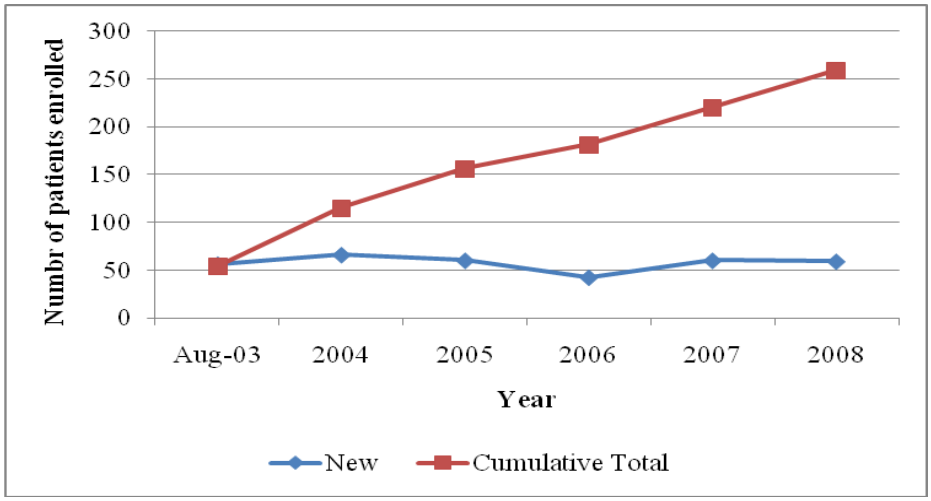

Figure 5: Enrolment for care and treatment from August 2003 to 2008
Source: NAS Programme reports

Survival/adherence for persons enrolled in ART has not shown much fluctuation over the years for either male or female clients, taking into account the small numbers involved. From 2003 to the end of 2008 only 9 children under 15 years, and 168 clients, 15 years and older had been enrolled in the ART programme. Of the 177 clients enrolled for ART over the six-year period, 82 (46.3%) were women and 95 (53.7%) men. These statistics do not include clients treated in private clinics. Seven of the women and 5 men died during that period as shown in Table 4.

Challenge: Need to know why there are fluctuations of female clients enrolled for ART.

While there were approximately 15 men enrolled per year up to 2007, the number of women enrolled for treatment fluctuated over the same period. The challenges for the ART programme include understanding the fluctuations of the female clients enrolled in the programme.

Table 4: Enrolment in ART by sex, 2003-2008

	Enrolled in ART	On treatment after 12 months	Deaths
Female	82	65	7
Male	95	74	5
Total	177	139	12

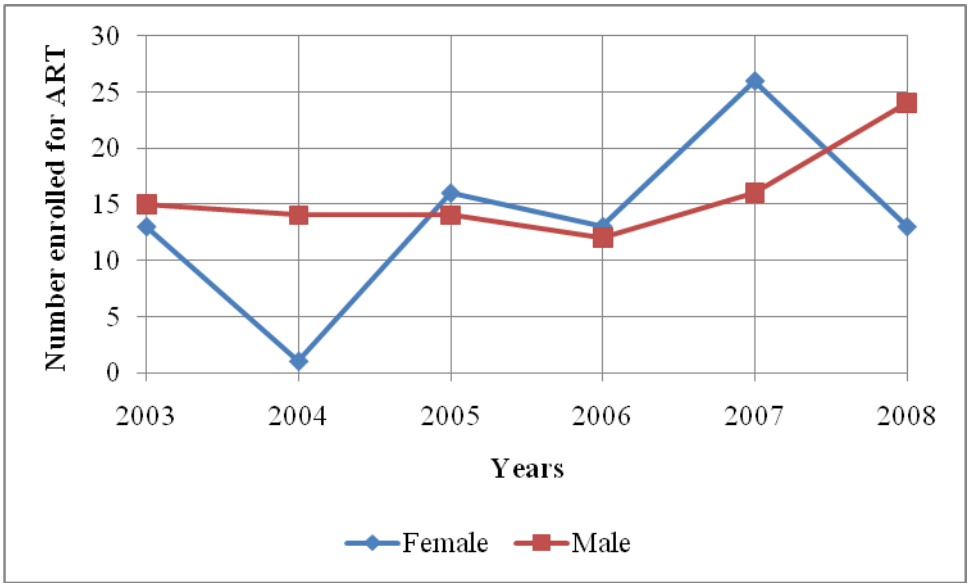

Figure 6: Enrolment in ART by sex, 2003-2008
Source: NAS Programme reports

Nutritional assessment and counselling play an important role in the management of HIV/AIDS clients, and is offered as part of the treatment service. The major challenge to delivery of nutritional services has been shortage of human resources.

Challenge: Shortage of human resources for delivery of nutritional services, and likely human resource capacity challenge with new ART sites.

The current NSP target of 1500 service deliverers trained in HIV by the end of 2009 has already been exceeded with 2597 persons trained by the end of 2008. This all encompassing indicator is, unfortunately, not informative of the gaps in the capacity needs for the different HIV/AIDS service areas. Training targets should be service-area specific.

It had been planned to increase the number of ARV sites by June 2009 to facilitate increased access to high quality care at health facilities within the health districts through decentralization of the services. So far no more treatment sites have been established, although refurbishment has started on three health centres that will eventually be accredited for ART. The country will face the human resource capacity challenge with new ART sites.

(ii) AIDS related hospitalization

A retrospective study was conducted to analyze trends in HIV/AIDS related hospitalizations, covering the period January 2003 to December 2008. The main finding revealed that over the period, there were six hundred and one (601) AIDS-related admissions to the Milton Cato Memorial Hospital, comprising 310 males and 291 females. There were 116 repeat

admissions with some clients having as many as 9 re-admissions. Most of the admissions fell within the age group 35 – 39 years.

The Male Medical Ward (MMW) and the Maternity Ward showed an increasing trend in admissions. There were 75 admissions in 2006 and 67 in 2007 to the MMW. The data revealed a high incidence of teenage or young girls being admitted to the Maternity Ward. Among the major causes of admissions, Pneumonia accounts for 29 percent, followed by Gastro Enteritis with 17 percent, and Candidiasis with 15 percent.

The average length of stay was higher for males in 2006 (10.36 days) compared with 9.22 days for females. With regard to the occupational status, more than half (53.7 percent) of those persons admitted during the review period were unemployed.

(iii) *Sexually transmitted infections (STI) and opportunistic infections (OI)*

STI data is routinely collected through the Communicable Disease Data collection system. The current indicator focuses on confirmed STI cases rather than the number of persons treated. All clients diagnosed with tuberculosis are routinely tested for HIV and all symptomatic HIV positive persons who access medical services are expected to be tested for tuberculosis. Four persons were treated for TB and HIV in 2006. The Ministry of Health and the Environment has committed itself to enhancing prevention measures, treatment and identification of the two diseases (HIV and tuberculosis) as well as the continuous provision of effective treatment options. There are no major challenges, since TB is not a major disease in the country.

(iv) *Care and support*

The care and support response is primarily addressing orphans and vulnerable children (OVC). Orphans and vulnerable children are defined as: 'Children under the age of 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'[3].

According to the CHAA study findings, PLHIV are characterized into two groups based on their financial resources. Firstly, people with economic resources that get private care in St. Vincent and the Grenadines or go overseas for treatment. These individuals are harder to identify since they do not access the public system because of fear of discrimination and stigmatization if their HIV status were to be known. Secondly, persons who are poor, with low literacy, few skills, and limited economic resources. A typical client seen in the public system falls within the lower income bracket and is unemployed.

All persons with HIV infection who attend a public clinic for care and treatment are assessed regarding their social, economic and psychological situation. Financial assistance is provided through the Ministry of National Mobilization Family Services Department. Priority for financial assistance is given to orphans, the physically impaired and the elderly. Assistance is provided in various forms, e.g. school lunches, school supplies and school fees, monthly stipends and monthly food packages. Pregnant and post-natal mothers, in need of food assistance, receive the support through health centres. In 2007, 100 children infected and affected by HIV/AIDS received school-related assistance. Financial support is also provided for general care of the children at orphanages. One hundred OVC are expected to be receiving psychosocial support by the end of 2009, although 65 of the 83 registered OVC

[3] http://www.unicef.org/media/media_44928.html

were receiving the support by the end of December 2008. A major challenge is lack of definitive data that gives the true picture of the overall number of OVC in St. Vincent and the Grenadines. HBC is not yet established in the communities. There are, however, two functional NGOs providing HBC training for individuals.

NAS's psychological programme provides assistance with psychological issues relating to coping with the HIV/AIDS diagnosis. In 2008 thirty-seven persons were referred for psychological support, 27 for adherence counselling and 36 for pre-ART counselling. There are two registered NGO support groups: CARE SVG started under the National HIV/AIDS Secretariat and Friends for Life SVG Plus. A Human Rights Desk (HRD) operated at NAS from January 2007 to November 2008 with funding from the CRN+ Global fund project. During that period it received 58 complaints related to discrimination issues. The demand for an HRD is being assessed with a view to obtaining new funding for its services. There is a referral mechanism in place to address PLHIV complaints.

Challenge: Lack of definitive data on OVC and funding for priority activities.

Stigma and discrimination had been monitored by HIV/AIDS monitoring and evaluation programme through data collected by the Community Outreach and HIV Human Rights Advocates and they forwarded monthly data to NAS before funding ran out in November 2008.

1.2.4 Laboratory Support Services

The clinical laboratory has provided invaluable service to enhance the treatment of AIDS clients. Routine services offered include the provision of CD4 counts, 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 (CAREC) in Trinidad and Tobago. Early infant diagnosis by DNA PCR is currently provided through the Clinton Foundation with specimens sent to the National Institute for Communicable Diseases National Health Laboratory Service, Gauteng, in South Africa *(www.nicd.ac.za).* Laboratory training has been completed for the diagnosis of opportunistic infections and material and supplies are currently being procured to strengthen the system.

The Laboratory trains HCW in HIV rapid test techniques. Of the 23 persons trained in October 2008, eighteen have been certified and ready to be deployed. A major problem with the training services is the non-permanency of trained people deployed in health care facilities accredited with HIV testing. A number of health facilities that should be offering HIV rapid tests are not offering the services because trained HCW have been transferred.

Challenge: Non-permanency of trained people deployed in health care facilities accredited with HIV testing

All donated blood for transfusion is screened for HIV and other transmissible infections by the national blood bank facility at the MCMH Laboratory. The Laboratory participates in an External Quality Assessment Scheme for HIV.

Achievement: All donated blood for transfusion is screened for HIV and other transmissible infections with external quality assessment.

1.2.5 Policy

The strategic activity of formulating an HIV/AIDS policy in the NSP 2004-2009 is under the NSP objective of strengthening prevention and control programmes to target adolescents, young adults and high risk vulnerable groups[4]. It had been hoped that a draft policy would be ready by the end of 2008 but this was not possible. It is now rescheduled for completion by the end of July 2009. There are no written and approved policies to guide any of the national response strategies. Condom-related activities are, however, guided by the regional condom policy[5]. National response with treatment is guided more by precedence in the absence of a written policy. There are thematic policies and guidelines for PMTCT and testing and counselling either as VCT or as provider initiated testing and counselling (PITC). Among the public sectors the Ministry of Education is the only public sector with a draft HIV/AIDS policy.

Challenge: Lack of officially approved policies to guide any of the national response strategies and a need to update some laws for protection of individuals, irrespective of disease.

There is no evidence that the existing laws have had either a positive or negative impact to the national response. There is, however, a challenge to update some laws, without being disease specific, to take into account existing circumstances for protection of individuals.

1.2.6 M&E

Since the establishment of NAS with the World Bank funding, monitoring and evaluation activities for HIV/AIDS have been managed by an M&E Advisor in NAS. The HIV/AIDS M&E is advised and supported by a nine-member advisory team: the Monitoring and Evaluation Reference Group (MERG) composed of representatives from the Ministry of Health and the Environment, public-sector institutions and non-governmental organizations. This group provides technical support and advice with the implementation of the HIV/AIDS M&E Plan.

The work of the M&E has been supported by a number of international, regional and bilateral partners in:

- Capacity building
- Development and installation of a patient tracking system
- Development of indicators
- Development of M&E plan
- Facilitating a female condom usage study, including the provision of 3000 condoms for the study
- Financing a mentorship programme
- Financing assessment of the laws of St. Vincent and the Grenadines
- Training in patient monitoring

The current strengths of the HIV/AIDS M&E system are:

- Existence of an operational framework and M&E plan that are being used
- A functional data collection, processing and analysis system

[4] Ministry of Health and Environment. *St. Vincent and the Grenadines HIV/AIDS/STI National Strategic Plan 2004-2009*

[5] PANCAP. *Regional model condom policy*. June 2008

- A team of hard working committed health care workers who collect, document and forward the required data, on a monthly basis, to support HIV/AIDS M&E Indicators.

The system is, however, still faced with weaknesses and challenges among which are:
- Dependency on project funding
- Lack of operations research to fill information gaps such as information on MARP.
- Lack of a culture of M&E in all areas of health services
- Lack of a culture of data use for decision making within the health system as a whole
- Shortage of trained and qualified people to work in the M&E system at all levels.

With M&E system established in the health sector within the Health Planning Information Unit (HPIU), monitoring and evaluation of the national HIV/AIDS response will be absorbed in HPIU. This will ease the human resources challenges and possibly resolve the dependency on project funding. The integration will also be in line with the "Three Ones" principle.

1.2.7 Financial

The government of St. Vincent and the Grenadines has invested financially in the national response to HIV/AIDS epidemic supported by development partners and grants from international financing sources. Expenditure has been in all response areas of prevention, treatment, impact mitigation, programme management and administration, human resources, social protection, social services, human rights, research and as shown in Table 5, infrastructure development. 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. Further details are shown in Annex 3.

Table 5: AIDS spending during period January 2006 to December 2008

Source	2006-2007	2008	Uses of Funds
World Bank (Loan, Credit, Grant)	EC$ 7,398,331.08	EC$ 3,725,918.00	• Infrastructure • Pharmaceuticals including laboratory reagents (CD4 etc.), and supplies and condoms • Consultancy Services • Training • CSO Subproject
Government (Consolidated Fund)	EC$ 670,811.00	EC$500,000.00*	• Personal Emoluments (NAS) • Office management and supplies
OECS Global Fund	EC$ 345,173.04	EC$ 143,517.23	• PMTCT • Training of Care and Treatment Team • Adherence Programme • Orphans and Vulnerable Children • BCC
Pan Caribbean Partnership	EC$ 79,047.62	0.00	• Law, Ethics and Human Rights National Assessment

Source	2006-2007	2008	Uses of Funds
DFID	EC$ 92,266.06	0.00	• Care and Treatment (Quick Start)
TOTAL	EC$ 8,585,628.80	EC$ 4,369,135.23	

* Estimated expenditure
Source:

Fourteen CSOs (FBOs, CBOs, NGOs and the private sector) are implementing HIV/AIDS-related activities through funding from the World Bank Project, albeit with varying degrees of depth and coverage. Funding had also been obtained from the Global Fund under a regional application.

2 Preparation process

The HIV/AIDS NSP 2010-2014 was prepared through an intensively interactive and participatory process managed by NAS. A Steering Committee of six persons was established to guide the preparation of the strategic plan and 2-year action plan.

Five technical sub-committees (TSC), each chaired by a member of the Steering Committee, were established in advance with clear terms of reference for each of the priority areas that were to be covered by the NSP. The priority areas are:

1. Policy development and legislation
2. Multisectoral involvement and decentralization
3. Prevention services
4. Care, treatment and support services
5. Strategic information, M&E and research

All sub-committees were made up of representatives of all sectors: public, private, civil society and PLHIV. The overall objective of the TSC was to develop the next HIV/AIDS National Strategic Plan. The specific objectives included:

- Reviewing the national programme and relevant documents
- Assessing progress of the national response for each priority area
- Identifying needs and opportunities
- Suggesting priorities for the 5-year period 2010-2014
- Proposing strategic objectives, indicators and targets
- Proposing implementing organizations for major activities

The TSC were guided to take into account the Caribbean Regional Strategic Framework as they considered the strategic objectives and expected outcomes for SVG. A full day workshop was organized for all members of the TSC to review their collective contributions and agree on the:

- Country situation assessment
- Vision and Goals for NSP 2010-2014
- Priority strategic objectives for each priority area
- Expected results for each strategic objective
- Activities that should be undertaken towards achieving the expected results for each priority strategic objective

The contributions of the TSC and background information obtained from the document review including epidemiological data and reports from the M&E were the basis of the *Situation country assessment*.

The NSP preparation process was supported by two External Consultants recruited by UNAIDS EC Office in Barbados through the World Bank ASAP in Washington, D.C., USA. One consultant supported the preparation of Parts I-IV and one the preparation of Part V.

3 Vision and Goals

The Government of St. Vincent and the Grenadines subscribes to the unanimously adopted Declaration of Commitment on HIV/AIDS, acknowledging the epidemic to be a "global emergency and one of the most formidable challenges to human life and dignity" (the UNGASS Declaration). St. Vincent and the Grenadines was also a full participant and contributor to the production of the Caribbean Regional Strategic Framework 2008-2012. The National Strategic Plan 2010-2014 is informed by the UNGASS Declaration and the Caribbean Regional Strategic Framework 2008-2012 and synchronizes with the CRSF.

VISION

To substantially reduce the spread and impact of HIV in St. Vincent and the Grenadines through sustainable systems of Universal Access to HIV prevention, treatment, care and support and empowerment of the population to prevent HIV infection.

St. Vincent and the Grenadines commits itself to the goals agreed upon collectively by the Caribbean states of reducing the estimated new HIV infections and mortality due to HIV by 25% by 2012.

NATIONAL GOALS

The national goals are informed by the results of the situation assessment in Part I as indicated in Section 1.1:

- **To reduce the estimated number of new HIV infections by 30% by 2014**
- **To reduce mortality due to HIV by 30% by 2014.**

Part II Strategic Objectives

4 Guiding Principles and Strategic Approaches

St. Vincent and the Grenadines endorses the following guiding principles and strategic approaches.

4.1 Guiding principles

4.1.1 Political leadership

Political commitment is required to achieve a sustained and effective national response to HIV.

4.1.2 Gender equity

Gender equity is important for the development, planning and implementation processes.

4.1.3 Good governance

A successful national and regional HIV response requires leadership that mobilizes and manages resources in an effective, transparent and accountable manner.

4.1.4 St. Vincent and the Grenadines as a member of the Caribbean

Success of St. Vincent and the Grenadines programmes is essential for overall regional success. The NSP is therefore guided by the CRSF to ensure that the national response is in line with the regional response.

4.1.5 Multisectoral approach

The HIV epidemic is not only a health issue; it also has economic, social and cultural aspects. The response requires the ongoing commitment, support and involvement of all sectors within the society.

4.1.6 Inclusiveness and Greater Involvement of People living with AIDS

The meaningful involvement of people living with and affected by HIV, and other most-at-risk persons in the design, implementation, monitoring and evaluation of the national response to HIV is vital.

4.1.7 Equity

National HIV responses will ensure that all persons have equal access to prevention, treatment, care and support services.

4.1.8 Human rights

Equality before the law and freedom from discrimination is respected, protected and fulfilled in St. Vincent and the Grenadines. The country implements the ten key principles in the ILO

Code of practice on HIV/AIDS and the world of work[6] to ensure human rights are upheld in places of work.

4.1.9 Evidence-based

All interventions are based on the available data and international best practice.

4.1.10 Sustainability

The effects of the HIV epidemic will be with us for generations, so it is important that the programmes designed and implemented are sustainable over the long term.

4.2 Strategic approaches

4.2.1 Prevention

In the absence of a cure for AIDS and with the high lifetime costs associated with treatment, preventing future HIV infections remains a priority.

4.2.2 Strengthening health and social systems

Effective health and social systems are critical to the delivery of HIV programmes. Both systems need to be strengthened to provide good quality, sustainable support to the HIV response.

4.2.3 Monitoring and evaluating programmes

Monitoring the implementation and outcomes of the national and regional HIV response is necessary to improve programme design and management and justify the support from international partners.

4.2.4 Bilateral, regional and international co-operation and collaboration

Regional cooperation and collaboration outlined in the CRSF as "public goods and services" refers to goods and services which can be more efficiently provided from the regional than national level. The country will maintain bilateral and international cooperation and collaboration as elaborated in Section 7 page 33.

[6] See: http://www.ilo.org/global/What_we_do/Publications/lang--en/docName--KD00015/index.htm

5 Priority areas

St. Vincent and the Grenadines intends to continue to address the challenges facing the country as a result of the HIV/AIDS epidemic. Considerable progress has been made in the areas of treatment for PLHIV; preventing the transmission of HIV from mother to child; and providing HIV rapid test to the populace. The efforts made so far must be continued and strengthened to reduce the spread and impact of HIV in the country.

The main messages of the epidemic in St. Vincent and the Grenadines have been:

- That the epidemic may be becoming generalized. This observation is based on antenatal data (which for the past five years has been slightly over 1%) and limited seroprevalence data on vulnerable groups, except for prisoners. The response has, therefore, to address the whole population but with priority to understanding the factors driving the epidemic and obtaining more information on MARPs through enhanced surveillance.
- The need to decentralize the services and integrate them in the primary health care services to ensure sustainability in a small economy country such as St. Vincent and the Grenadines.
- That stigma and discrimination associated with HIV must be seriously addressed through continued education of the general public.
- That adherence to ARV therapy and disclosure to sexual partners must be encouraged.
- That involvement in the multi-sectoral response must be targeted to the critical stakeholders who are most likely to have an impact on reversing the epidemic.
- A need for operational research to assess the effectiveness of preventive interventions that have been implemented over the last strategic planning period and guide future efforts.

The priorities of this strategic plan are the following.

- Enhancement and expansion of HIV/AIDS prevention programmes.
- Strengthening of HIV/AIDS surveillance, especially as it relates to MARPs and other vulnerable groups.
- Increased focus on stigma and discrimination reduction.
- Strengthening the ARV treatment programmes.
- Sustainability through human resource management, decentralization and integration of HIV/AIDS services, and health systems strengthening.
- Conducting further research in relation to the drivers of the epidemic, core societal issues influencing the disease spread, and the impact of intervention programmes.
- Drafting of legislation and policies to govern the management of HIV/AIDS
- Ensuring greater involvement of critical stakeholders.

The following priority areas for action, over the next five years, are based on the need to build on programmatic strengths built up over the years and address weaknesses identified:

1. Policy development and legislation
2. Multisectoral involvement and decentralization
3. Prevention services
4. Care, treatment and support services
5. Strategic information, M&E and research

6 Strategic objectives

6.1 PRIORITY AREA 1 – Policy Development and Legislation

Several factors hinder access to HIV prevention, treatment, care and support programmes in St. Vincent and the Grenadines. The prevailing social and cultural norms are intolerant of behaviours which threaten strong religious customs. Despite considerable progress, HIV related stigma and discrimination persist. Unequal gender relationships and other inequities contribute to the continued spread of HIV and limit access to services.

Two Strategic Objectives have been defined for the period of the NSP:

Strategic Objectives for Policy Development and Legislation

1. **To develop policies, programmes and legislation that promote human rights, including gender equity, and reduce socio-cultural barriers in order to achieve Universal Access.**

2. **To reduce stigma and discrimination associated with HIV and vulnerable groups.**

6.1.1 Strategic Objective 1.1: To develop policies, programmes and legislation that promote human rights, including gender equity, and reduce socio-cultural barriers in order to achieve Universal Access.

Expected results:

- Legislation that addresses the issues related to legal, ethical and human rights of those infected with, or affected by, HIV.
- Policies that ensure delivery of effective, efficient and focused preventive, care and treatment services
- A national response environment that promotes gender equity, empowerment to access services and less vulnerability to HIV infection
- Increased participation of vulnerable groups in the response to HIV.

6.1.2 Strategic Objective 1.2: To reduce stigma and discrimination associated with HIV and vulnerable groups

Expected results:

- Cooperative programmes against stigma and discrimination among public, civil society, and private sectors and PLHIV
- PLHIV and other vulnerable groups access educational institutions, health services, occupations and other services free of discrimination.

6.2 PRIORITY AREA 2 – Multisectoral Involvement and Decentralization

An expanded and well-coordinated multi-sectoral response is essential to control the HIV epidemic. The purpose is to increase technical, political and financial support in order to maximise the HIV response in each sector and achieve the widest possible coverage of services. St. Vincent and the Grenadines will focus on the consolidation, further development and strengthening of the HIV responses within all public sectors, as well as on the implementation of HIV workplace policies and programmes in both government institutions and private sector businesses. Participation in the response will be increased through strengthening health and social systems and improving infrastructure, training relevant workers in all sectors and strengthening the organizational and managerial capacities of PLHIV networks as well as of other civil society organizations (NGOs, CBOs, FBOs).

The following Strategic Objectives have been defined for the period of the NSP:

Strategic Objectives for Multisectoral Involvement and Decentralization

1. **To enhance the ownership of national HIV programmes and the responsibility for the national response to the epidemic.**
2. **To strengthen the multi-sectoral response to HIV, including involvement of key government organizations, NGOs, CBOs, FBOs, PLHIV networks, the private sector, trade unions and vulnerable groups.**
3. **To train relevant workers in all sectors to provide HIV prevention, treatment, care and support services.**
4. **To strengthen health and social systems and improve infrastructure to provide comprehensive and integrated HIV services.**
5. **To support national public and private sector organizations to introduce comprehensive workplace policies and programmes.**
6. **To promote and protect the health of students and staff and to mitigate the impact of HIV on the education system.**

6.2.1 Strategic Objective 2.1: To enhance the ownership of national HIV programmes and the responsibility for the national response to the epidemic.

Expected results:

- Political, non-partisan commitment for national HIV programmes with increased financial contributions to the national response.
- HIV included in development plans with the aim of achieving a sustainable response.

6.2.2 Strategic Objective 2.2: To strengthen the multi-sectoral response to HIV, including involvement of key government ministries, NGOs, CBOs, faith-based organizations, PLHIV networks, the private sector, trade unions and vulnerable groups.

Expected results:

- Strengthened multi-sectoral coordinating mechanisms
- Strengthened capacity of NGOs, CBOs, FBOs and PLHIV umbrella networks to contribute more effectively to the HIV response (see Strategic Objective 3.3)

6.2.3 Strategic Objective 2.3: To train relevant workers in all sectors to provide HIV prevention, treatment, care and support services.

Expected results:

- A wide range of trained HCW to provide HIV prevention, treatment, care and support services
- Focused and targeted training programmes in HIV prevention for high risk populations and M&E for programme managers (see Priority Area 1).
- A comprehensive programme for training and maintaining a complement of peer educators in workplaces.

6.2.4 Strategic Objective 2.4: To strengthen health and social systems and improve infrastructure to provide comprehensive and integrated HIV services.

Expected results:

- Integrated HIV services into primary health care delivery system
- Laboratory, surveillance and M&E services capable of supporting all preventive and treatment national responses
- An effective system for the management and regulation of strategic human and public health supplies for the provision of HIV services
- Safety and quality assurance systems established and functioning
- Improved capacity of referral systems and networks of social agencies and organizations to support PLHIV

6.2.5 Strategic Objective 2.5: To support national public and private sector organizations to introduce comprehensive workplace policies and programmes.

Expected national result:

- Beneficial workplace policies and programmes in formal and informal sectors

6.2.6 Strategic Objective 2.6: To promote and protect the health of students and staff and to mitigate the impact of HIV on the education system.

Expected results:

- Overarching education sector HIV policies introduced.
- Strengthened HIV education and awareness activities conducted in the school community.
- The development of curriculum and education programmes, based on effective strategies for behaviour change, skills development and participatory learning, all set in the context of health promotion for responsible lifestyles.
- Access to youth-friendly health and social services ensured. (National Family Planning Programme)
- All primary, secondary and tertiary level students participate in well designed and gender-sensitive health and family life skills and HIV/STI prevention education programmes.

6.3 PRIORITY AREA 3 - Prevention of HIV Transmission Services

The HIV epidemic in St. Vincent and the Grenadines is primarily due to sexual transmission, mainly heterosexual. A BSS survey conducted in 2005-2006 showed that there is a relatively high level of knowledge about HIV among the general population. The survey also showed that the youth, in spite of the high level of knowledge about HIV transmission, were indulging in risky sexual behaviours as shown in Part I, section 1.1.5. Prevention efforts in the new NSP will address the different issues that increase the vulnerability of both men and women to HIV and implement national strategies that are based on best practice, including addressing issues related to poverty and decentralisation. Prevention programmes will target women and men, young men and young women; with men, focusing on transforming concepts of masculinity and sexual relations that increase their risk of HIV transmission. For women, the focus will be the same, including addressing women's empowerment in sexual decision making and their right to refuse sex. Men must be actively involved in HIV prevention work.

St. Vincent and the Grenadines will implement specific targeted interventions among most-at-risk populations, including young men and women, MSM, transactional sex workers, and prisoners. Prevention interventions will need to go beyond individual and interpersonal approaches to develop strategies that address the social context that supports risky behaviours. Effective behaviour change communication strategies must take account of issues relating to poverty, gender and other cultural and social norms.

Elimination of stigma and discrimination towards men and women living with HIV will be promoted (see Priority Area 1), but PLHIV can play a greater role in preventing the further spread of HIV. This NSP proposes enhanced efforts towards voluntary disclosure of HIV status, and positive prevention in a more supportive environment.

The following Strategic Objectives have been defined for Priority Area 3 for the NSP:

Strategic Objectives for Prevention of HIV Transmission Services

1. **To establish friendly, comprehensive, gender-sensitive and targeted prevention programmes for:**
   - **Youth 10-14 and 15-24 years of age: boys, girls, young men, young women**
   - **Women 25-55 years of age and men 40-60 years of age**
   - **Uniformed officers**
   - **Prisoners**
   - **Taxi and minibus drivers**
   - **Men who have sex with men**
   - **Mental health patients**
   - **Sex workers (most likely "transactional"), their clients**

2. **To provide services for prevention of mother to child transmission of HIV to all pregnant women, and their families.**

3. **To strengthen prevention efforts among PLHIV as part of comprehensive care.**

4. To reduce vulnerability to HIV through early identification and treatment of other sexually transmitted infections (STI).

6.3.1 Strategic Objective 3.1: To establish friendly, comprehensive, gender-sensitive and targeted prevention programmes

Expected results:

- Improved targeted behaviour change communication programmes to address youth, women 25-55 years and men 40 years and over and MARP
- Strengthened peer education programmes for school-based and community-based youth
- National policies ensuring access to HIV testing and counselling for all needing the services, including minors (Priority Area 1).
- Access to accurate, gender-sensitive information and skills on adolescence, sexuality and their HIV/STI vulnerability ensured for young people particularly within school settings.
- Comprehensive condom programmes for youths developed; addressing, accessibility, availability and condom negotiation skills.
- Civil society organizations supported to reach youths with programmes to reduce their HIV vulnerability, including life skills and income-generating activities.

6.3.2 Strategic Objective 3.2: To provide services for prevention of mother to child transmission of HIV to all pregnant women and their families.

Expected results:

- PMTCT Plus services at all primary care facilities PMTCT programmes

6.3.3 Strategic Objective 3.3: To strengthen prevention efforts among PLHIV, as part of comprehensive care (see Strategic Objective 4.1).

Expected results:

- Positive prevention, promoted for PLHIV, including disclosure of their status to their sexual partners

6.3.4 Strategic Objective 3.4: To reduce vulnerability to HIV through early identification and treatment of other sexually transmitted infections (STI).

Expected results:

- HIV testing offered to all persons attending STI clinics, according to national standards
- Availability of drugs for treatment of STI secured.
- Staff responsible for provision of STI treatment and counselling, trained in simple diagnostic technology for diagnosis of aetiological agents for STI

6.4 PRIORITY AREA 4 - Treatment, Care and Support

St. Vincent and the Grenadines has made significant strides in the provision of treatment, care and support services for PLHIV, but a lot still needs to be done. The priority is to reach those PLHIV still in need of treatment and to improve their adherence. The management of sexually transmitted infections, tuberculosis and opportunistic infections will also be improved (see Priority Area 3). HIV services will be further decentralised and integrated within existing primary health care services while the links between prevention and treatment services will be enhanced. Comprehensive care will include nutritional and psychosocial support, as well as services for orphans and children made vulnerable by HIV, and their families (see Priority Area 1).

The following Strategic Objectives have been defined for Priority Area 4 for the period of the NSP

Strategic Objectives for Treatment, Care and Support

1. **To increase access to treatment, care and support services for persons living with HIV.**
2. **To improve the management of tuberculosis (TB), opportunistic infections (OI) and sexually transmitted infections (STI) by early identification and treatment.**
3. **To improve access to nutritional and psychosocial services for persons living with HIV.**

6.4.1 Strategic Objective 4.1: To increase access to treatment and care services for persons living with HIV.

Expected results:

- Universal access to ARV treatment and increased adherence to treatment and care, achieved through:
  - Increased access to laboratory-supported-monitored treatment including drug resistance surveillance with best practices.
  - Ongoing training of PLHIV and support groups in comprehensive self care and prevention.
  - Availability of drugs and other HIV commodities ensured (see Priority Area 2).

- Guidelines for STI management and updated ART guidelines.

6.4.2 Strategic Objective 4.2: To improve management of tuberculosis (TB), opportunistic infections (OI), and sexually transmitted infections (STI) by early identification and treatment.

Expected results:

- Improved management of TB, OI and STI by early identification and treatment (see Priority Area 2).

6.4.3 Strategic Objective 4.3: To improve access to nutritional and psychosocial services for persons living with HIV.

Expected results:

- Nutritional and psychosocial services fully integrated with treatment, care and support of PLHIV.

6.5 PRIORITY AREA 5 - Strategic Information, M&E and Research

An HIV/AIDS monitoring and evaluation (M&E) system has been established and functioning as well as it can with limited staff. HIV/AIDS M&E is being integrated in the Ministry of Health and the Environment's Information Unit as indicated in Part I section 1.2.6 in line with the "Three Ones" principle. Monitoring, evaluation and research will provide information for making decisions, increase understanding of the factors that drive the HIV epidemic, and strengthen advocacy efforts for resources from national, regional and international agencies. A national research agenda will be defined, research capacity strengthened and HIV related research facilitated. Research findings will be disseminated to ensure that lessons can be used to guide policy development and programme design.

St. Vincent and the Grenadines commits itself to collecting data on regional and international indicators in fulfilment of the country's regional and international obligations.

The following Strategic Objectives have been defined for Priority Area 5 for the period of the NSP:

Strategic Objectives for Information, M&E and Research

1. **To track progress in the implementation of National HIV responses.**
2. **To maintain and strengthen HIV/AIDS/STI surveillance**
3. **To develop appropriate evidence-based policies, practices and interventions through the use of research findings and M&E data.**

6.5.1 Strategic Objective 5.1: To track progress in the implementation of National responses.

Expected results:

- Regular reports on the national response indicators used by decision makers and programme managers

6.5.2 Strategic Objective 5.2: To maintain and strengthen HIV/AIDS/STI surveillance

Expected results:

- HIV/AIDS/STI surveillance system enhanced.

6.5.3 Strategic Objective 5.3: To develop appropriate evidence-based policies, practices and interventions through the use of research findings and M&E data.

Expected results:

- National research agenda on filling data and information gaps developed, surveys done and operational research conducted.

7 Regional and International Cooperation and Collaboration

St. Vincent and the Grenadines has, over the years, benefited from bilateral, regional and international support and co-operation in the fight against the HIV epidemic and other areas. The size of the country and level of its resources demand co-operation with regional countries for efficient delivery of some services.

Examples of regional collaboration include bulk procurement of drugs, the development of regional guidelines and protocols and training programmes. Regional collaboration in services can add value by providing access to services that cannot be provided cost-effectively by a small country such as St. Vincent and the Grenadines, by lowering national costs. St. Vincent and the Grenadines will seek support and collaboration from PANCAP and other bilateral, regional and international partners in the areas of:

- Technical and financial support assistance for
  - HIV prevention services.
  - training in HIV treatment, care and support, and for implementation of programmes to manage HIV, TB, and STI
  - building the capacity of NGOs, CBOs and faith-based organizations and networks in the areas of organizational development, leadership, advocacy and HIV programming with emphasis on prevention
  - fighting against stigma and discrimination
  - increasing country capacity to conduct gender analysis and sensitivity
  - training in the management and surveillance of STI
  - collection of data on indicators such as some of the core indicators in this NSP.
  - special studies including KABP, BSS and studies among MARP.
  - socio-economic impact studies, cost-effectiveness studies and national HIV spending assessments conducted to inform on appropriate HIV-related policies and programmes

- Research in:
  - drivers of the epidemic.
  - understanding of constraining and facilitating factors for disclosure of HIV status (such as stigma and discrimination).
  - issues related to HIV, TB and STI treatment in order to improve access and quality of services.
  - impact of HIV and AIDS at the workplace, and on factors that influence the implementation of effective HIV workplace policies and programmes.

- Regional co-operation in:
  - a regional procurement process for commodities and supplies to pool resources and benefit from economies of scale.
  - HIV pharmacological vigilance and for the prevention, monitoring and surveillance of HIV drug resistance.
  - Sharing of best practices of prevention and promotion strategies, especially in connection with the youth, population groups with professions believed to make them

high risk for HIV infection e.g. minibus and taxi drivers, fishermen and offshore workers.

- Documentation and dissemination of best practices and lessons learned about coordinating multi-sectoral actions for the HIV response.

- Development of and advocacy for adoption of model policies and legislation for social protection and improved access to prevention and treatment services

Part III: Implementation Framework

8 Implementation framework

Annex 4 gives a matrix of activities that will have to be implemented for the expected results of each strategic objective. Tentative timing for each activity is given for the first two years of the NSP with an indication of the organization responsible for overseeing the implementation of the activity.

8.1 Implementation environment

8.1.1 Human resources

St. Vincent and the Grenadines suffers from a shortage of human resources qualified in all areas of the HIV/AIDS national response. This is common to countries of the population size similar to St. Vincent and the Grenadines. The strategies planned for the implementation of the NSP 2010-2014 include capacity development through institutional and in-service training for health care providers, and developing the capacity of the CSO partners. CSOs which directly work with specific vulnerable populations will be targeted to build strategic partnerships to respond to the epidemic. This will ensure that the three-ones principle is fully implemented, and that there is no duplication of efforts.

CSOs are playing a very important part in the national response to the prevention of HIV but most of them have resource and management weaknesses that will have to be addressed for effective implementation of the NSP. The implementation framework includes a number of such strategies to improve the CSOs' capacity to deliver the services.

8.1.2 Financial resources

The country has very limited financial resources to meet all its social demands. Most of the financial inputs in the national response to the HIV/AIDS epidemic have been from international and bilateral soft loans and grants such as World Bank financing and the Global Fund as shown in Table 5. Although the Government will continue to contribute more financial resources to the response, external financing will continue to be vital for an effective implementation of the NSP, so as not to lose the momentum established in the various programmes, including ART, as well as to address the need to move beyond mere sensitization for the prevention of HIV infection. The Government will, therefore, have to come up with strategies for resource mobilization if the NSP is to be implemented as planned.

8.1.3 Regional and international cooperation

St. Vincent and the Grenadines will continue to draw on the regional resources and co-operation as a member of OECS and PANCAP. The NSP identifies areas in which St. Vincent and the Grenadines will seek regional and international support. Among such areas are technical and financial support for research in epidemic drivers, including the difficult to reach high risk populations of sex workers and men who have sex with men. The country will also participate in cost-saving regional bulk purchases of commodities and sharing of information on good practices particularly in connection with monitoring drug resistance.

8.1.4 Involvement of public and private sectors

The fight against HIV/AIDS is the collective responsibility of all sectors of society: public and private. The multi-sectoral coordinating structure will continue to guide the national response by identifying areas of the response best executed by the public or private sector. The research agenda of the NSP will eventually provide information needed for a better understanding of the most cost-effective interventions for a country of the size of St. Vincent and the Grenadines. The role of NGOs and CSOs will remain crucial in the attempt to implement this plan.

8.1.5 Involvement of PLHIV

People living with HIV are fully involved in the national response and will continue to be supported in their involvement. The establishment of PLHIV networks and support groups will increase PLHIV contribution in the planning and decision making on prevention and support issues.

8.1.6 Specific role of the Ministry of Health

There are a number of strategies required to ensure successful implementation of a sustainable response to HIV that would be addressed at a Ministry of Health level including the following:

- A strategy to review, examine and address the management of human resources in the health sector in order that the sector may be strengthened, thus ensuring effectiveness, not only in the response to the HIV/STI epidemic but to other health conditions.
- A strategy to strengthen the role of the Ministry of Health in the context of setting standards and policy and quality assurance.
- Strategies to strengthen health sector public - private partnership would be considered in the context of providing the entire community with quality services; and employing all the resources of the society.

8.1.7 Involvement of Non-Health Line Ministries

Key ministries and departments will be targeted for implementation of specific aspects of the national response. These include the Ministries of Education, Tourism, National Security, and Social Development, and the Departments of Labour and Gender Affairs. Strategies would have to be implemented that would result in increased ownership and sustainability of the response among those targeted.

PART IV: MONITORING AND EVALUATION FRAMEWORK

9 M&E Environment

Monitoring the national response to the HIV/AIDS epidemic has been a vertical activity financially supported through grants and other external funding sources. A new monitoring environment is being established under which the monitoring and evaluation of the national response will be under the Health Information Unit (HPIU) in the Ministry of Health and the Environment, monitoring as part of the overall M&E services of the health sector. This will ease the human resources challenges and possibly resolve the dependency on project funding. The integration will also be in line with the "Three Ones" principle.

In spite of the unified monitoring services, M&E for HIV/AIDS will continue to focus on the key areas:

(i) Helping to create an environment for the system to function well by training stakeholders in the concepts of monitoring and evaluation.
(ii) Ensuring that the kind of data needed for monitoring the HIV response is collected and verified in an organized manner.
(iii) Ensuring that data is analysed, reported and disseminated for use by decision makers and implementing partners.

9.1 Monitoring the National Response

The national response is monitored by well selected indicators for trends and the collective impact of various interventions. Some of the indicators for national monitoring are also used for global monitoring, for example, UNGASS and MDG. Twenty-seven such indicators are identified.

Impact Indicators	**Comments**	
	UNGASS	**Source of information**
1. Percentage of pregnant women aged 15-24 years that are HIV positive (Used as a proxy for the percentage of young men and women aged 15-24 years that are HIV positive)	✓	PMTCT programme data**.** Use "% of ANC attendees age 15-24 whose HIV test results are positive, out of all ANC attendees age 15-24 who were tested for HIV" as a proxy for the national indicator.
2. Percentage of MARPs that are HIV positive among: a) male prisoners b) sex workers, c) men who have sex with men	✓	HIV sero-surveys (prisoners**)**; integrated biological and behavioural surveys (SW, MSM)
3. Percentage of HIV-infected infants born to HIV positive mothers who are infected	✓	PMTCT programme records**.**
4. Percentage of total deaths attributable to HIV		Mortality records from National Surveillance Programme
5. Percentage of PLHIV known to be on treatment 12 months after initiation of ART	✓	HIV patient monitoring records

PRIORITY AREA 1 – Policy development and legislation			
NSP Strategic Objective	**Indicator**	**Comments**	
		UNGASS	**Source of information**
1.1 To reduce stigma and discrimination associated with HIV and vulnerable groups.	6. Number of activities to reduce the barriers of Stigma & discrimination to PLHIV for seeking care & treatment		Stigma & Discrimination Programme Records

PRIORITY AREA 2 – Multisectoral involvement and decentralization			
NSP Strategic Objective	**Indicator**	**Comments**	
		UNGASS	**Source of information**
2.1 To enhance the ownership of national HIV programmes and the responsibility for driving the response to the epidemic	7. National Composite Policy Index	✓	Refer to UNGASS Guidelines for Construction of Core Indicators
	8. Amount of national fund spent by the Government on HIV/AIDS	✓	Ministry of Finance & Planning Ministry of Health & the Environment
2.2 To strengthen the multi-sectoral response to HIV, including involvement of key government organizations, NGOs, CBOs, FBOs, PLHIV networks, the private sector, trade unions and vulnerable groups	9. Number of Line Ministries that have implemented work plans according to the HIV/AIDS Strategic Plan		Line Ministries Programme Records
2.3 To train relevant workers in all sectors to provide HIV prevention, treatment, care and support services	10. Number of service deliverers trained in gender responsive and human rights based HIV prevention treatment, care and support services delineated by their position and type of training		NAS Training Records
2.3 To train relevant workers in all sectors to provide HIV prevention, treatment, care and support services	11. Number of penal institution employees trained in HIV prevention/promotion		Line Ministries Coordinator
2.4 To strengthen health and social systems and improve infrastructure to provide comprehensive and	12. Percentage of health care providers who took Post Exposure Prophylaxis (PEP) according to national		Infection Control Records

PRIORITY AREA 2 – Multisectoral involvement and decentralization			
NSP Strategic Objective	**Indicator**	**Comments**	
		UNGASS	**Source of information**
integrated HIV services	guidelines		
	13. Number of health facilities offering gender responsive and human rights based PITC		NAS Reports

PRIORITY AREA 3 - Prevention of HIV transmission services			
NSP Strategic Objective	**Indicator**	**Comments**	
		UNGASS	**Source of information**
3.1 To establish friendly, comprehensive, gender-sensitive and targeted prevention programmes	14. Percentage of MARPs reached by prevention programmes	✓	BSS
	15. Percentage of young men and women 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner	✓	BSS
	16. Percentage of young women & men who had sex before age 15	✓	BSS
	17. Number of schools that provided life skills based HIV education during the last academic year	✓	Line Ministries Coordinator Programme Records
	18. Number of male and female condoms distributed through public sector including Line Ministries in the last 12 months		NFPP Programme Records CSOs involved in condom distribution Programme Records
3.2 To provide services for prevention of mother to child transmission of HIV to all pregnant women and their families.	19. Number and percentage of pregnant women attending ANC who were counselled & tested for HIV and received their results		PMTCT Reporting Format; Laboratory Report Format
	20. Number of HIV positive pregnant women receiving a complete course of ARV Prophylaxis to reduce the risk of MTCT	✓	PMTCT Reporting Format

PRIORITY AREA 3 - Prevention of HIV transmission services			
NSP Strategic Objective	**Indicator**	**Comments**	
		UNGASS	**Source of information**
3.3 To strengthen prevention efforts among PLHIV as part of comprehensive care	21. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	✓	Counselling and Testing Programme Records.
	22. Number of workshops held to increase knowledge of PLHIV in care and about effective HIV prevention techniques		Facility Records; NAS Counsellors' Diaries

PRIORITY AREA 4 - Treatment, care and support			
NSP Strategic Objective	**Indicator**	**Comments**	
		UNGASS	**Source of information**
4.1 To increase access to treatment, care and support services for persons living with HIV	23. Number and percentage of women and men with advanced HIV infection receiving ART	✓	Patient monitoring and HIV clinical care records
	24. Number of health facilities offering ART		NAS Reports
4.2 To improve the management of TB, OI and STI by early identification and treatment.	25. Number of confirmed cases of STI	✓	MoHE Facility Records
4.3 To improve access to nutritional and psychosocial services for persons living with HIV.	26. Number of OVC whose households received free basic support to care for the child	✓	Social worker Records

PRIORITY AREA 5 - Strategic information, M&E and research			
NSP Strategic Objective	**Indicator**	**Comments**	
		UNGASS	**Source of information**
5.1 To track progress in the implementation of National HIV responses.	27. Percentage of HIV/AIDS indicators for which data is available		M&E Reporting Format

9.2 High Priority Core Indicators With Baselines and Targets

Among these core indicators, the following will have top priority in monitoring the key areas in the continued national response to the epidemic:

High priority core indicator	Top priority area monitored	Baseline	Target	
			2011	2014
1. Percentage of pregnant women aged 15-24 years that are HIV positive	The collective impact of HIV preventive interventions	1.36%	1.1%	0.8%
2. Percentage of MARPs that are HIV positive among:: a) male prisoners b) sex workers, c) men who have sex with men	Epidemic drivers. The indicator will, by proxy, track progress made in obtaining data on key MARPs	a) 4.1% (2005) b) Unknown c) TBD (Survey being conducted)		a) 3.6% b) TBD c) TBD
3. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	HIV counselling and testing	15-19 years 6% 20-24 years 12% 25-49 years 12%		7.2% 14.4% 14.4%
4. Percentage of PLHIV known to be on treatment 12 months after initiation of ART	Treatment adherence and survival	Adult Male 46% Adult Female 79%	50% 84%	60% 90%
5. Number and % of women and men with advanced HIV infection receiving ART (Clinic Attendees)	Treatment coverage	Adult Male (80%) (2006) Adult Female (93%) (2006)	>80% >80%	>80% >80%
6. Number of health facilities offering PITC	Integration of HIV/AIDS and PHC services	TBD	TBD	TBD
7. Number of health facilities offering ART		1 (2009)	3	4
8. Amount of national funds spent by the Government on HIV/AIDS	National commitment and independence of external financing of the national response	TBD	TBD	TDB

9.3 Monitoring Programme Activities

The NSP provides indicators for monitoring specific interventions, activity by activity, according to the strategic objectives and their expected results. The monitoring framework matrix, in Annex 5, gives, for each strategic objective, output indicators corresponding to the activities in the NSP implementation framework.

9.4 Evaluation of the National Strategic Plan

A mid-term evaluation of the NSP will be conducted following the first two years of implementation. The primary purpose would be to assess progress towards achieving the goals of the plan including implementation challenges and to make recommendations to address identified challenges. The evaluation would also consider new trends and strategic information that may necessitate a change in strategic direction of the plan.

Part V: NSP Indicative Cost

10 Indicative Costs of HIV & AIDS National Strategic Plan 2010-2014

The indicative cost of the NSP 2010-2014 is about EC$ 31.0 million or US$ 11.5 million over a period of five years. Table 6 and Figure 7 provide a summary of the cost of the five strategic interventions.

Table 6: Summary of the cost of National Strategic Plan 2010-2014

Strategic Interventions	EC$	US$	Percent Allocation
Priority 1: Policy development and legislation	1,462,599	541,703	4.7%
Priority 2: Multi-sectoral involvement and decentralization	7,938,419	2,940,155	25.6%
Priority 3: Prevention services	10,047,900	3,721,444	32.4%
Priority 4: Care, treatment and support services	5,154,373	1,909,027	16.6%
Priority 5: Strategic information, M&E and research	3,189,060	1,181,133	10.3%
Programme management	3,233,086	1,197,439	10.4%
Total	**31,025,436**	**11,490,902**	100.0%

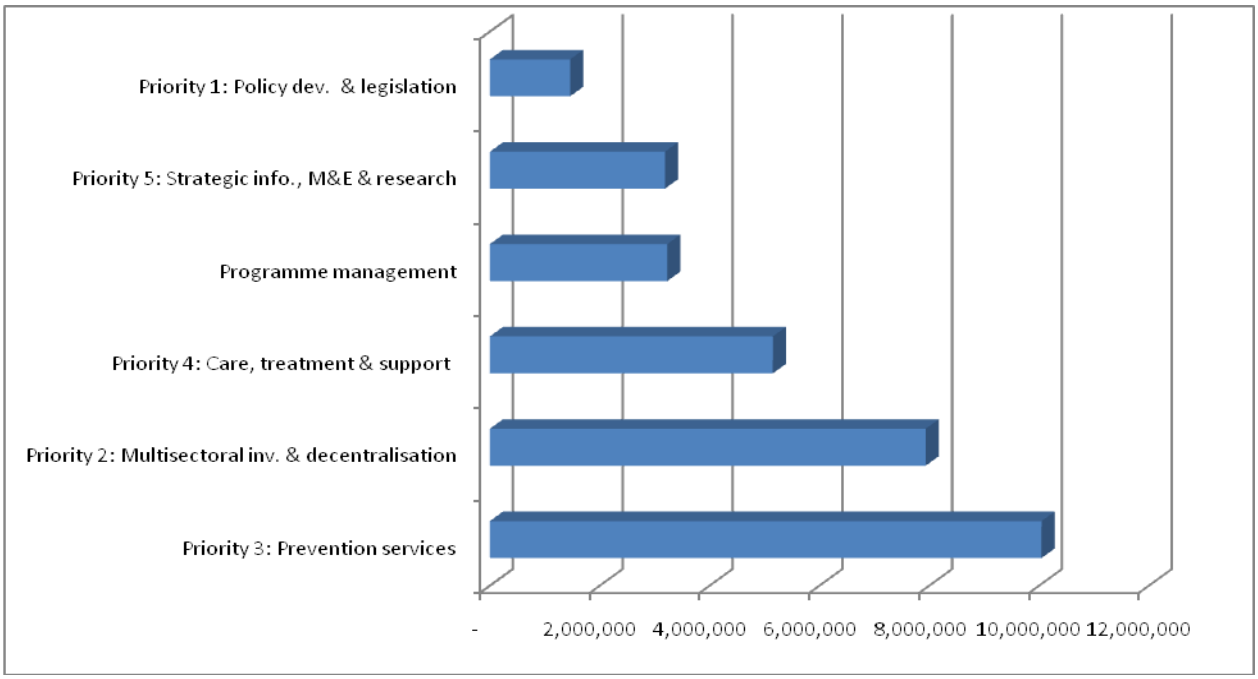

Figure 7: Summary of the cost of National Strategic Plan 2010-2014

Prevention interventions have been given high priority in resource allocation. This is partly because of the urgent need to protect the over 98% of the population who are not currently affected by the epidemic. As the national strategy states; it is important to prevent HIV transmission in most at risk groups (youth – males and females, men who have sex with men,

prisoners, sex workers, and minibus drivers as well as the general population. Table 7 and Figure 8 provide a summary of the yearly resource requirements for the key interventions.

Table 7: Summary of the yearly cost of the main priority areas of NSP 2010-2014

Interventions	2010	2011	2012	2013	2014	Total	
	EC$					EC$	US$
Priority 1: Policy development and legislation	336,650	381,010	225,216	201,377	318,346	1,462,599	541,703
Priority 2: Multi-sectoral involvement and decentralisation	1,670,972	1,231,644	1,922,963	1,490,897	1,621,942	7,938,419	2,940,155
Priority 3: Prevention services	1,568,839	1,809,196	2,009,703	2,208,733	2,451,430	10,047,900	3,721,444
Priority 4: Care, treatment and support services	931,609	1,003,584	1,051,343	1,089,321	1,078,516	5,154,373	1,909,027
Priority 5: Strategic information, M&E & research	596,612	617,212	637,812	658,412	679,012	3,189,060	1,181,133
Programme management	619,341	639,124	652,164	658,379	664,078	3,233,086	1,197,439
Total	**5,724,022**	**5,681,770**	**6,499,201**	**6,307,119**	**6,813,324**	**31,025,436**	**11,490,902**

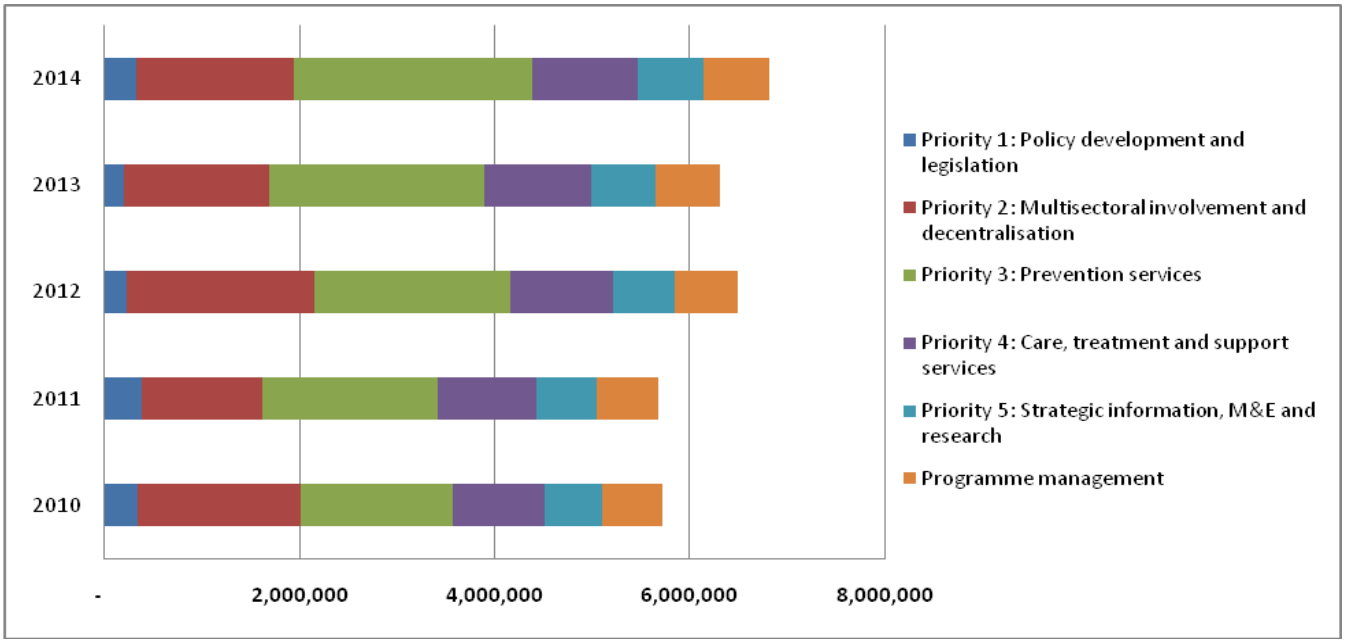

Figure 8: Summary of the yearly cost of the main priority areas of NSP 2010-2014

11 Resources Mobilisation Strategy

Since the resource shortfall for implementing NSP is large, we need to develop a resource mobilisation plan that will involve fund raising activities with development partners, the GOSVG and the private sector. In particular, solicitation of funding for the plan could be pursued as follows:

11.1 Government

The GOSVG is committed to combating the HIV/AIDS epidemic. This is critical because government ownership and leadership of the national response signifies: (i) Consistent programme direction and a coherent national response; (ii) Potentially substantial resources, including staff, offices, equipment and services; (iii) Relentless coordination of external support; and (iii) Access to the whole spectrum of activities, disciplines and interests in the public sector, including ministries, departments and agencies. The GOSVG could increase budgetary funding over the current level (by about 20-25%) to defray costs of additional staff deemed necessary to administer and manage the programme more effectively. In particular by:

- Continuing to provide counterpart funding for strengthening the health sector infrastructure response to HIV/AIDS interventions;
- Recruiting and hiring additional laboratory technicians for health centres to enable the health facilities to provide a wide range of health care services, including testing for HIV/AIDS, STI and TB;
- Supporting local training and study tours abroad for key staff to enhance skills and management capacity for efficient implementation of the national response.
- Ensuring high-level political leadership for the national response. This is crucial because the viability and sustainability of the programme will depend on the extent to which the response to HIV/STI/TB is built into the national development framework – something which only governments can effect;
- Agreeing and soliciting for a follow-on World Bank grant to continue and complete work on health systems improvement which began under the current World Bank project. In addition, the Government needs to request from the World Bank, an extension of the current project closing date in order to be able to fully utilise the funds already committed by the Bank to the country but cannot be disbursed by the due date of the project agreement; and
- Organising at least two fund raising meetings in 2009 to include potential development partners as well as private sector stakeholders.

11.2 Stand-alone Global Fund HIV/AIDS Programme in St. Vincent and the Grenadines

Recent (December 2008) assessment of the capacity for implementation of Global Fund HIV/AIDS Programme in St. Vincent and the Grenadines indicates the country has in place institutional capacity for implementation of a stand-alone results-based programme. The report suggests an arrangement that would follow a "consortia approach" that combines the capabilities existing in the Ministry of Finance, the OECS Secretariat, PPS and the Ministry of Health and the Environment (MOHE). Due to the large amount of resources needed to implement the NSP 2010-2014, the GOSVG should consider further building of internal capacities in 2009 and tendering a stand-alone proposal to the Global Fund.

11.3 Development Partners

Bilateral donors remain an important, if not the most important, source of financial and human resources, goods and services for the HIV/AIDS/STI national response for many countries. However, St. Vincent and the Grenadines, being a middle-income country, does not expect much support from this source. But concerted efforts should be made towards soliciting resources from the following sources:

- U.K. Department for International Development (DFID). In 2006/07, DFID provided a grant to the GOSVG of about US$ 34,172. DFID should be approached to solicit further support to the national response;
- The Republic of China (Taiwan) sometimes provides small grants in some countries in the Caribbean region to support the country's national response. It is important for the GOSVG to approach this donor for support to the national response;
- President's Emergency Plan for AIDS Relief (PEPFAR)/USAID/CDC are potential donors on HIV/AIDS interventions and efforts should be made to solicit funding from these development partners;
- CAREC sometimes provides assistance on some aspects of HIV/AIDS interventions and could be approached for assistance required for implementing the new NSP;
- PANCAP provided EC$ 79,047 to the GOSVG in 2006/07 to support the national response. PANCAP could be approached to attract further support;
- International HIV/AIDS Alliance Caribbean Regional Programme provides funding on some aspects of HIV/AIDS interventions and their support to GOSVG should not be overlooked;
- WHO/PAHO provided EC$150,000 to the GOSVG in 2008/09 to support the national response and efforts should be made to solicit follow-on assistance; and
- Other donors that may be invited to fund-raising meetings include the Clinton Foundation, Bill Gates Foundation, EU, the Caribbean Development Bank and any other development partner that is likely to support the GOSVG national response.

11.4 The UN system

The UN system is now focused more on catalytic action, technical assistance and advocacy, including efforts to leverage additional resources. Concurrently, the establishment of UNAIDS is meant to maximize the resources and ensure greater coherence of the efforts of different UN system agencies in support of country responses. With the establishment of UNAIDS and the increasing effectiveness of UN Theme Groups on HIV/AIDS in countries, it is anticipated that there will be stronger and better coordination not only of the UN system's support but also that of overall external aid in general. Through UNAIDS and its co-sponsors, a number of common goods, besides a stronger and more coherent UN system response, are becoming increasingly available to all countries, including:

- Improved access to and exchange of best practices on the HIV/AIDS interventions;
- Improved access to technical resources (e.g. through technical resource networks);
- Better access to goods and services, including condoms and drugs.

PAHO (which includes CAREC) has contributed capacity building in laboratory services; initiatives in establishment of a Caribbean Lab Network to increase access to diagnostic laboratory services; capacity building in HIV rapid testing; strengthening of Treatment and Care Programme; monitoring of HIV drug resistance and training in PITC.

UNAIDS has mobilised financial support for the Eastern Caribbean countries, to help with the implementation of current Global Fund grant and World AIDS Day. The GOSVG should continue to seek help from this agency to implement the new NSP;

UNAIDS is currently working with PANCAP to help submit proposal for Round 9 which will directly benefit SVG if successful. The GOSVG through NAS should take an active part in this proposal development to facilitate its eventual success; and

UNFPA has been supporting health and life skills education in schools and it may be important to solicit support to defray additional costs entailed in the operational plan. UNFPA has also supported behaviour change programmers for youth; sexual reproductive health and HIV linkages initiatives; provision of male and female condoms and models; capacity building in these areas and this should be reflected.

11.5 Non-Government Organizations and Communities

These organizations play a key role in mobilising resources, human and financial, and their potential should be tapped. Alliance, for example, has been supporting the HIV/AIDS interventions and should be approached to continue their support. Other national and international NGOs could be approached to give support to the national response.

Annex 1: NSP Preparation Team

A. Members of the Steering Committee

	Name	Affiliation
1.	Dr. Del Hamilton	Director, NAS, MoHE
2.	Ms Lucine Edwards	Health Planner, MoHE
3.	Ms Patsy Wyllie	Chief Health Educator, MoHE
4.	Dr. Conrad Nedd	Clinical Care Coordinator, MoHE
5.	Ms Marjorie Browne	M&E Advisor, NAS, MoHE
6.	Dr. Jennifer George	Epidemiologist, MoHE

B. Members of the Technical Sub-Committees

1. Policy development and legislation

	Name	Affiliation
1.	Ms Lucine Edwards	Health Planner, MoHE (Chairperson)
2.	Ms Phyllis Primus	St. Vincent Employers' Federation
3.	Ms Jacqueline Soso-Vincent	Civil Society Organizations, Field Officer
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5.	Ms Jeanie Ollivierre	Human Rights Association
6.	Ms Sandra Augustus	Gender Affairs Department
7.	Ms Odinger Louie-Warner	Treatment Advocate, MCMH
8.	Mr. Maxwell S. Providence	Evangelical Churches of the West Indies (ECW)
9.		MoLA Representative

2. Multisectoral Involvement and Decentralization

	Name	Affiliation
1.	Dr. Del Hamilton	Director, NAS, MoHE (Chairperson)
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8.	Ms Marina Lampkin	Ministry of Tourism
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10.	Ms Anita Nanton	FBO Representative
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3. Prevention Services

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3. Ms Naomi Prince	Coordinator, NFPP, MoHE
4. Ms Margarita Tash	PMTCT Representative, MoHE
5. Ms Diana Bailey	VCT Coordinator, NAS, MoHE
6. Mr. Patrick Prescod	PSI Monitor
7. Mr. Salim October	Caribbean HIV & AIDS Alliance, SVG Country Manager
8. Ms Odinger Louie-Warner	Treatment Advocate, MCMH
9. Mr. Hawkins Nanton	Representative from the Media
10. Mr. Kenyatta Lewis	FBO Representative
11. Ms Verlene Saunders	Director, SVPPA
12. Ms Deborah Dalrymple	Marion House Representative
13. Mr. Anthony Jack	Animator, Caribbean HIV & AIDS Alliance
14. Ms Abner Richards	MoE Representative

4. Treatment, Care and Support Services

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3. Ms Joyce Burgin	Assistant Nutritionist, MoHE
4. Ms Racquel Jacobs-Lawrence	Counsellor, NAS, MoHE
5. Ms Roselle Solomon	Social Worker, NAS, MoHE
6. Dr. Don Antonio Martin	Infectious Diseases Specialist, MCMH
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8. Ms Margarita Tash	Clinical Nurse Manager, Clinical Care Team, MoHE
9. Mr. Robert Joyette	Civil Society Representative
10. Mr. John Bascombe	Private Laboratory Representative
11. Dr. Rosemary Boyle	Paediatric Consultant, MCMH
12. Dr. Camille Nicholls	Obstetrics and Gynaecology, Consultant, MCMH
13. Ms Anita Nanton	House of Hope Representative
14. Mr. Steve Millington	Senior Pharmacist, MoHE
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16. Ms. Shelly –Ann Questelles	Animator, Caribbean HIV & AIDS Alliance

5. Strategic Information, M&E and Research

Name	Affiliation
1. Ms Marjorie Browne	M&E Advisor, NAS, MoHE (Chairperson)
2. Ms Gatlin Roberts	Chief Statistician, Statistics Office
3. Dr. José Davy	MCMH, MoHE
4. Dr. Navindra Persaud	Evaluation Director, Caribbean HIV & AIDS Alliance

Name	Affiliation
5. Ms Shelly-Ann Questelles	Animator, Caribbean HIV & AIDS Alliance
6. Ms Arlene James	Health Nursing Supervisor, CNS, MoHE
7. Dr. Jennifer George	Epidemiologist, MoHE

Annex 2: References

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Annex 3: Sources and Uses of Funds[7]

Source	2006-2007 (EC$)	2008 (EC$)	Uses of Funds
World Bank (Loan, Credit, Grant)	**7,398,331.08**	**3,725,918.00**	• **Works** including refurbishment of Health Centres and MCMH Treatment Site, construction of the NAS building, networking of the MCMH for the HIS • **Goods** including equipment and furniture for VCT sites, Pharmacies, MCMH Treatment Site, Laboratory and Ministries; Electronic Billboards for IEC; Condom Vending Machines • **Pharmaceuticals** including antiretroviral drugs, OI drugs, laboratory reagents (CD4 etc.), HIV rapid test kits and condoms • **Consultant Services** including NAS staff, Laboratory staff, Epidemiology and IEC/BCC (Mass Media, Calypso competition, Jamaican Play) • **Training** (internal and external) including University training in Public Health, Epidemiology and Pharmacology, Local training for HCW and other sectors • **CSO Subproject** Goods and Services including financial social support for PLHIV
Government (Consolidated Fund)	**670,811.00**	**499,699.00**	• **Personal Emoluments (NAS)** • **Utilities (NAS)** • **Supplies and Materials (NAS)** • **Communication Expenses (NAS)** • **Operating and Maintenance Services (NAS)** • **Local Travel and Subsistence (NAS)**
OECS Global Fund	**345,173.04**	**143,517.23**	• **PMTCT** • **Training of Care and Treatment Team** • **Adherence Programme** • **Peer Communicators' stipend** • **Treatment Advocates' stipend** • **Orphans and Vulnerable Children**
Pan Caribbean Partnership	**79,047.62**	**0.00**	• **Law, Ethics and Human Rights National Assessment**
DFID	**92,266.06**	**0.00**	• **Care and Treatment (Quick Start)**
Total	**8,585,628.80**	**4,369,134.23**	

[7] More detailed information is available from NAS project and programme reports

Annex 4: Implementation Activities

Priority area 1: Policy development and legislation

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
1. To develop policies, programmes and legislation that promote human rights, including gender equity, and reduce socio-cultural barriers in order to achieve Universal Access.	• Legislation that addresses the issues related to legal, ethical and human rights of those infected with, or affected by, HIV.	• Draft and enact legislation specific to stigma and discrimination, ethical and Human Rights issues to protect individuals suffering from any illness.								X	MoLA, MoHE
	• Policies that ensure delivery of effective, efficient and focused preventive, care and treatment services	• Develop gender responsive and human rights based operational policies and supporting laws for condom access and provision of services to MARPs and appropriate HIV preventive methods for minors.								X	MoLA, MoHE CHAA, MoE
		• Enact supporting laws for condom access and provision of services to MARPs and appropriate HIV preventive methods for minors.								X	MoLA, MoHE MoE,
		• Develop gender responsive and human rights based National HIV policy to guide services such as prevention, care, treatment, laboratory services etc.				X					MoHE, MoE
	• A national response environment that promotes gender equity, empowerment to access services and less vulnerability to HIV infection	• Develop operational policies and put legislation in place that will support and encourage development empowerment programmes based on operational research.				X				X	MoLA, MoHE
		• Develop policy that will ensure gender equity in regard to HIV responses.				X					MoHE, Gender Affairs
		• Develop policy, with standards and guidelines, for persons providing HIV services to empower them implement best practice.				X					MoHE
	• Increased participation of vulnerable groups in the response to HIV.	• Organize discussion fora with decision makers and vulnerable groups to discuss HIV/AIDS issues	X	X	X	X	X	X	X	X	NAS, NNN, CHAA, HPU
2. To reduce stigma and discrimination associated with HIV and vulnerable groups.	• Cooperative programmes against stigma and discrimination among public and private sectors and PLHIV	• Organize two workshops for government and nongovernmental organizations to develop programmes to tackle stigma and discrimination with implementation and monitoring strategies				X					NAS, HPU
		• Prepare guidelines for the effective functioning of PLHIV support groups.	X								NAS, MoNM

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
	• PLHIV and other vulnerable groups access educational institutions, health services, occupations and other services free of discrimination.	• Arrange meetings with national opinion leaders to motivate them to advocate for HIV and related human rights issues	X	X	X	X	X	X	X	X	NAS
		• Workshops to develop gender responsive and human rights based workplace programmes to address stigma and discrimination									
		• Conduct a survey on the extent and magnitude of stigma and discrimination in St. Vincent and the Grenadines.				X					HPU and HPIU
		• Implement evidence-based initiatives to reduce stigma and discrimination									NAS, HPU, CSOs, CHAA

Priority area 2: Multisectoral involvement and decentralization

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
1. To enhance the ownership of national HIV programmes and the responsibility for the national response to the epidemic.	• Political, non-partisan commitment for national HIV programmes with increased financial contributions to the national response.	• Organize annual discussion on HIV/AIDS with Parliamentarians				X				X	NAS
		• Implement annual sensitization workshop with parliamentarians on HIV and AIDS with a focus on **gender and human rights** for the **reduction of stigma and discrimination**		X				X			HPU, NAS
		• Maintain ongoing process									NAS
	• HIV included in development plans with the aim of achieving a sustainable response.	• Conduct a review of development plans of stakeholders (key non-health line ministries, FBOs, NGO and CBOs) to assess the level of HIV inclusion in their work plans and level of gender responsiveness	X		X		X		X		HPU, Gender Affairs, NAS, Employers' Federation
		• Conduct stakeholder workshops on gender and HIV in the workplace		X		X		X		X	HPU, Gender Affairs, NAS, Employers' Federation
		• Based on the findings of the review, conduct meetings and workshops with stakeholders to motivate them to include HIV into their work plans		X		X		X		X	NAS
2. To strengthen the multi-sectoral response to HIV, including involvement of key government organizations, NGOs, CBOs, FBOs, PLHIV networks, the private sector, trade unions and vulnerable groups.	• Strengthened multi-sectoral coordinating mechanisms	• Carry out a restructuring of the National AIDS Council (NAC) to reduce number of members	X								MoHE
		• Conduct two training sessions in programme development for HIV/AIDS within each sector, public and private, according to national policies.	X								Employers' Federation and NAS
		• Convene sensitization meetings for the Permanent Secretaries and Heads of Private Sectors on mainstreaming HIV/AIDS in their sectoral activities	X								MoHE
		• Convene 2 meetings with Permanent Secretaries and Heads of Private Sectors on mainstreaming HIV/AIDS in their sectoral activities		X			X				MoHE, NAS
		• Create opportunities for dialogue with PLHIV, policy makers, women's and men's organizations, media and others on the gendered dimensions of HIV	X		X		X		X		Gender Affairs, NAS,
		• Training of Focal Points that is gender responsive and human rights based		X				X			NAS

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
	• Strengthened capacity of NGOs, CBOs, FBOs and PLHIV umbrella networks to contribute more effectively to the HIV response (see Strategic Objective 3.3)	• Establish a new support group for PLHIV and train in social capital development		X							House of Hope
		• Train PLHIV in Social Capital Development	X	X	X	X	X	X	X	X	NNN, NAS, CHAA
		• Conduct a needs assessment of the capacity of NGOs, CBOs, FBOs and PLHIV		X							NNN, NAS, CHAA
		• Organize 3 training sessions according to the findings of the needs assessment for FBOs, NGOs, CBOs			X	X			X		NNN, NAS, CHAA
		• Conduct gender responsive and human rights based HIV prevention training for CBOs, NGOs, women's and men's organizations, vulnerable groups, PLHIV			X	X			X		NNN, NAS, CHAA, Gender Affairs
3. To train relevant workers in all sectors to provide HIV prevention, treatment, care and support services.	• A wide range of trained HCW to provide HIV prevention, treatment, care and support services	• Carry out a human resources needs assessment (the tasks include: development of ToR for the assessment, recruitment of a consultant, data collection, data analysis, report preparation, dissemination of results etc.)			X						MoHE, NAS
		• Develop and institutionalize gender responsive and human rights based HIV training curricula for HCW training institutions professionals					X				MoHE, NAS, Community college
		• Develop an in-service training programme for HCW					X				Community Colleges, MoHE
	• Focused and targeted training programmes in HIV prevention for high risk populations and M&E for programme managers (see Priority Area 1).	• Train relevant health workers to ensure gender-sensitive and non-discriminatory HIV services to the public	X				X				MoHE, NAS, Gender Affairs
		• Train Peer Communicators and Animators and PLHIV	X				X				NAS, HH, CHAA
		• Train HCW, district by district, in HIV programme management, monitoring and evaluation etc.		X			X				HPIU, MoHE
	• A comprehensive programme for training and maintaining a complement of peer educators in workplaces.	• Train female and male peer educators and animators in gender responsive and human rights based HIV prevention interventions									NAS, HH, CHAA, Gender Affairs
4. To strengthen health and social systems and improve infrastructure to	• Integrated HIV services into primary health care delivery system	• Integrate HIV services into existing PHC delivery system by • rolling out PITC at all health care provision points and	X	X	X	X	X	X	X	X	MoHE, NAS
		• establishing 3 public sites for ART		X			X				MoHE, NAS

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
provide comprehensive and integrated HIV services.		• Undertake periodic inspection of health facilities to ensure that they are kept at appropriate standard for delivery of HIV/AIDS services				X				X	MoHE
	• Laboratory, surveillance and M&E services capable of supporting all preventive and treatment national responses	• Train laboratory technologists to provide services needed for diagnosis, clinical staging and monitoring treatment outcomes and Refer to Priority Area 5, strategic objective 2		X			X				MoHE, MCMH
	• Safety and quality assurance systems established and functioning	• Undertake quality assessment of VCT services	X	X	X	X	X	X	X	X	MCMH Laboratory
		• Train health care workers in quality assurance systems based on the assessment results		X		X		X		X	MCMH Laboratory
	• An effective system for the management and regulation of strategic human and public health supplies for the provision of HIV services	• Monitor the management and regulation of strategic public health supplies including HIV medicines, diagnostics and other commodities to ensure adhering to national standards	X	X	X	X	X	X	X	X	MoHE, CMS, Chief Pharmacist
	• Improved capacity of referral systems and networks of social agencies and organizations to support PLHIV	• Organize consultation meetings with all stakeholders to discuss referral systems and networks of social agencies for PLHIV	X	X	X	X	X	X	X	X	MoNM, NAS, CSOs, PLHIV
		• Train social support organizations in social capital development		X		X					MoNM,
5. To support national public and private sector organizations to introduce comprehensive workplace policies and programmes.	• Beneficial workplace policies and programmes in formal and informal sectors	• Organize consultation meetings with Focal Points in non-health ministries and Employers' Federation to discuss workplace policies development and implementation	X				X				NAS, Employers' Federation
		• Develop and implement HIV/AIDS workplace policies	X	X	X	X	X	X	X	X	MoHE, NAS, Ministries and Employers' Federation
6. To promote and protect the health of students and staff and to mitigate the impact of HIV on the education system.	• Overarching education sector HIV policies introduced	• Complete the development of the education sector policy and ensure incorporation in the overall national HIV policy								X	MoE, MoHE
	• Strengthened HIV education and awareness activities conducted in the school community.	• Conduct at least two activities annually				X				X	MoE

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
	• Access to youth friendly health and social services ensured.	• Collaborate with the National Family Planning programme.	X	X	X	X	X	X	X	X	NFPP, NAS
	• All primary, secondary and tertiary level students participate in well designed and gender-sensitive health and family life skills and HIV/STI prevention education programmes	• Review Family Life Education curriculum and strengthen it to include positive life style skills training				X					MoE
		• Develop curriculum and education programmes based on effective strategies for behaviour change, skills development and participatory learning, all set in the context of health promotion for responsible lifestyles								X	MoE

Priority area 3: Prevention services

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
1. To establish friendly, comprehensive, gender-sensitive and targeted prevention programmes	• Improved targeted behaviour change communication programmes to address youth, women 25-55 years and men 40 years and over and MARP	• Review Family Life Education Curriculum and strengthen by mainstreaming gender into approaches and content about sex and sexuality		X							MoE, HPU
		• Development and implementation of programmes focusing on improving communication between sexual partners which acknowledges the difficulties women encounter in talking and negotiating with men about sex			X				X		NAS, HPU, Gender Affairs,
		• Review prevention programmes to include more male participation by targeting organizations of males			X				X		NAS, HPU, Gender Affairs,
		• Develop risk reduction strategies that consider the implications of gender against the social, political, economic and cultural background of target audiences.			X				X		NAS, HPU, Gender Affairs,
		• Train pre-school and primary school teachers in gender responsive and human rights based HIV/STI prevention and life style skills				X					MoE, HPU
		• Meetings with Youth Department, Gender Affairs, and CSOs involved in HIV/AIDS activities to organize monthly sessions at schools to discuss HIV prevention and life style skills	X	X	X	X	X	X	X	X	NAS, HPU
		• Develop relevant youth friendly materials that are gender responsive and human rights based		X							MoE, HPU, NAS
		• Recruit a Behavioural Communication Change Specialist to work with the target groups						X			MoHE, NAS
		• Organise 3 retreats per year for in-school and out-of-school youth		X	X	X		X	X	X	MoE, HPU, NAS
		• Recruit 10 youth leaders (to be paid) to work with adolescent groups at health centres.	X	X	X	X	X	X	X	X	HPU, NAS
		• Hold 4 BCC sessions with uniformed men every year	X	X	X	X	X	X	X	X	MoNS, HPU, NAS
		• Provide STI prevention counselling for antenatal and family planning clients	X	X	X	X	X	X	X	X	MoHE
		• Train Mental Health Staff in VCT and HIV/STI prevention			X	X					NAS

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
		• Organise outreach programmes in collaboration with Alliance and Planned Parenthood Association for MSM and SW		X							NAS, PPA, CHAA
		• Train prison officers in promoting HIV prevention according to standardized training manual	X				X				CHAA
	• Strengthened peer education programmes for school-based and community-based youth	• Institutionalize peer education by recruiting and train 9 peer educators			X				X		MoE
	• Access to accurate, gender-sensitive information and skills on adolescence, sexuality and their HIV/STI vulnerability ensured for young people particularly within school settings.	• Develop appropriate information, education communication and skills-building materials on adolescence sexuality and adolescent STI vulnerability for youth • Disseminate materials								X	MoE, NAS, HPU
	• Comprehensive condom programmes for youths developed addressing, accessibility, availability and condom negotiation skills.	• Conduct a mapping exercise to determine the organizations currently providing condom programmes for youth and determine accessibility and availability of condoms				X					MoE, NAS, HPU, SVPPA, NYC
		• Convene stakeholder meeting to develop a plan of action to reach youth						X			MoE, NAS, HPU
	• Civil society organizations supported to reach youths with programmes to reduce their HIV vulnerability including life skills and income-generating activities.	• Conduct a mapping exercise to determine the organizations currently reaching youth and the services offered to the youth				X					MoE, NAS, HPU
		• Convene stakeholder meeting to develop a plan of action to reach youth						X			MoE, NAS, HPU
2. To provide services for prevention of mother to child transmission of HIV to all pregnant women and their families.	• PMTCT Plus services at all primary care facilities PMTCT programmes	• Train all midwives and all final year nursing students in PMTCT				X				X	Community Colleges, NAS
		• Develop a PMTCT Referral Manual and disseminate to all relevant persons			X						NAS
		• Develop and implement programmes to increase male involvement in PMTCT. Programmes should be assessed to determine barriers to more male involvement.					X				NAS, NFPP, HPU, Gender Affairs

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
3. To strengthen prevention efforts among PLHIV as part of comprehensive care.	• Positive prevention promoted for PLHIV including disclosure of their status to their sexual partners	• Contact tracing and testing with PMTCT services according to the national guidelines	X	X	X	X	X	X	X	X	CNS, NAS
		• HIV Prevention counselling for all infected pregnant women	X	X	X	X	X	X	X	X	CNS, NAS
		• Train health workers in the use of partner notification, counselling and referral services guidelines	X								CNS, NAS
4. To reduce vulnerability to HIV through early identification and treatment of other sexually transmitted infections (STI).	• HIV testing offered to all persons attending STI clinics according to national standards	• Contact tracing and partner notification counselling for all PLHIV according to the national guidelines	X	X	X	X	X	X	X	X	CNS, NAS
		• Workshops held for PLHIV on HIV and gender based violence (GBV)				X					Gender Affairs, NAS
		• Gender responsive and human rights based interventions developed on gender based violence and HIV				X					Gender Affairs, NAS
		• Gender responsive and human rights based capacity building for PLHIV on gender and sexual decision making				X					Gender Affairs, NAS
		• Counsel PLHIV in STI prevention	X	X	X	X	X	X	X	X	NAS
		• Provide ongoing post-test counselling	X	X	X	X	X	X	X	X	NAS
		• Provide provider initiated testing and counselling for STI clients	X	X	X	X	X	X	X	X	NAS, CNS
	• Availability of drugs for treatment of STI secured.	• Prepare guidelines for Syndromic Management of STI Manual						X			NAS
		• Procure common drugs for the treatment of STIs	X	X	X	X	X	X	X	X	CMS, Chief Pharmacist
	• Staff responsible for provision of STI treatment and counselling trained in simple diagnostic technology for diagnosis of aetiological agents for STI	• Train health care workers in STI treatment and counselling							X		NAS

Priority area 4: Care, treatment and support services

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
1. To increase access to treatment, care and support services for persons living with HIV.	• Increased access to laboratory-supported-monitored treatment including drug resistance surveillance with best practices.	• Identify and develop six health centres as HIV treatment sites.	X								MoHE
		• Establish 3 ART sites in the first two years.					X	X	X		MoHE
		• Develop a streamlined service of specimen collection and delivery to the laboratory in support of ARV treatment.	X								MoHE, MCMH Laboratory
		• Recruit and train laboratory technologists to support HIV diagnosis and monitoring to include access to in country viral load testing and externally resourced resistance testing		X							MoHE, MCMH Laboratory
		• Draft policy document on protection of privacy and confidentiality of clients (including PLHIV) See Priority Area 1, strategic objective 1.	X								MoHE, NAS
		• Develop and implement gender responsive and human rights based policy on patient rights to privacy and confidentiality including PLHIV	X								MoHE
		• Fully implement adherence strategy at all treatment sites	X					X			MoHE
		• Develop and implement gender responsive adherence strategy to support the differential adherence to treatment among men and women				X					NAS
		• Conduct gender responsive and human rights based workshops for PLHIV and caregivers and support groups including self care and health seeking behaviour				X					NAS, Gender Affairs
		• Monitor early warning indicators in accordance with HIV drug resistance surveillance plan	X	X	X	X	X	X	X	X	MoHE
	• Ongoing training of PLHIV and support groups in comprehensive self care and prevention.	• Conduct workshops for PLHIV and caregivers including support groups in all areas of care and treatment including self-care and health-seeking behaviour	X	X	X	X	X	X	X	X	NAS
	• Availability of drugs and other HIV commodities ensured (see Priority Area 2).	• Develop and implement the drug supply management plan	X								MoHE, CMS

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
	• Guidelines for STI management and updated ART guidelines.	• Update guidelines for the management of HIV/AIDS								X	MoHE, Clinical Care Team
2. To improve the management of tuberculosis (TB), opportunistic infections (OI) and sexually transmitted infections (STI) by early identification and treatment.	• Improved management of TB, OI and STI by early identification and treatment (see Priority Area 2).	• Train HCW in the use of adopted Caribbean guidelines for management of TB and HIV •					X				MoHE, NAS
		• Train laboratory workers in laboratory support to the diagnosis of TB, OI and STI	X					X			NAS, MCMH Laboratory
		• Adopt, disseminate and conduct training in the use of guidelines for management of TB, OI and STI		X							MoHE
		• Develop and implement the drug supply management plan for TB, OI and STI	X								MoHE, CMS
3. To improve access to nutritional and psychosocial services for persons living with HIV	• Nutritional and psychosocial services fully integrated with treatment, care and support of PLHIV	• Provide gender responsive psychosocial support for HIV positive men and women	X	X	X	X	X	X	X	X	NAS
		• Develop a national food bank and distribution network, in collaboration with stakeholders, designed to address nutritional needs			X						MoNM, NAS
		• Develop a network of social service providers, in collaboration with stakeholders.				X					MoNM, NAS
		• Establish a referral system for each service, in collaboration with stakeholders.				X					NAS
		• Develop a comprehensive gender responsive and human rights based package of tools for rapid assessment of needs and interventions for care and support of OVC.					X				MoNM, NAS

Priority area 5: Strategic information, M&E and research

Strategic objective	Expected results (outputs)	Activities	Year 1				Year 2				Responsibility
1. To track progress in the implementation of National HIV responses.	• Regular reports on the national response indicators used by decision makers and programme managers	• Train PLHIV groups, women and men's NGOs, organizations of vulnerable groups and other relevant stakeholders in the monitoring and evaluation process		X				X			HPIU, CHAA
		• Collect, collate and analyze data	X	X	X	X	X	X	X	X	HPIU
		• Train new HCW in the development and use of gender sensitive data collection tools	X				X				HPIU
		• Dissemination of reports to relevant stakeholders	X	X	X	X	X	X	X	X	HPIU
2. To maintain and strengthen HIV/AIDS/STI surveillance	• HIV/AIDS/STI surveillance system enhanced	• Organize working sessions with the private sector on how to collect and channel HIV/AIDS surveillance data to the data repository.	X								HPIU
		• Carry out annual data audits (quality checks)				X				X	HPIU
		• Assess HIV/AIDS/STI surveillance system							X		HPIU, CHAA
		• Train staff in gender analysis for the use of collected data				X					HPIU
3. To develop appropriate evidence-based policies, practices and interventions through the use of research findings and M&E data	• National research agenda, on filling data and information gaps, developed, surveys done and operational research conducted	• Using gender analysis evaluate existing prevention programmes i.e. IEC, BCC and VCT			X			X	X		HPIU
		• Conduct an economic impact assessment of HIV/AIDS in St. Vincent and the Grenadines to determine the differential impact on women and men, boys and girls in rural and urban areas		X							MoF, NAS
		• Antenatal client survey (BSS/ sero-prevalence/process data)									HPIU
		• Train HCW in data use for planning and decision making (operational research)									HPIU, CHAA
		• Organize research symposia for sharing research results				X				X	HPIU
		• Prepare an annual research agenda	X				X				HPIU
		• Employ gender responsive methodologies and guidelines in the conducting of all research		X							HPIU, Gender Affairs
		• Undertake research to unravel the epidemic drivers									HPIU, CHAA
		• Undertake operational research on the effectiveness of the prevention interventions									HPIU, CHAA

Annex 5: Programme Monitoring

Monitoring Programme Activities

The National HIV/AIDS M&E Plan[8] will be followed in monitoring the NSP with any necessary amendments when HIV/AIDS monitoring and evaluation is fully integrated in the HPIU. The plan gives sources of the data needed for each indicator.

Although data is generated by a number of stakeholders, HPIU will be the depository for HIV-related data following the integration of HIV/AIDS monitoring and evaluation into the health sector M&E. Data related to HIV and AIDS is generated through a series of reporting formats. These reports are a means by which stakeholders follow programme implementation and plan future funding and technical support activities.

Monthly Reporting Formats

Service delivery sites complete and submit reporting formats to the NAS M&E Unit on a monthly basis. At present, there are 10 different reporting formats, reflecting the following service areas addressed by the National M&E Framework:

(i) Voluntary Counselling and Testing (VCT)
(ii) Prevention of Mother to Child Transmission (PMTCT)
(iii) Care, Treatment and Support
(iv) Behaviour Change Communication and use of Mass Media for behaviour change
(v) Orphans and Vulnerable Children (OVC)
(vi) Condom Distribution
(vii) NGO/CBO Activities
(viii) Line Ministries
(ix) Stigma and Discrimination
(x) Sexually Transmitted Infections (STI)

With the exception of the "NGO/CBO Reporting Format", the monthly reporting formats are completed by HIV/AIDS service providers in public-sector health facilities. Private-sector providers submit a minimal amount of data (e.g., private laboratories submit monthly information on HIV tests conducted). The private-sector also responds to ad-hoc data requests from the NAS.

Monthly Data Submitted to NAS by Different Entities within the Ministry of Health and the Environment

Certain HIV-related information is channelled through other entities rather than going directly to the NAS. Entities that receive critical information include the following: Infection Control Unit, National Surveillance Programme, and the National Pathology Laboratory (public sector). In addition, private-sector laboratories report information to the NAS that is not captured in the monthly reporting formats.

[8] NAS. National HIV/AIDS monitoring and evaluation plan, St. Vincent and the Grenadines, 2006-2009

Monthly Data Generated through Parallel Donor Systems

It is important to note, that in addition to the national formats, there are several other forms that were developed to facilitate reporting on the OECS Global Fund indicators. In addition to meeting Global Fund reporting requirements, these forms supply the NAS with important supplemental information on the epidemic and its interventions. For example, the Global Fund has served as a catalyst to more closely monitor training activities. For the purposes of the Global Fund, NAS developed a format that documents number of service providers trained; topics covered; dates of training, etc. The merit of collecting this information extends far beyond Global Fund reporting.

The NAS M&E Unit recognizes that the establishment of parallel tools and systems is neither advisable nor sustainable. NAS plans to work towards harmonization of M&E activities, tools, and systems among donors. NAS has identified this as a priority activity in the short term.

Quarterly Reporting Formats

There are two service areas for which data is collected via quarterly reporting formats rather than monthly formats. These areas are:

- Post Exposure Prophylaxis (PEP)
- Monitoring and Evaluation

Given the relative infrequency with which events documented on those forms occur (e.g., incidents of accidental exposure; M&E trainings), quarterly formats are adequate.

Annual Reporting Formats

There are macro-level parameters that are only assessed on an annual basis. Those parameters relate to 'National Programme Impacts' and 'Partnership Programme Management'. Data to support the indicators for these service areas are provided by the National Laboratory, Ministry of Health and the Environment and the Project Coordination Unit, Ministry of Finance and Planning. With respect to National Programme Impacts, the NAS M&E Unit liaises with the National Surveillance Programme to generate estimates of the national impact indicators (e.g., proportion of all deaths attributable to HIV/AIDS).