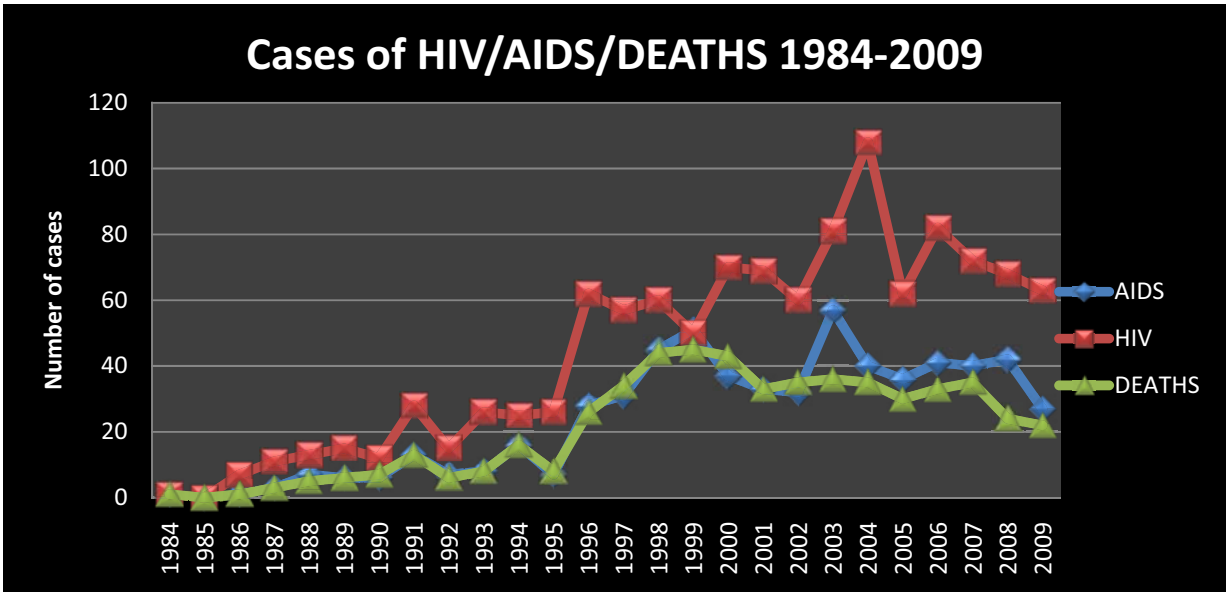
Status at a Glance

The Government of St. Vincent and the Grenadines continues with great political will to prevent and control the spread of HIV/AIDS within its Nation. The local fight against HIV/AIDS is undertaken by both the public sector, the Ministry of Health and the Environment which is guided primarily by the National AIDS Secretariat and the private sector, namely Civil Society Organizations, Faith Based Organizations and Non-governmental Organizations. Joint efforts with regional and International agencies such as PAHO, World Bank, UNAIDS and OECS HAPU allow for continuous financial and technical assistance which in turn is beneficial to St. Vincent and the Grenadines regards to financial and technical assistance. Also, local Non-Governmental agencies such as Planned Parenthood Association, Population Services International (PSI), Caribbean HIV/AIDS Alliance (CHAA) and House of Hope whom rely on external agencies for financial and technical support are involved in prevention programmes covering all spheres of the Society.

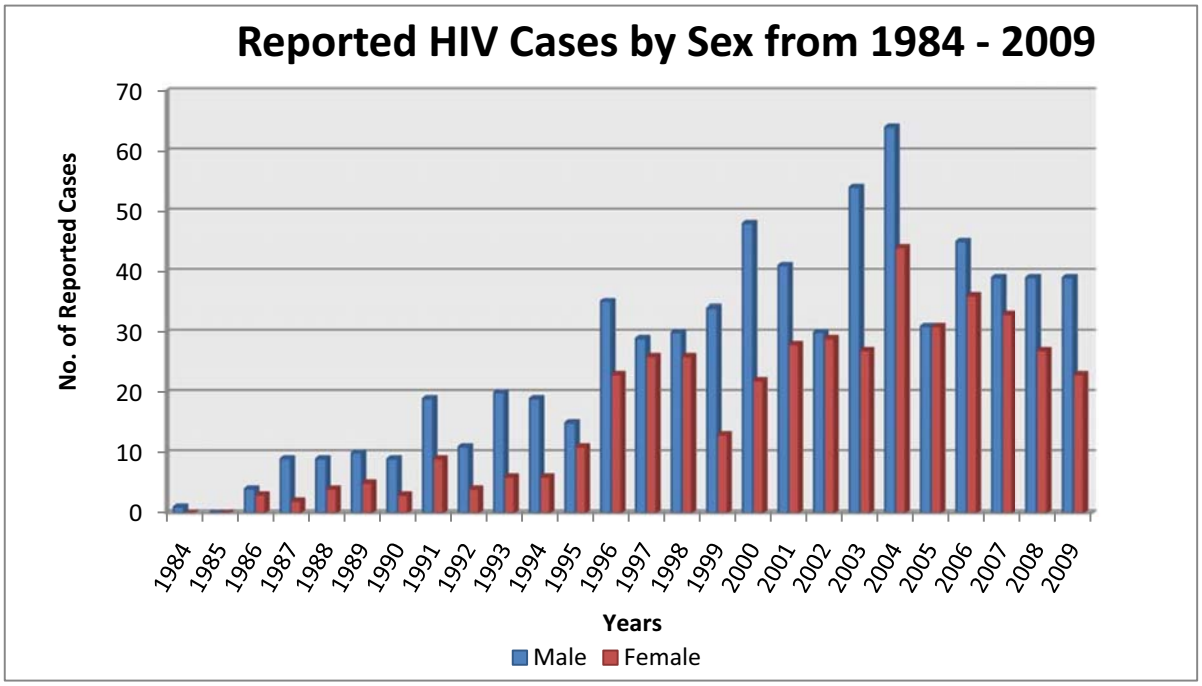
The spread of HIV has slowly begun to decrease since the upscale of the HIV/AIDS prevention and control programme in 2004 in St. Vincent and the Grenadines. As seen in Graph 1 below, over the last two years (2008 and 2009), the HIV incidence has continued its general decrease in trend. The rigorous care and treatment programme has enabled that AIDS is no longer synonymous with death. The number of deaths attributable to AIDS has decreased significantly over this period by 32 % (68 deaths in 2006-2007 and 46 deaths in 2008-2009), therefore allowing the number of persons with HIV to experience a longer survival time.



Graph 1: Number of cases of HIV/AIDS/DEATHS from 1984-2009

The incidence of HIV infection is steadily increasing in women although men continue to bear the major burden of the disease as shown in Graph 2. During the period 2006-2007 the ratio of

HIV in men to women was 1.2:1 while the ratio of men to women with HIV infection is approximately 1.6: 1 during this reporting period 2008-2009. However, it is imperative to note that the uptake of VCT services is primarily done by women thus enabling higher diagnostic rates in this sex.



Graph 2: Distribution of HIV cases by sex from 1984-2009

The major mode of transmission of the disease is through heterosexual contact, which generally accounts for 70% of all HIV infections. Recorded homosexual or bisexual and vertical transmissions account for ten (10) and four (4) percent, respectively.

The programme priorities over the last two years (2008 & 2009) have been that of consolidation whereby HIV/AIDS programmes have gone through a solidification and integration process. Programmes such as Monitoring and evaluation, Behaviour change communication, Laboratory support services, Voluntary Counselling and testing and prevention programmes have been integrated into pre-existing programmes within the Ministry of Health and the Environment.

One of the major milestones during this period was the development of a National Strategic Plan 2010-2014 for HIV/AIDS. The new strategic plan is geared to address the strengthening of selected parameters such as policy and legislation, multisectoral involvement and decentralization, prevention services, care-treatment and support services along with strategic information, Monitoring and evaluation and research.

In order to produce a comprehensive overview of the HIV/AIDS prevention and control programmes in SVG, discussions were held with relevant stakeholders for the purpose of the UNGASS report 2008-2009 and all other National reporting requirements.

Table 1: OVERVIEW OF THE UNGASS INDICATORS DATA

<table>
<tr><th>INDICATOR</th><th colspan="2">CALCULATED INDICATOR</th></tr>
<tr><td rowspan="5">1: AIDS Spending by financing source for reporting Period January 2008 to December 2009.

Source: Ministry of Finance, Planning and Development; Ministry of Health and the Environment Accounts Department.</td><td>Project Coordinating Unit (World Bank)</td><td>2008: EC$ 3,725,918.00
2009: EC$ 6,016,941.00
Sub-Total:
EC$ 9,742,859.00</td></tr>
<tr><td>National AIDS Secretariat (Recurrent Budget)</td><td>2008: EC$ 499,699.00
2009: EC$ 594,661.00
Sub-Total:
EC$ 1,094,360</td></tr>
<tr><td>Global Fund</td><td>2008: EC$ 143,517.23
2009: EC$ 376,388.41
Sub-Total
EC$ 519,905.64</td></tr>
<tr><td>Pan American Health Organization</td><td>2008: EC$ 0
2009: EC$ 79,876.52
Sub-Total
EC$ 79,876.52</td></tr>
<tr><td>TOTAL</td><td>2008: EC$ 4,369,134.23
2009: EC$ 7,067,866.93
Total:
11,437,001.16</td></tr>
<tr><td>2: Government HIV and AIDS Policies
National Composite Policy Index (NCPI)</td><td colspan="2">See NCPI data, Part A and Part B.</td></tr>
<tr><td>3: Percentage of donated blood units screened for HIV in a quality assured manner

Source: Ministry of Health and the Environment, Milton Cato Memorial Hospital.</td><td colspan="2">2008: 1156 units (100%)
2009: 982 units (100%)</td></tr>
<tr><td>4: HIV Treatment: Antiretroviral Therapy

Percentage of adults and children with advanced HIV infection receiving antiretroviral Therapy.

Source: HIV/AIDS/STI Clinic, Milton Cato Memorial Hospital</td><td colspan="2">
<table>
<tr><th rowspan="2">Sex</th><th colspan="3">2008</th><th colspan="3">2009</th></tr>
<tr><th><15</th><th>>15</th><th>Total</th><th><15</th><th>>15</th><th>Total</th></tr>
<tr><td>Male</td><td>1</td><td>65</td><td>66</td><td>1</td><td>86</td><td>87</td></tr>
<tr><td>Female</td><td>1</td><td>53</td><td>54</td><td>2</td><td>73</td><td>75</td></tr>
<tr><td>Total</td><td>2</td><td>118</td><td>120</td><td>3</td><td>159</td><td>162</td></tr>
</table>
2008: 73.17%
2009: 89.01%
<u>IN ADDITION</u>
2008: 20 Private Patients (all over 15 yrs)
2009: 20 Private Patients (all over 15 yrs)</td></tr>
</table>

INDICATOR	CALCULATED INDICATOR
5: Prevention of Mother-to-Child Transmission Percentage of HIV-infected pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission. **Source:** HIV/AIDS/STI Clinic, Milton Cato Memorial Hospital	**2008:** 95.45% (n=21) **2009:** 82.35% (n=14)
6: Co-management of Tuberculosis and HIV Treatment. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV. **Source:** HIV/AIDS/STI Clinic, Milton Cato Memorial Hospital	27.2% (n=3) **2008=2 (>15 yrs and female)** **2009=1 (>15 yrs and male)**

INDICATOR	CALCULATED INDICATOR
7: HIV Testing in the General Population Percentage of women and men aged 15 – 49 who received an HIV test in the last 12 months and who know their results. **Source:** Ministry of Health & the Environment, OECS, BSS 2005	
8: HIV Testing in Most-at-risk Populations Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results. Source: Ministry of Health & the Environment, OECS, BSS	Mini-bus and Taxi drivers 57 drivers (17%)
9: Most-at-risk Populations: Prevention Programme Percentage of most-at-risk populations reached with HIV prevention programmes	Data Not Available

Age Group (yrs)	Males (%)	Females (%)	Both Sexes (%)
15-19	**10 (4)**	**23 (8)**	**6**
20-24	**23 (12)**	**24 (12)**	**12**
25-49	**26 (9)**	**41(16)**	**12**

<table>
<tr><th>INDICATOR</th><th>CALCULATED INDICATOR</th></tr>
<tr><td>10: Support for Children Affected by HIV and AIDS

Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child.</td><td>127 OVCs</td></tr>
<tr><td>11: Life-Skills based HIV Education in Schools

Percentage of schools that provided life-skills based HIV education in the last academic year.</td><td>100 % Primary Schools (n=66)
100 % Secondary Schools (n=24)</td></tr>
<tr><td>12: Orphans: School Attendance

Current school attendance among orphans and non-orphans aged 10 – 14.</td><td>Data Not Available</td></tr>
<tr><td>13: Young People: Knowledge about HIV Prevention

Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

Source: Ministry of Health & the Environment, OECS BSS 2005</td><td><table>
<tr><th>Age Group (yrs)</th><th>Males (%)</th><th>Females (%)</th><th>Both Sexes</th></tr>
<tr><td>15-19</td><td>151 (59)</td><td>115 (40)</td><td>266 (49)</td></tr>
<tr><td>20-24</td><td>113 (58)</td><td>98 (41)</td><td>211 (49)</td></tr>
</table></td></tr>
<tr><td>14: Most-at-risk Population: Knowledge about HIV Transmission Prevention

Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.</td><td>Youth on the Block
205 (53%)</td></tr>
</table>

INDICATOR	CALCULATED INDICATOR
15: Sex before the age of 15 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15. **Source:** Ministry of Health & the Environment, OECS BSS 2005	**Age Group (yrs)** / **Males (%)** / **Females (%)** / **Both Sexes (%)** **15-19** / **74 (29)** / **49 (17)** / **23** **20-24** / **64 (33)** / **24 (10)** / **20**
16: Higher-risk Sex Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months **Source:** Ministry of Health & the Environment, OECS BSS 2005	**Age Group (yrs)** / **Males (%)** / **Females (%)** / **Both Sexes (%)** **15-19** / **41 (16)** / **29 (10)** / **70 (13)** **20-24** / **101 (52)** / **36 (15)** / **137 (32)** **25-49** / **38 (13)** / **15 (5)** / **53 (9)**
17: Condom Use During Higher-risk Sex Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse. Source: OECS BSS 2005-2006	**Age Group (yrs)** / **Males (%)** / **Females (%)** / **Both Sexes (%)** **15-19** / **26 (62)** / **16 (55)** / **42 (59)** **20-24** / **63 (62)** / **18 (50)** / **81 (59)** **25-49** / **N/A** / **N/A** / **N/A**
18: Sex Workers: Condom Use Percentage of female and male sex workers reporting the use of a condom with their recent client.	Data Not Available

INDICATOR	CALCULATED INDICATOR
19: Men Who Have Sex with Men: Condom Use Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	Data Not Available
20: Injecting Drug Users: Condom Use Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.	NOT APPLICABLE
21: Injecting Drug Users: Safe Injecting Practices Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.	Data Not Available
22: Reduction in HIV Prevalence Percentage of young people aged 15 – 24 who are HIV infected. **Source:** Ministry of Health & the Environment, HIV/AIDS Case Surveillance	N=14; 2.45% Denominator=571

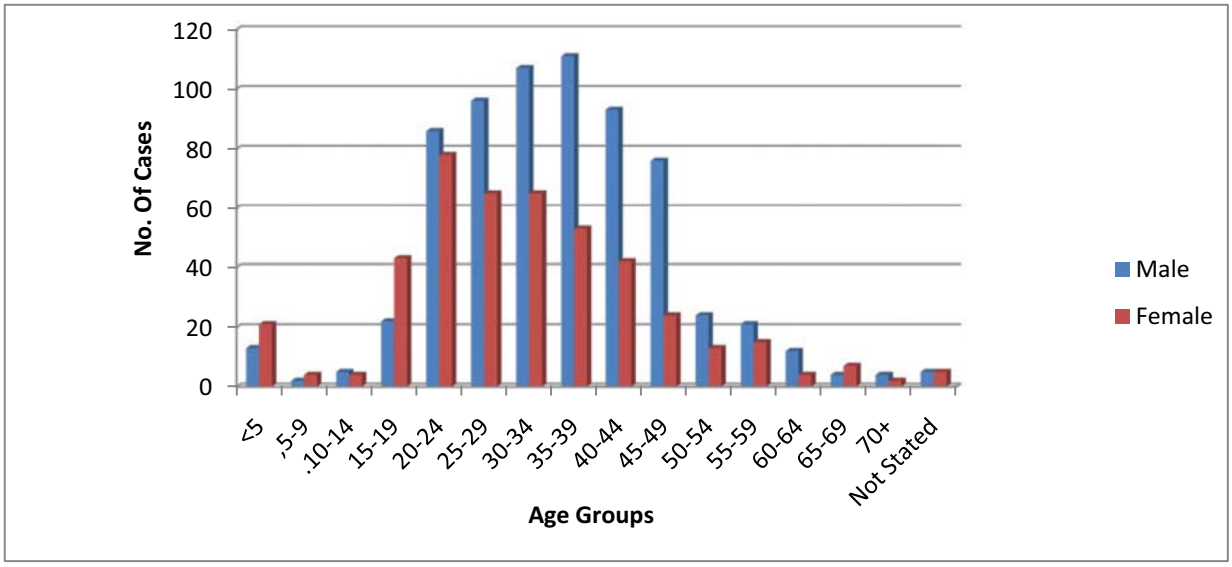
INDICATOR	CALCULATED INDICATOR		
23: Most-at-risk Populations: Reduction in HIV Prevalence Percentage of most-at-risk populations who are HIV-infected.	**Prisoners** **4.1% (n=344)**		
24: HIV Treatment: Survival After 12 Months on Antiretroviral Therapy Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	**Year**	**Males**	**Females**
	2008 (87.2%)	**<15:** 1 **>15:** 17	**<15:** 0 **>15:** 16
	2009 (85.7%)	**<15:** 0 **>15:** 19	**<15:** 0 **>15:** 11
25: Reduction in Mother-to-child Transmission Percentage of infants born to HIV-infected mothers who are infected.	0%		

Overview of the AIDS epidemic

The epidemic in St. Vincent and the Grenadines is still generalized in nature as it is not concentrated in any specific sub-population (vulnerable or most-at-risk population). The prevalence amongst antenatal clients remains at approximately 1%.

As mentioned in the section "Status at a Glance", the HIV/AIDS epidemic has slowly begun to taper and AIDS is no longer synonymous with death. Based on Graph 1, it is correct to infer that HIV incidence rates, AIDS prevalence rates and deaths attributable to AIDS rates are on the decline.

As shown in Graph 3 below, the majority of male incident cases of HIV have occurred within the ages 20-49 years old while the majority of female incident cases are within the ages 20-39 years old. This trend continued during the period 2008-2009. Although the general number of male cases being diagnosed HIV positive is higher, more females in the age groups under 19 years and 65-69 years old have been diagnosed HIV positive.



Graph 3: Cumulative number of incident cases from 1984-2009

Although the HIV/AIDS epidemic is generalized in St. Vincent and the Grenadines, it continues to affect persons of lower socio-economic status to a greater degree as many of the positively diagnosed cases are unemployed or occupy manual jobs such as construction or other menial jobs. The occurrence of HIV is not localized in any one geographical area and is widespread throughout St. Vincent and the Grenadines.

National Response to the AIDS epidemic

The period 2008-2009 officially marks the conclusion of the 2004-2009 strategic plan activities for the prevention and control of HIV/AIDS in St. Vincent and the Grenadines. This period was characterized as one of consolidation and sustainability in order to ensure the longevity of the fight against HIV/AIDS. The National programme response activities and data results shown in Table 1 (Overview of the UNGASS Indicators Data) are significant enough to provide evidence that the strategic priorities of the 2004-2009 strategic plan have been reinforced during 2008-2009. Services such as VCT, stigma and discrimination, care and treatment, advocacy, training, social support, laboratory support services, monitoring and evaluation, surveillance and behaviour change communication and other prevention activities have been strengthened, integrated into and sustained by the Ministry of Health and the Environment and external agencies.

As previously mentioned, the National response over the last two years has been geared at strengthening all HIV/AIDS prevention and control programmes and also transitioning many programmes into the MOHE pre-existing programme areas. This last process was imperative as the Country's main source of funding was through World Bank funding which will be phased out by the end of 2010.

AIDS Spending

Referring to the data in Table 1, overview of the UNGASS indicators data, the AIDS spending in 2008 and 2009 provided by varying financing sources have far exceeded that of 2006 and 2007 by EC $2,851,372.36 dollars although the sources have been less.

World Bank funds were essentially utilised for the execution of civil works such as the construction of a policlinic in a rural district in order to facilitate the decentralization of health services especially for prevention activities and treatment and care for persons living with HIV/AIDS. In addition, resources were made available to assist in the construction of the Curriculum Unit within the Ministry of Education which currently houses an HIV resource centre. Extensive amounts of funding were also made available for numerous out-reach programmes geared towards behaviour change, HIV sensitization and awareness of the general public. This was successfully achieved not only by National AIDS Secretariat activities but along with line ministries, civil society organizations, faith based organizations and NGO involvement.

Resources provided by Global Fund have also been utilised to a greater degree due to the recruitment of staff (focal point) to directly oversee the execution of projects such as out-reach programmes and social support programmes for people affected and infected with HIV/AIDS.

Pan Americana Health Organization funding was specifically utilised in order to facilitate the development and dissemination of the National Strategic Plan 2010-2014 for HIV/AIDS. Also, the uptake of funds were useful in order to implement activities for designated World Health Assembly special health day (World AIDS Day) which is aimed at raising general public awareness.

Policy and Programming

The planning process in St. Vincent and the Grenadines has been guided by the development of programme specific vertical protocols and guidelines for various services offered by the National AIDS Secretariat. However, there is no holistic HIV policy that addresses all aspects of the prevention, management, care and support of a person living with HIV/AIDS; thus, it has become a national priority for our country.

During the reporting period, the focus was on evaluating the HIV/AIDS epidemic and its programmes in order to develop a national strategic plan for 2010-2014. This process was made possible through regional support and numerous national stakeholder meeting with personnel from the public sector, civil society organizations, faith based organizations and non-governmental organizations. The strategic plan for St. Vincent and the Grenadines is harmonized and aligned with the Caribbean Regional Strategic Framework in order to maintain a standardized public health approach towards the fight against HIV/AIDS.

Future planning processes will be dependent on the recently (2009) concluded study of the impact of HIV on its socio-economic development which will in turn guide resource allocation for HIV/AIDS which is a major milestone achieved when compared to previous years.

The multisectoral approach was strengthened in 2008 and 2009 where the involvement of civil society organizations and line ministries peaked along with the firmer establishment of non-governmental organizations such as Caribbean HIV/AIDS Alliance.

The extent of policy and legislation development still continues to move slowly although programmes have already been implemented to support stigma and discrimination, universal

access to services, prevention and care and support. The promotion and protection of human rights is explicitly mentioned in both past and present strategic plans by way of advocacy campaigns.

Evidence exists through surveillance data that our HIV/AIDS epidemic is generalized throughout St. Vincent and the Grenadines and not focused on any one geographical area. Thus, the plan for decentralization of services is based on strategic placement of the policlinics to coincide with the geographical make up of the country and not necessarily to provide services for an area with higher prevalence rates. This then ensures easier access to health care services for all members of the society.

Prevention

Voluntary Counselling and Testing (VCT)

One of the remarkable achievements of the VCT service during the reporting period was the ability to have accomplished 100% (n=39) upgrade of the health centres into VCT sites in addition to the HIV/AIDS/STI clinic, the NAS and also to incorporate the service at a Non-Governmental Organization level while simultaneously maintaining the regional quality standards. This was not only characterised by physical infrastructure improvements but entailed the training of approximately 150 health care workers in VCT and 23 health care workers in HIV Rapid Testing which couples those previously trained.

Provider Initiated HIV Testing and Counselling (PITC) has been incorporated into the VCT service in order to increase the awareness on the importance of HIV testing and counselling while ensuring universal access for all persons with HIV/AIDS and giving the opportunity for HIV prevention. Approximately 100 health care workers have been trained in PITC. Although the country has not yet developed National guidelines on the implementation of PITC at the health centres, the WHO guidelines are guiding the National implementation process which addresses confidentiality, informed consent and access to quality counselling.

The data resulting from the 2005 OECS BSS is currently being used to reflect the uptake of VCT services in St. Vincent and the Grenadines as shown in Table 1. However, with the upscale of the HIV/AIDS prevention and control programme the service has become decentralized and extensively marketed through numerous out-reach programmes that target all members of the society. The programme has successfully incorporated peer communicators to educate Vincentians on the available services. VCT uptake peaks on special renowned health days such as National HIV Testing Day.

The upscale of the VCT programme has forced the development of a VCT database to effectively monitor and evaluate the programme. As shown in Table 2 below, over the period 2008-2009 the service has been accepted by 5571 individuals, the majority being females 25 years and over (1813/32%).

Sex	2008				2009			
	<15	15-24	25+	Total	<15	15-24	25+	Total
Male	0	262	457	719	**5**	**500**	**1047**	**1552**
Female	4	494	577	1071	**16**	**977**	**1236**	**2229**
Total	**4**	**756**	**1034**	**1790**	**21**	**1477**	**2283**	**3781**

Table 2: Number of individuals who received HIV testing and know their results

Prevention Mother to Child Transmission (PMTCT)

PMTCT is being successfully implemented at the HIV/AIDS/STI clinic although it still continues to be a centralized service. The programme continues to be guided by the PMTCT committee. This period is specifically noted for the 0% transmission rate to infants born to HIV positive mothers although over the period two babies died and three were lost to follow-up. All babies born to HIV positive mothers are offered and encouraged to be tested by dry blood spot sampling.

The number of pregnant women accepting PMTCT services consistently remains around 99%. The remaining population of pregnant women who did not access antenatal care are captured during labour and delivery when HIV rapid testing is done to ascertain HIV status.

In 2008 and 2009, the number of pregnant women testing positive for HIV exceeded that of the previous reporting period by 16%. However, the incidence rates in pregnant women were less. Of the 42 HIV positive pregnant women in 2008-2009, 28 cases were repeaters while only 14 were new cases.

Blood Safety

All donated blood at the National Laboratory continues to be screened for HIV, Hepatitis B and C, HTLV 1 and 2 and VDRL. The laboratory maintains its quality control measures for blood testing and continues to be assessed at regular intervals through an external Quality Assurance Scheme.

The HIV Seroprevalence amongst blood donors remains consistently low and is estimated at 0.3%.

Condom Promotion and Distribution

Condom promotion and distribution through St. Vincent and the Grenadines continues to be a service offered by the Ministry of Health and the Environment managed by the National Family Planning Unit. The distribution has not only been offered to public health centres but also to private sector institutions such as private physicians, NGOs such as Red Cross, Planned Parent Hood and Caribbean HIV/AIDS Alliance and at office and community settings.

A major milestone in this programme has been the procurement of 50 vending machines of which 38 have been strategically placed in areas of high social activity.

Although the uptake of the female condom has not yet yielded exceptionally high results, continuous marketing and promotion continues in order to stem the transmission of HIV by empowering women on the decision of negotiating contraception during sexual intercourse. The number of male condoms distributed through the programme in 2009 was 349,011 while only 1958 female condoms were distributed to both public and private sector. The distribution rate of condoms continues to be high although there have been some challenges encountered.

Information-Education-Communication (IEC)

The National AIDS secretariat has given IEC high priority on the agenda in order to gain acceptable knowledge, behaviour, attitude and practices towards the prevention of HIV/AIDS sexual health and health services. The programme is currently geared to target the general community through the procurement and erection of electronic billboards that primarily display behaviour change and prevention messages. The billboards are strategically placed at the only two entry points to the capital of the country, St. Vincent.

Over the last two years, advocacy programmes targeted at youths have been a major focus. Sensitization material was developed and disseminated through workshops and out-reach activities targeting in-school youths.

General Community out-reach activities have been achieved through a multi-sectorial approach engaging CBOs, FBOs, NGOs and National AIDS Secretariat staff. The recruitment of peer communicators at the public sector level was responsible for conducting advocacy campaigns in various communities throughout St. Vincent and the Grenadines.

Prevention Programmes Addressing Most-At-Risk Populations

The establishment of the Caribbean HIV/AIDS Alliance in St. Vincent and the Grenadines has been beneficial by fulfilling its mandate to access most-at-risk populations. During the reporting period 2008-2009, the Alliance has made immense strides in identifying and working with populations such as men who have sex with men, sex workers and PLHIV. Of the 1143 persons reached (794 male; 337 female; 12 missing data), 282 MSMs were identified along with 59 sex workers and 24 sex workers-MSMs. These populations are reached through peer communicators that inform, educate and communicate information based on IEC material produced and disseminated by the Alliance.

The Alliance plays a key role in the distribution of commodities such as condoms (male and female) and lubricants to not only their target populations but also to the general community. The Alliance has distributed approximately 217,536 condoms (214,209 male condoms & 3327 female condoms) and 31440 lubricants.

The Caribbean HIV/AIDS Alliance has also provided technical expertise through training programmes of 31 service providers in HIV/AIDS prevention.

The collection of strategic information through research is priority for CHAA. In 2009, two studies were conducted addressing faith based organization involvement with HIV/AIDS and

HIV Education in Schools
The Ministry of Health and the Environment, through World Bank funds were able to significantly contribute to the construction of the Curriculum Unit in the Ministry of Education which houses the HIV/AIDS resource centre.

The curriculum, through the Health and Family Life Education (HFLE) programme, enables that all primary schools from Grade K onwards and secondary schools (up to forms 3) throughout St. Vincent and the Grenadines has incorporated this subject area. The subject area covers issues related to sexual health and HIV/AIDS material, thus enabling 100% coverage amongst in-school youth.

Prisoners
As the prison population has been identified as a most-at-risk group, the HIV/AIDS prevention and control programme has strategically attached a counsellor to attend to the prisoners where VCT services and other prevention activities are offered.

Care and treatment & support
The treatment, care and support services for PLHIV began provision of treatment with highly active antiretroviral therapy in 2003 as a centralized service. The current construction of a policlinic in a rural area will enable the decentralization of ART services in St. Vincent and the Grenadines which constitutes phase 1 in the decentralization of services as two other sites are already earmarked for this purpose.

Over the last two years (2008-2009), the HIV/AIDS/STI clinic has succeeded in keeping more active patients in follow up care peaking at the end of 2009 with 296 clients registered. The clinic, on average, continues to register approximately 57 new patients on a yearly basis. This achievement is coupled with the fact that clients are accessing voluntary counselling and testing services for screening and thus early diagnosis of HIV is occurring. This impacts positively on the initiation of ARV treatment as it yields better prognosis for clients than when HIV diagnosis is late. As a result, over the last two years clients are initiating treatment in early stages of diagnosis thus increasing the survival rates of the clients to approximately 85% as compared to clients that initiated treatment 3-5 years ago that only achieved survival rates of approximately 40%. The period has experienced has only experienced the “stock out” out of one drug which was quickly substituted by another which also impacts positively on the survival rates. The follow-up of patients has improved substantially however, poor adherence and patients’ decision to opt out of treatment still continues to be a challenge.

The co-existence of TB/HIV has highly impacted on the incidence of tuberculosis during the period 2008-2009. Of the 20 incident cases of tuberculosis diagnosed, 55% (n=11) have both tuberculosis and HIV. The testing of all patients diagnosed with tuberculosis for HIV is practised and all symptomatic HIV infected clients are tested for tuberculosis.

Line Ministries/Civil Society Organizations (CSO)
The incorporation of line ministries and CSOs has extended the multi-sectorial approach to combat the fight against HIV/AIDS. The period was achieved active involvement of 14 CSOs and 11 line ministries whom prepared action plans geared to address advocacy, prevention and

stigma and discrimination. The conducted activities were able to reach all aspects of the society through drama, song and rallies.

Non-Governmental Organizations (NGO)
The Planned Parenthood Association (PPA) is an existing NGO that continues to actively offer palliative care and sexual reproductive health care services to members of the society. The Organization works in collaboration with the PSI and CHAA to effectively carry out their functions as there is overlapping of the populations being reached.

The PPA has intensified its support to persons infected and affected by HIV by offering monthly social assistance to the more underprivileged clients. The PPA initiated training of 12 persons addressing skills in home based care for PLHIV in order to fill the void of clientele that have no family support.

Programmes geared towards advocacy, counselling and testing, prevention, training and dissemination of IEC material are also main activities of the PPA. The services offered are strengthened by the recruitment of Peace Corps that increase man power and offer technical expertise in the marketing of services and development of IEC material.

Orphans and Vulnerable Children (OVC's)
The care and support services offered to orphans and vulnerable children in St. Vincent and the Grenadines continues to benefit from a multisectoral approach. The Government of St. Vincent and the Grenadines along with local NGOs and external funding agencies have over the last two years have broadened support services offered to OVCs from financial and other material support to psychological support. This has been accomplished through the launching of a mentorship programme for HIV/AIDS orphans. This creates an enabling and supportive environment for children infected and affected by HIV/AIDS.

Future National Plans
The Government of St. Vincent and the Grenadines has ensured continued support for the fight against HIV/AIDS for the next five years through the development of the HIV/AIDS National Strategic Plan 2010-2014. The plan was developed in collaboration with public sector, civil society organizations, non-governmental organizations and faith based organizations with technical expertise from external agencies through focus group and one-on-one discussions and general meetings.

The main focus for HIV/AIDS is to build on programmatic strengths of already existing programmes and address weaknesses identified. The priority areas identified 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

The development and implementation of policy and legislation is indeed a national priority over the next five years in order to promote human rights, including gender equity, and to reduce

socio-cultural barriers in order to achieve universal access. Although stigma and discrimination has been addressed to some extent in St. Vincent and the Grenadines, the need for formal approaches such as development of cooperative programmes against stigma and discrimination among public and private sectors and PLHIV is a must for the future. The focus is also set on the development and implementation of HIV workplace policies and programmes in both government institutions and private sector businesses.

A known success in relation to the prevention and control of HIV/AIDS is the sustainment of multisectoral involvement and decentralization of services. Thus, the national plan is to increase technical, political and financial support in order to maximise the HIV response in each sector and to attain the highest possible coverage of services. This will be done through consolidation of services, developing and strengthening of HIV responses within all public sectors. The national response will be increased through strengthening health and social systems and improving infrastructure, training relevant workers in all sectors and through strengthening the organizational and managerial capacities of PLHIV networks and other civil society organizations.

Evidence based conclusions have been made that the population has a generally high level of knowledge about HIV and specifically about HIV transmission but still indulge in risky sexual behaviours based on the OECS BSS 2005. Thus, the future prevention services will be to 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 while simultaneously addressing issues related to poverty and decentralization. The aim is to implement specific targeted interventions among most-at-risk populations including sex workers, men who have sex with men and prisoners.

Another major priority area over the next five years with regards to treatment, care and support services is to reach PLHIV still in need of treatment and to improve their adherence. These mentioned services will also include the up-scale in the management of sexually transmitted infections, tuberculosis and opportunistic infections. The main focus will be on decentralizing all HIV services within existing primary health care services while simultaneously enhancing the link between prevention and treatment services.

With the consolidation and upscale of the HIV/AIDS prevention and treatment programme the need for continued monitoring and evaluation is imperative along with filling information gaps through the collection of strategic information by way of research. Research studies focusing on most at risk populations namely MSM (BSS and HIV Seroprevalence survey) is priority for further policy and programme planning. The implementation of a National Health Information System will enhance HIV surveillance and all other associated parameters related to the management of PLHIV.

Best Practises

In St. Vincent and the Grenadines our best practise has been highlighted by way of the treatment and care programme. The HIV/AIDS/STI clinic, although a centralized service, easily serves people living with HIV/AIDS as its location is in the capital of the island. The service is made more accessible through the provision of travel reimbursements to clients that require financial assistance in order to facilitate the process of accessing care and treatment.

The clinic is staffed with health care workers that have undergone extensive specialized training in the treatment of HIV/AIDS. The small size of the island coupled with being a country of low epidemicity creates a relatively easy service provider-client relationship that ensures easy follow-up of clients.

The formation of a PMTCT committee which oversees the prevention of mother-to-child transmission is currently one of the most important best practises in St. Vincent and the Grenadines. The committee has worked ardently to develop a country specific PMTCT protocol that guides this service.

In terms of advocacy, the National AIDS Secretariat has successfully implemented the incorporation of PLHIV as peer communicators and treatment advocates in order to effectively advocate treatment adherence. These peer communicators have also been actively involved in community out-reach programmes advocating the importance of prevention methods in order to stem the transmission of HIV/AIDS.

Successes

The HIV/AIDS prevention and control programme has achieved numerous successes as a result of the great political will of the Government of St. Vincent and the Grenadines, the availability of resources and the high level of dedication of personnel from both public and private sector. Success stories are fitting for every aspect of the HIV/AIDS prevention and control programme.

The establishment of the Caribbean HIV/AIDS Alliance in St. Vincent and the Grenadines has successfully attempted to bridge the gap between prevention and support services and most-at-risk groups such as men who have sex with men and sex workers. The work of the alliance is done through peer communicators. The programme is effectively monitored and quarterly reports are produced and disseminated to the Ministry of Health and the Environment. Similar work is done by the PSI where their prevention programme is not only geared towards sex workers and men who have sex with men but also to youth on the block.

The drive to advocate behaviour change and market prevention methods is also a huge success as it is characterised by a multi-sectorial approach involving faith based organizations, community based organizations, non-governmental organizations along with the public sector health care workers. Media coverage has been at an optimum level in order to ensure the widespread dissemination of advocacy campaigns. The sectors have targeted the general community while simultaneously placing tremendous emphasis on youths. Out-reach programmes have been successfully implemented in approximately 60% of the schools on the mainland.

Voluntary Counselling and testing is accessible to 100% of the population at numerous sites throughout St. Vincent and the Grenadines. As a result, the daily uptake of VCT services and rapid testing is being conducted at both public and private institutions.

Care and treatment continues to be successfully monitored through the electronic tracking system in the HIV/AIDS/STI clinic. The free readily available drugs for PLHIV (including pregnant women) have been a major success.

The capacity building in laboratory support services has been beneficial to the HIV/AIDS programme. The National Laboratory continues to facilitate the diagnostic processes for early detection of HIV in babies and ensure the daily testing of samples for HIV.

Major challenges and remedial actions

Although the successes have been vast, there are still many challenges that are being faced during the fight against HIV/AIDS in St. Vincent and the Grenadines. The mere fact that our Island is a multi-island state creates limitations in the development and implementation of programmes in the Grenadine Islands. Thus, training of health care workers is imperative for members of staff in these islands in order to ensure that one public health approach is being practised.

Human resource continues to be a major challenge for both public and private sector facilities. The high level of internal mobility of staff and migration to foreign territories exacerbates the issue of human resource. The vertical nature of the programme was also instrumental in creating a subsequent human resource shortage as the close out of externally financed projects is drawing to a near. The Ministry of Health and the Environment has therefore taken the initiative to integrate many of the services of the prevention and control programme into already pre-existing programmes as mentioned before.

There is a huge challenge faced with PLHIV as they themselves are still battling with the fear of being discriminated and stigmatized. Thus, the incorporation of PLHIV as peer communicators has assisted in addressing this issue.

The PMTCT is facing an even bigger challenge with the number of known HIV positive women becoming pregnant on multiple occasions. The PMTCT committee has committed themselves to address and upscale prevention methods in HIV pregnant women.

There is still a wide information gap in knowledge surrounding most-at risk groups in St. Vincent and the Grenadines. One of the major groups of concern is the men that have sex with men. The Ministry of Health and the Environment is planning to conduct a behavioural survey and Seroprevalence study amongst men who have sex with men in order to gain strategic information for the purpose of effective policy and programme development geared towards men who have sex with men.

The activities carried out by both public and private sector have been immense, however, the effectiveness of prevention programmes have been difficult to measure as it requires the realization of behavioural surveys. The Ministry of Health & the Environment conducted a behavioural survey in 2005 and aim to conduct another geared towards the general population. This will offer the necessary information to evaluate the accomplishments of the prevention programmes through comparative analysis with the OECS BSS 2005.

Support from the country's development partners

The National response to HIV/AIDS has achieved many milestones as a result of regional and international support and collaboration. The country continues to depend on external financial and technical support due to the characteristics of the country and the limited existing national resources available.

Care, Treatment and support

In order to maintain a constant supply of anti retroviral treatment, continued regional collaboration is necessary to procure drugs in bulk at affordable prices. The decentralization of services will depend on the development of treatment guidelines to provide direction for training of health care providers as highlighted in a previous UNGASS report 2006-2007.

Research

In order to fill information gaps for policy and programme planning, continued support from external agencies is necessary to assist in capacity building to carry out appropriate scientific research.

Most-at risk Populations

As a known global driver of the HIV/AIDS epidemic, accessing most-at-risk populations is still great challenge. Populations such as men who have sex with men and sex workers still remain a hard to reach population in our country and depends on regional agencies to guarantee the implementation of prevention activities for most-at-risk populations.

Monitoring and evaluation environment

Monitoring and evaluation of the 14 programme areas continues with limited staff. As mentioned before, the monitoring and evaluation programme has been integrated into the health information unit within the Ministry of Health and the environment. Although this allows for the funnelling of information to the central level more effectively it has created a vicious cycle where new staff will have to be trained in monitoring and evaluation concepts and processes. This form of capacity building is already being discussed with external agencies and plans are in progress for training.