# ST.VINCENT AND THE GRENADINES

# HIV/AIDS/STI

# NATIONAL STRATEGIC PLAN

# 2004 - 2009


*WE CAN DO IT TOGETHER*

***Ministry of Health and the Environment***

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# ABBREVIATIONS

| | | |
|---|---|---|
| AIDS | - | Acquired Immune Deficiency Syndrome |
| ARV | - | Antiretroviral |
| CAREC | - | Caribbean Epidemiology Centre |
| CCM | - | Country Coordinating Mechanism |
| CSW | - | Commercial Sex Worker |
| GPA/WHO | - | Global Programme on AIDS/World Health Organization |
| FHI | - | Family Health International |
| HIV | - | Human Immunodeficiency Virus |
| HFLE | - | Health and Family Life Education |
| IEC | - | Information, Education and Communication |
| IT | - | Information Technology |
| LEHR | - | Law, Ethics and Human Rights |
| M & E | - | Monitoring and Evaluation |
| MOEYS | - | Ministry of Education, Youth and Sports |
| MOHE | - | Ministry of Health and the Environment |
| MSM | - | Men who have Sex with Men |
| MTCT | - | Mother to Child Transmission |
| OI | - | Opportunistic Infections |
| PAHO | - | Pan American Health Organization |
| PEP | - | Post Exposure Prophylaxis |
| PLWHA | - | People Living with HIV/AIDS |
| PMTCT | - | Prevention of Mother To Child Transmission |
| STI | - | Sexually Transmitted Infections |
| SVG | - | St Vincent and the Grenadines |
| UWI | - | University of the West Indies |
| VCT | - | Voluntary Counselling and Testing |

# INTRODUCTION

St. Vincent and the Grenadines (SVG) like the rest of the world has not been exempted from the impact of the HIV/AIDS pandemic. The government's response has been swift, recognizing the fact that this epidemic has serious developmental implications if left unchallenged. The HIV epidemic is driven by a number of factors including cultural, behavioural and socio-economic. The importance of the involvement of the entire nation to prevent HIV and care for persons affected and infected by HIV/AIDS cannot be over emphasized since no one person, ministry or organization can reach and solve the problems of the nation. A strategic plan is a necessary tool to guide all stakeholders and create a synergistic approach instead of duplicated efforts. A significant progress indicator was the development of this strategic plan which was launched in December 2001. The plan then outlined the following six priority areas:

I. Strengthen intersectoral management, organizational structures and institutional capacity.
II. Design and implement care, support and treatment programmes for PLWHA and their families.
III. Develop and implement HIV/AIDS/STI and control programmes with priority given to youth and high-risk/vulnerable groups.
IV. Conduct research and training programmes
V. Upgrade surveillance systems
VI. Implement advocacy programmes

The time frame of the first strategic plan was 2002-2006. It was developed utilizing several working groups who accessed information from relevant institutions, NGOs, private sector personnel, PWLHA, religious organizations, the Chamber of Commerce, teachers, police officers, other public servants and the general public. A CAREC/PAHO Team also assisted in the development of the initial plan.

The Government of St. Vincent and the Grenadines in its mission to scale up the HIV/AIDS prevention and control programme began negotiations with the World Bank in 2003 to finance the programme. The World Bank funded project necessitated the development of an updated strategic plan to synchronize the time frames of the project and the national strategic plan as well as to expand the plan to encompass a multisectoral implementation approach. This revised strategic plan covers the period 2004-2009. The process of updating the strategies was undertaken at a workshop in February 2004 and involved all stakeholders, with technical assistance from the Caribbean Epidemiology Centre. This strategic plan maintains the priority areas articulated in the original plan.

Since the preparation of the original strategic plan, a number of changes and improvements have taken place with regard to the government's response to the epidemic. A care and treatment programme was established where medication is being provided free of cost to the clients. Persons living with HIV/AIDS and their families receive financial support as needed. The human resource in the government programme was expanded. Initially there was one person - the programme coordinator. Now, the staff includes a director, four counsellors, one social worker, one psychologist, a clerk/typist and an office attendant.

The strategic plan will be implemented by all stakeholders with technical guidance from the HIV/AIDS/STI programme in the Ministry of Health and the Environment. The implementing stakeholders include other technical departments in the Ministry of Health and the Environment, Non-Health Line Ministries, Non Governmental Organizations, Community Based Organizations, Faith Based Organizations and the Private Sector. The strategic plan will be monitored using indicators defined nationally, regionally and internationally.

## PURPOSE OF THE STRATEGIC PLAN

- To identify strategies, actions and resources that would be used to guide St. Vincent and the Grenadines' response to the HIV/AIDS epidemic.

- To promote the growth and development of the multisectoral National AIDS Council (NAC), Country Coordinating Mechanism (CCM) and other coordinating mechanisms for sustainable national response against HIV/AIDS/STI.

- To allow government, planners and decision-makers at all levels to participate in concrete strategic interventions.

- To reduce and minimize duplication of efforts and maximize the use of appropriate resources.

- To facilitate the expansion and development of work plans by all sectors.

- To mobilize all players to participate in the planning, implementation and evaluation of national strategic plan.

## ESSENTIAL FEATURES OF A NATIONAL RESPONSE

In order to achieve success in implementing a strategic response the following features are essential:

- A strong political will and leadership.

- Societal openness and determination to fight against stigma and discrimination.

- Multisectoral and multilevel action.

- Community based response

- Societal policy reform to reduce vulnerability.

- A long term and sustained response.

- Learning from experience.

- Adequate resources

## GOALS

The following overarching goals were identified:

- To reduce the incidence of HIV
- Decrease the case fatality rate of persons living with HIV/AIDS
- Offer support to people living with HIV/AIDS and their families

## COUNTRY PROFILE

**Socioeconomic, Political and Demographic Overview**

Saint Vincent and the Grenadines (SVG) is located 13 degrees North latitude and 61 degrees West longitude and is one of the island chains of the Windward Islands in the Eastern Caribbean. It is situated 21 miles/33.6 kilometres south of St. Lucia and 100 miles/160 kilometres west of Barbados. Saint Vincent and the Grenadines is 18 miles/28.8 kilometres long and 11 miles/17.7 kilometres wide with an area of 150 square miles/388 square kilometres inclusive of mainland Saint Vincent and the inhabited islands and islets of Bequia, Mustique, Mayreau, Canouan, Union Island and Palm Island.

Mainland St. Vincent is volcanic in origin with a central chain of mountain peaks. The highest peak is the La Soufriere Mountain (volcano) which stands 4,000 ft/1,220 meters. The volcano last erupted in 1979. The smaller islands which make up the Grenadines are primarily of coral formation.

Saint Vincent and the Grenadines has a tropical climate, with "wet" and "dry" seasons. The annual average temperature is 81 degrees Fahrenheit /27 degrees Celsius with a rainfall of 80 inches /203.2 mm on the coast to 160 inches/406.4 mm in the central range. Saint Vincent and the Grenadines (SVG) is susceptible to occasional hurricanes, tropical storms, volcanic eruptions and earthquakes.

The country attained political independence from Great Britain in 1979, and inherited a Westminster Parliamentary Democracy system of Government with elections every five years. In the General Elections held March 2001 the Unity

Labour Party captured the majority of seats and formed the new Government.

The Government, in the current Medium Term Economic Strategy Paper, embraces a philosophy of private sector-led development, and is therefore committed to the development of basic physical infrastructure, improving the social environment, establishing fiscal and regulatory tools which would facilitate this type of development. Further, emphasis is given to economic diversification, tourism, financial services, information technology, human resource development and public sector reform. These areas are targeted as vital elements that must be addressed if significant strides are to be made in moving towards sustainable socio-economic development.

Estimates from the Statistical Office in the Central Planning Division put the Gross Domestic Product (GDP) of St. Vincent and the Grenadines for 2002 at 805.85 million East Caribbean dollars or ($296.61Mil. U.S). This represented a 3.76 percent increase over the year 2001 figure of 776.67 million East Caribbean dollars or ($285.87Mil. U.S).

GDP per capita for 2002 was estimated by the Statistical Office to be seven thousand, four hundred and sixty-eight (EC$7,468) East Caribbean dollars or US$2,749.

The data available for the year 2002 indicates that the service sector continues to be the major contributor to the GDP of St. Vincent and the Grenadines both in real terms and in nominal terms. The Agricultural sector, contributed up to 25% of the country's GDP on an annual basis up to early 1990's. In 2002 it fell to fifth position after government services, wholesale and retail trade, transport and construction. Other important sectors of the economy in terms of percentage contribution to GDP in 2002 are banks and insurances, electricity and water and manufacturing.

Cable and Wireless (West Indies) Ltd. was the sole provider of telephone services for more than 100 years, they provided local and international services. The telecommunications market was liberalized in year 2003 and licenses have been issued to two other service providers namely: The Digicel Company and AT&T Wireless. These companies commenced operation in 2003 and they both offer cellular service only. Communication via the Internet is another available option. The use of CB radios in times of crisis and as a pleasurable past time also facilitates communication.

The mass media plays a significant role in the communication industry in St. Vincent and the Grenadines with seven radio stations currently operating on the island, one television station, and a cable television service provider as well as three weekly newspapers.

In the absence of an international airport, LIAT, and Caribbean Star Dash 8

aircraft, Caribbean Sun, small jets and "Hercules" military planes are accommodated at the nation's main E.T Joshua airport located at Amos Vale. Small airstrips accommodating light air crafts are available in Bequia, Union Island, Mustique and Canouan. Air access to St. Vincent and the Grenadines, out of North America and Europe is through one of five (5) main gateways – Barbados, St. Lucia, Puerto Rico, Trinidad or Grenada. Connections through these gateways are to St. Vincent, Union Island, Canouan, Mustique and Bequia. St. Vincent is linked to the Grenadines by sea and air transport, with docking facilities on all inhabited Grenadine islands. A deepwater pier located in capital Kingstown accommodates cruise liners while the smaller wharfs provide berthing facilities for schooners involved in brisk inter- island trade.

The islands' transportation market is served by a number of privately owned taxis, minibuses, coaches and motor vehicle rentals. Transportation between St. Vincent and the other islands is provided by regular ferry services or air shuttle services, which are privately owned. There is also an abundance of water taxis operating between and around the islands of the Grenadines.

The Poverty Assessment Study Report of 1996 for Saint Vincent and the Grenadines identified some of the issues reflecting the economic circumstances of the population studied. Thirteen communities were studied and the report concluded that based on interviewees' reported expenditures on food and non-food items, 35% of households and 41.9 % of the population were poor. Of households, 30.5% and 32.6% of the population were indigent, since their expenditures were inadequate to cover their dietary requirements thus jeopardizing their ability to maintain a healthy existence. The report further stated that poverty was greater among female heads of households (34.1 %) than among male heads of households (27.9%), while the rural population (38.7%) was slightly more economically disadvantaged than the urban population. Moreover, it was noted that 1/3 of the population lived below the poverty line. Employment rates are said to be 80.2% while the estimated unemployment was 19.85 in 1991.

Children attending primary school, ages 5-15 years, total 21,451 from the 60 Government-owned primary, one school for Children with Special needs, and 6 privately owned primary schools. There are 21 secondary schools with an enrolment of 7,939. No recent studies have been undertaken to obtain literacy rates but it has been estimated that some 10% of the population have no formal education and are deemed functionally illiterate.

In the 2001 population census, the total population for the country was recorded at 106,253, with males accounting for 53,626 or 50.5 % and females 52,627 or 45.5 %. Of the total population, 30.7 % were under 15 years of age; the age group 15-29 years represented 27.8 % while the age group 30-44 years represented 21.1 %. The age group 45-64 years accounted for 13.2 % while the

65 years and over category represented 7.3 %. The population of St. Vincent and the Grenadines can be considered a youthful population since the number of persons under the age of 29 years is almost 60 %.

The crude birth rate of the country continued to decline and stood at 18.7 per 1000 population in 2002. Total fertility recorded 2.4 births per woman and total life expectancy at birth has increased to 73 years. The rate of natural increase was on average 17.5 in the 1992 to 1995 period but has decreased on the average to 12.9 in the 1996 - 1999 period.

**Health and Social Services**

Government is committed to enhancing the quality of life for individuals and the society in general. They propose to develop policies aimed at providing adequate health facilities, improving access and equity as well as addressing nutritional problems such as food security. High on the Government's agenda is the improvement of social infrastructure; the provision of quality potable water at reasonable prices; adequate housing; poverty alleviation; improved gender relations; care and security of the elderly; proper facilities and support programmes for physically challenged persons; enhanced programmes for street children and homeless persons; the implementation of holistic family life education programmes targeting youths and the restructured social security programmes.

Further, the Government has enunciated the desire to have people's participation in planning, implementation, evaluation and decision-making processes. Social partners have also been identified to work with institutions as a mechanism to ensure people's involvement.

The Ministry of Health and the Environment is the arm of the Government chiefly responsible for matters relating to health and the environment. The Philosophy of the Ministry is reflected in statements that address health care as a basic right, client participation at all levels of health care, utilizes the team approach, intersectoral collaboration, regional and international initiatives and support to realize national objectives and targets.

The Mission of the Ministry of Health and the Environment is to mobilize resources at local, regional and international levels for the purpose of planning, controlling and evaluating health delivery systems appropriate to the needs of the population. Further, it promotes the central role as intersectoral coordinating agency for activities relating to the protection and preservation of the environment.

The health care institutions in the country are mainly government operated with the largest 209-bedded secondary care facility located in the capital

Kingstown. Hospital services are also supplemented by five (5) rural hospitals located in the Health Districts of Georgetown, Marriaquia, Chateaubelair, Northern and Southern Grenadines. One privately run hospital, also situated in Kingstown, provides complementary services.

Thirty-nine health centres located in nine health districts provide primary health care service to the nation. Each health centre is staffed with at least one district nurse midwife, a nursing assistant and a community health aide. Other members of the district health team include a district medical officer, a health nursing supervisor, a pharmacist and an environmental health officer. Family Nurse Practitioners are assigned to school health services as their major responsibility.

The services offered at the primary health care level include: maternal (ante-, intra- and post-natal care), child health and family planning, immunization, special chronic disease services, emergency services, screening services (pap smears, prostate examination, diabetic screening), community nutrition, health promotion, education and pharmaceutical services. The Environmental Health services take responsibility for public health related matters, while the Environmental Health Services Unit focuses on the Environmental issues and is the focal point for coordinating all environmentally related activities. Psychiatric services are provided mainly through the government owned 120-bedded institution. The government also has the responsibility for the operation and management of the Lewis Punnett Home; a 113-bed home for the aged poor.

**Health Situation and Trends**

Over the last two decades, Chronic Non-Communicable Diseases have been considered the main causes of death, disability and illness in the country. In fact, the national mortality data indicated that between the years 1995-2000 the five (5) leading causes of death in order of rank were: Cancer (all forms), Ischaemic Heart Disease, Endocrine and Metabolic Diseases, Immunity Disorders under which Diabetes and HIV / AIDS fall, Cerebrovascular and Hypertensive Disease. Over the years Chronic Diseases have been responsible for more than 50 % of total deaths.

At the Milton Cato Memorial Hospital, approximately 8,800 patients are admitted each year and approximately 10.0 % of hospital admissions are attributed to diseases such as Diabetes, Hypertension and Heart Disease. The average length of stay on all wards of the hospital was computed at 5.6 days. However in a study done in 1997, it was found that the mean length of stay for a patient suffering from AIDS was 27 days. This was almost 5 times that of the average patient and will translate into higher levels of consumption of hospital services by AIDS patients. Regarding disability, Diabetes and Hypertension

contribute significantly to Strokes and Diabetes in itself is a major cause of Kidney Failure, Blindness and Limb Amputation that are not due to injuries. The data from the Milton Cato Memorial Hospital show that approximately 80.0 % of amputations done in anyone year are diabetic related.

## BACKGROUND TO THE HIV EPIDEMIC

### SITUATION ANALYSIS

***HIV/AIDS epidemic in St. Vincent and the Grenadines***

The first case of HIV infection in St. Vincent and the Grenadines was discovered in 1984 and it has been about two decades since the country has been plagued with this troubling disease. The total documented cases of HIV at the end of year 2004 was 796; total AIDS cases 431 (54 % of HIV cases); total deaths 405 (94 % of AIDS cases). The documented number of persons living with HIV/AIDS (PLWHA) as of December 2004 was 391 (49 % of the total HIV cases). Using the 2001 census population of 106,253 this calculates a documented HIV prevalence rate of 0.4 %. The male: female ratio stands at 1.7:1 with heterosexual contact as the most common form of transmission.

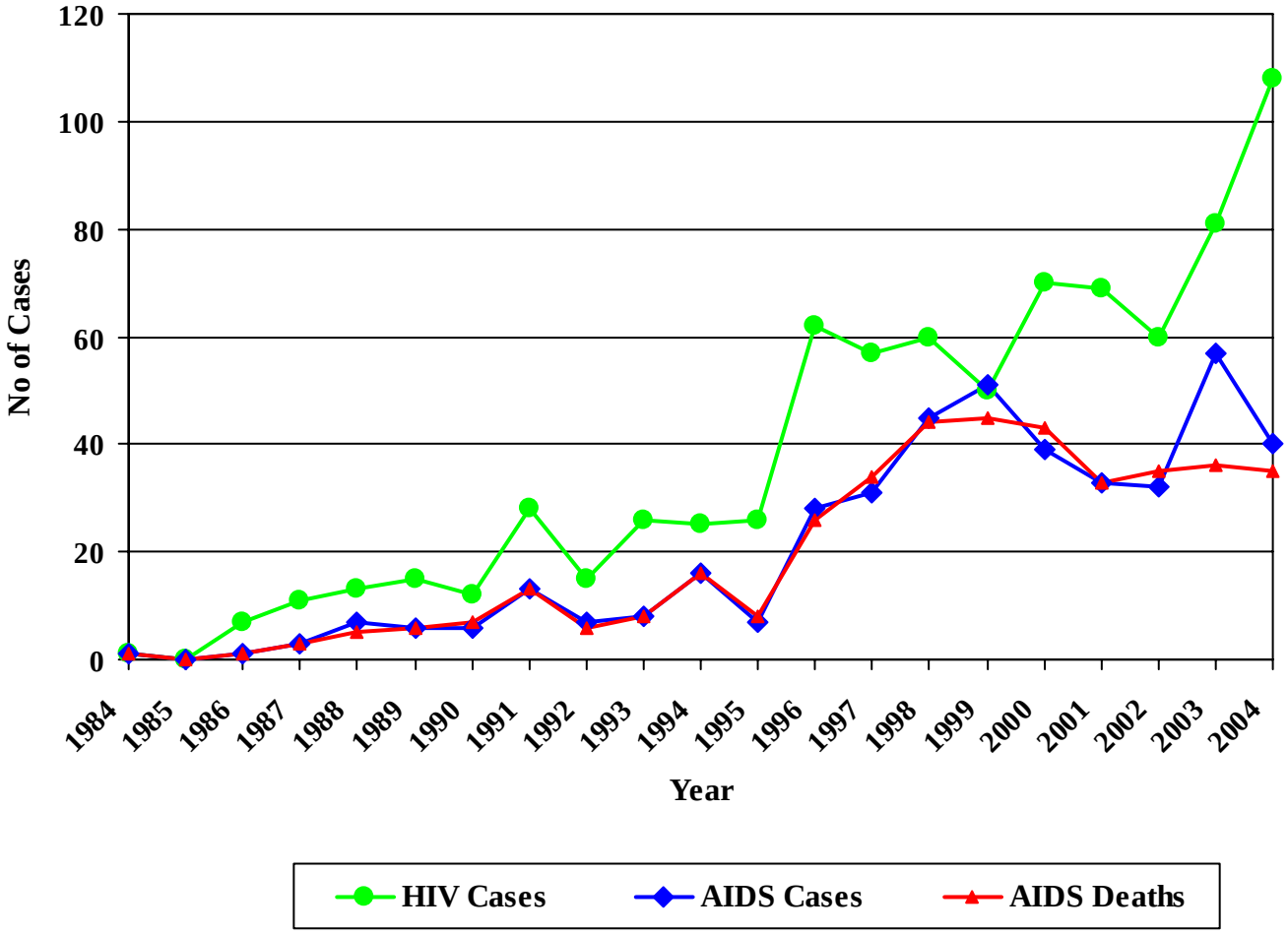
The HIV reported data in the first decade (1984-1993) of the epidemic, documented 128 cases, however during the second decade (1994-2003) a massive 560 cases were reported representing a four-fold increase. The year 2004 recorded the highest incidence ever with 108 HIV cases.

AIDS on the other hand recorded 52 cases in the first decade (1984-1993) of the epidemic then increased to 339 cases (7-fold) in the second decade (1994-2003). The annual incidence of AIDS gradually increased from 1 case in 1984 to 51 cases in 1999, before a 30 % decrease in year 2000 to record 39 cases. This decreasing trend continued until year 2002 before fluctuations in 2003 and 2004. (See graph on page 10)

AIDS-related deaths account for about 5% of total deaths annually with male AIDS-related deaths responsible for about 66 % and female deaths about 34 %. Approximately 60 % of AIDS –related deaths occur among the age-group 25-44 years. Case Fatality Rate that ranged between 95-100 % for years 1984 to 2002 declined significantly in 2003 and registered 63 %. In 2004, Case Fatality Rate increased to 88 %.

The chief reasons for AIDS-related deaths in order of rank have been documented as Pneumonia, Wasting Syndrome, Toxoplasmosis, Renal Failure and Meningitis.

***Cases of HIV, AIDS and AIDS-related Deaths in SVG***
***1984-2004***



*HIV/AIDS Statistics for the period 1984-2004*

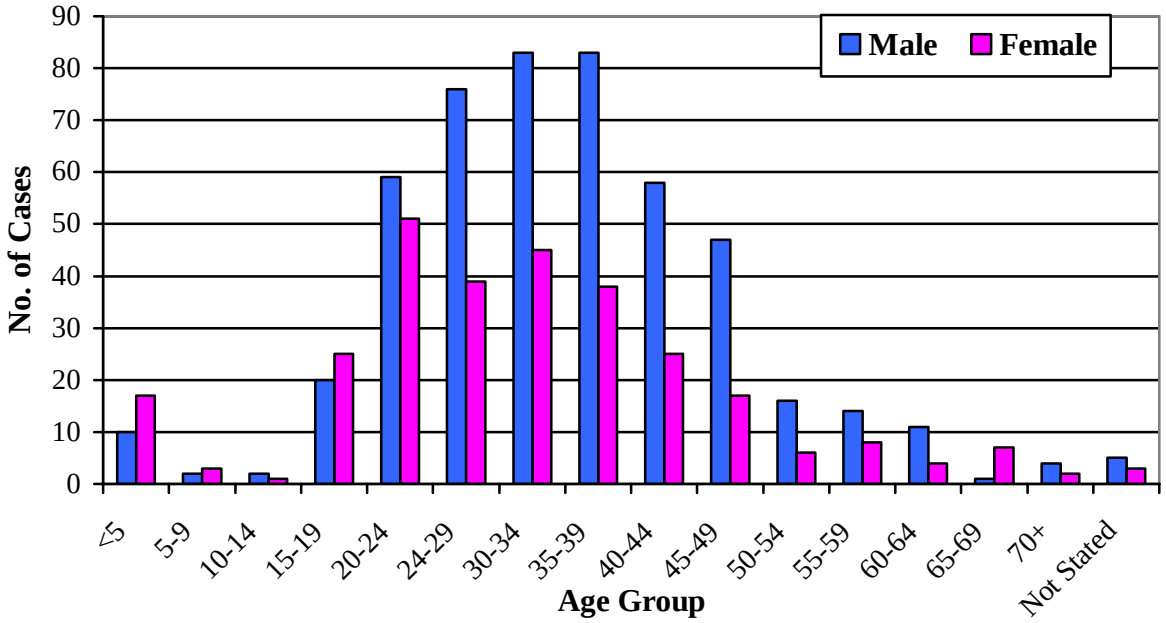
| YEAR | NO. OF HIV POSITIVE | M | F | U | NO. OF AIDS CASES | M | F | NO. OF AIDS-RELATED DEATHS | M | F |
|---|---|---|---|---|---|---|---|---|---|---|
| 1984 | 1 | 1 | 0 | | 1 | 1 | 0 | 1 | 1 | 0 |
| 1985 | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | 0 | 0 |
| 1986 | 7 | 4 | 3 | | 1 | 1 | 0 | 1 | 1 | 0 |
| 1987 | 11 | 9 | 2 | | 3 | 3 | 0 | 3 | 3 | 0 |
| 1988 | 13 | 9 | 4 | | 7 | 3 | 4 | 5 | 3 | 2 |
| 1989 | 15 | 10 | 5 | | 6 | 2 | 4 | 6 | 1 | 5 |
| 1990 | 12 | 9 | 3 | | 6 | 4 | 2 | 7 | 5 | 2 |
| 1991 | 28 | 19 | 9 | | 13 | 8 | 5 | 13 | 8 | 5 |
| 1992 | 15 | 11 | 4 | | 7 | 5 | 2 | 6 | 4 | 2 |
| 1993 | 26 | 20 | 6 | | 8 | 7 | 1 | 8 | 7 | 1 |
| 1994 | 25 | 19 | 6 | | 16 | 13 | 3 | 16 | 13 | 3 |
| 1995 | 26 | 15 | 11 | | 7 | 5 | 2 | 8 | 5 | 3 |
| 1996 | 62 | 35 | 23 | 4 | 28 | 21 | 7 | 26 | 20 | 6 |
| 1997 | 57 | 29 | 26 | 2 | 31 | 18 | 13 | 34 | 20 | 14 |
| 1998 | 60 | 30 | 26 | 4 | 45 | 27 | 18 | 44 | 26 | 18 |
| 1999 | 50 | 34 | 13 | 3 | 51 | 36 | 15 | 45 | 31 | 14 |
| 2000 | 70 | 48 | 22 | 0 | 39 | 27 | 12 | 43 | 31 | 12 |
| 2001 | 69 | 41 | 28 | 0 | 33 | 23 | 10 | 33 | 23 | 10 |
| 2002 | 60 | 30 | 29 | 1 | 32 | 18 | 14 | 35 | 20 | 15 |
| 2003 | 81 | 54 | 27 | 0 | 57 | 37 | 20 | 36 | 25 | 11 |
| 2004 | 108 | 64 | 44 | 0 | 40 | 26 | 14 | 35 | 21 | 14 |
| | TOTAL HIV CASES: | M | F | U | TOTAL AIDS CASES: | M | F | TOTAL DEATHS | M | F |
| | 796 | 491 62% | 291 36% | 14 2% | 431 | 285 | 146 | 405 | 268 | 137 |

**HIV and AIDS by Age Group and Sex**

According to the cumulative HIV data stratified by age group and sex, it has been observed that females outnumbered males in the 0-10 age group, as well as, the age groups 15-19 and 65-69. All other age group categories have been dominated by males. Individuals falling within the age group 20-44 years have accounted for 70 % of total cases while teenagers represented 6 % and MTCT cases 4 %.

A similar sex distribution presented itself in the AIDS category with the same age group (20-44) accounting for the majority of cases (67%). Please see the following graphs and table outlining HIV and AIDS data by Age Group and Sex, 1984- 2004.

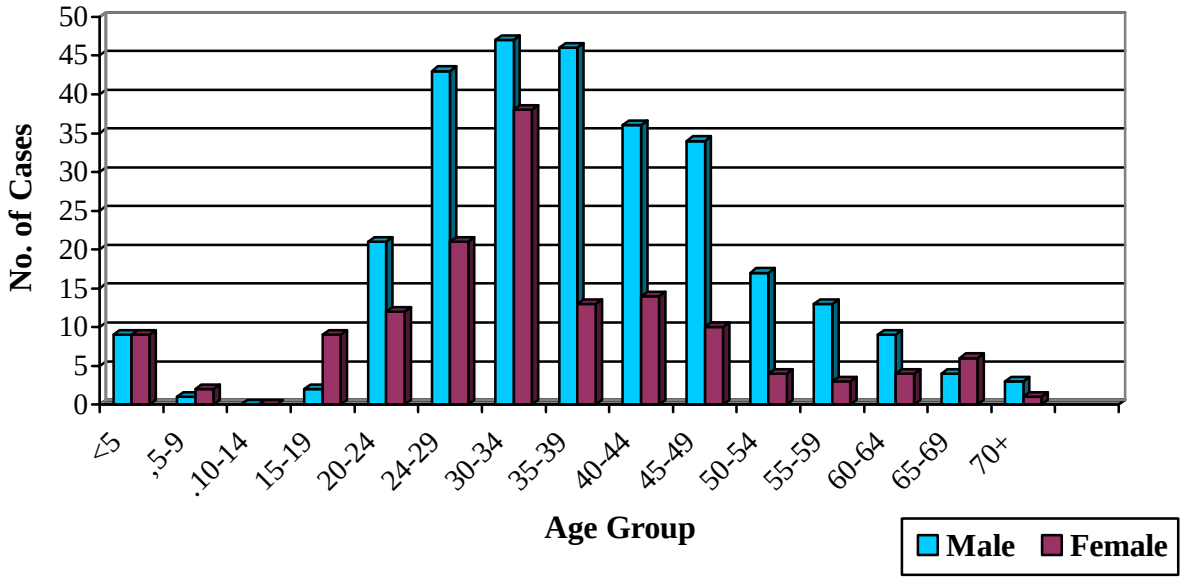
*HIV by Age Group and Sex, 1984-2004*




*HIV and AIDS by Age Group and Sex, 1984-2004*

| AGE GROUP (YEARS) | HIV | | | | AIDS | | | |
|---|---|---|---|---|---|---|---|---|
| | Male | Female | Not Stated | TOTAL | Male | Female | Not Stated | TOTAL |
| **<5 yrs** | 10 | 17 | | 27 | 9 | 9 | | 18 |
| **5 - 9** | 2 | 3 | | 5 | 1 | 2 | | 3 |
| **10 - 14** | 2 | 1 | | 3 | | | | 0 |
| **15 - 19** | 20 | 25 | | 45 | 2 | 9 | | 11 |
| **20 - 24** | 59 | 51 | | 110 | 21 | 12 | | 33 |
| **25 - 29** | 76 | 39 | 1 | 116 | 43 | 21 | | 64 |
| **30 - 34** | 83 | 45 | 2 | 130 | 47 | 38 | | 85 |
| **35 - 39** | 83 | 38 | 2 | 123 | 46 | 13 | | 59 |
| **40 - 44** | 58 | 25 | | 83 | 36 | 14 | | 50 |
| **45 - 49** | 47 | 17 | 3 | 67 | 34 | 10 | | 44 |
| **50 - 54** | 16 | 6 | 2 | 24 | 17 | 4 | | 21 |
| **55 - 59** | 14 | 8 | | 22 | 13 | 3 | | 16 |
| **60 - 64** | 11 | 4 | | 15 | 9 | 4 | | 13 |
| **65 - 69** | 1 | 7 | | 8 | 4 | 6 | | 10 |
| **70 +** | 4 | 2 | | 6 | 3 | 1 | | 4 |
| **Not Stated** | 5 | 3 | 4 | 12 | | | | 0 |
| **TOTAL** | **491** | **291** | **14** | **796** | **285** | **146** | **0** | **431** |

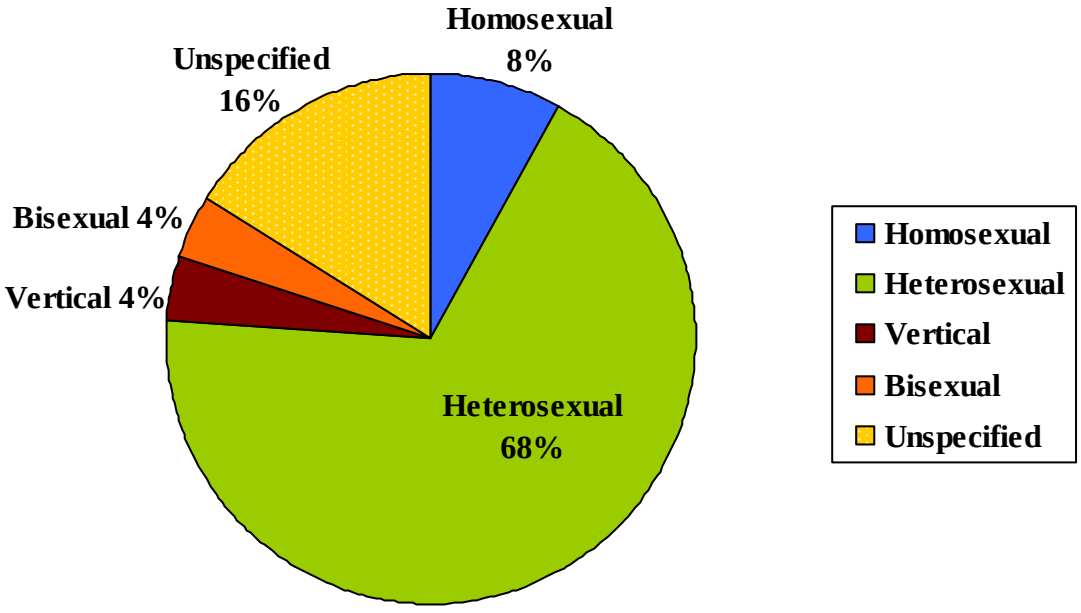
*AIDS by Age Group and Sex, 1984-2004*




**Transmission Categories**

The cumulative data from 1984- 2004 identified heterosexuals as the main route of transmission. As a matter of fact 68% of the people infected acquired their infection through that route. Only 12 % of cases have been reported as being spread through homosexual/ bisexual contact commonly referred to as men who have sex with men (MSM). Significantly, 16 % of all cases were Unspecified and interestingly, all these unspecified cases were registered as males. Vertical or mother–to–child transmission recorded 4 %. See Pie Chart below outlining the various transmission categories.

*H IV Risk Categories in SVG, 1984-2004*



**Mother To Child Transmission**

Mother to child transmission of HIV otherwise known as Vertical transmission was recorded for the first time in 1988 when one (1) case was identified. From that year to December of 2004, 30 such cases have been diagnosed. The year 1997 registered the most cases with a record of seven 7 vertical transmissions. From the overall total of 30 Vertical transmissions, 21 (70%) children succumbed to the disease. The sex distribution of Vertical transmission has clearly indicated a predominance of females, 60 % and 40 % males.

It has been proven that antiretroviral treatment to mothers during pregnancy can dramatically decrease the number of babies being born with HIV.

In October 1998, 10 years following the first diagnosed case of vertical transmission, a prevention of mother to child transmission (PMTCT) project was launched by the Kingstown Medical College in collaboration with the Ministry of Health and the Environment. The project that continued until December 2000, (13 months) piloted the antiretroviral drug Combivir. A total of 2,589 pregnant mothers took part in the study. As a result from the study, 16 (0.6%) HIV positive mothers were identified, of which one opted for termination of pregnancy. The neonates of the other 15 mothers were closely monitored with outcome as follows: After 18 months follow –up, 12 babies were sero negative for HIV, 1 baby was lost to follow –up and 2 babies died before reaching 6 months.

In January of year 2000, the Ministry of Health and the Environment assumed exclusively, the responsibility for a national PMTCT Programme offering voluntary counselling and HIV testing to all pregnant mothers and providing antiretroviral treatment (Nevirapine) to mothers and babies as necessary, as well as, replacement feed (infant formulas) for the babies up to six months.

A prevention of mother to child transmission policy manual aimed at addressing policy issues in the ante, intra and postnatal periods was formulated in year 2001. This manual is currently under revision and should be completed by the end of year 2005.

**RESPONSE ANALYSIS**

The first case of HIV was diagnosed in the Caribbean in 1982 and as a result all Caribbean countries on the technical advice of PAHO/WHO/CAREC established National AIDS Programmes with emphasis on six (6) target areas namely: (1) Epidemiology and Surveillance, (2) Programme Management, (3) Prevention of Perinatal Transmission, (4) Prevention of sexual transmission, (5) Reduction of the impact on HIV on individuals, communities and societies and (6) Prevention of transmission through blood and blood products.

Between 1993-1995, countries received assistance from the Global Programme on AIDS (GPA) to plan and implement their national Medium Term HIV/AIDS prevention and control programmes. This major activity was coordinated by the World Health Organization (WHO) with technical assistance from the Caribbean Epidemiology Centre (CAREC).

During this period, the Caribbean Programme focused on Prevention with less attention given to care and support of persons living with HIV/AIDS. The prevention approach attempted to provide information on awareness of the disease, its mode of transmission and healthy lifestyle practices to the greater number of presumably uninfected persons. It was further envisioned that information provided would empower individuals to make informed decisions and prevent stereotyping, stigmatization, negative reactions and attitudes to those infected. The outcome of these programmes varied from country to country but in general, Knowledge, Attitude, Behaviour and Practice (KABP) studies indicated high knowledge levels of the aetiology of the disease, transmission routes and prevention measures. However condom use was noted to be inconsistent and personal vulnerability minimal.

The Global Programme on AIDS was succeeded by the United Nations Joint Programme on AIDS (UNAIDS) which ushered in a new dimension of the process of planning and management. The focus turned to strategic planning on a wider basis with sustainability of programmes as an essential ingredient. Based on this approach the UNAIDS Caribbean Programme Office was established. Information has filtered down from the regional programme level to the national level and resulted in the review and analysis of the HIV/AIDS situation in St. Vincent and the Grenadines with the ultimate goal of positioning the national programme for an expanded response to strategic planning.

The Ministry of Health and the Environment (MOH&E), through the Community Health Service, has been consistent in its attempts to promote healthy living. It has monitored diseases through its implemented surveillance systems and has emphasized health promotion and health education as a pivotal strategy in disease prevention and control. Health policies, which respected the rights of clients and their right to access satisfactory health care

service, provided the general framework in which the health care service operated. Consequently, when the first case of HIV/AIDS was identified in 1984, the MOH&E was able to mobilize its resources to quickly implement measures to monitor and control the spread of what turned out to be one of the worst epidemics to hit St. Vincent and the Grenadines.

The first response was to educate all staff within the Ministry and have heads of programmes outline plans of action, should HIV persons be seen at any of various levels of the service. Similar educational programmes for other sectors of Government and the general public were conducted. The general initial public response was one of curiosity about the disease, a tendency towards labelling or associating a particular population sub-set as the source of the disease. Few admitted vulnerability to the disease, and many saw quarantine as a priority solution to the problem. A Cabinet appointed advisory committee was put in place to galvanize efforts directed at reducing the incidence of Human Immunodeficiency Virus/Sexually Transmitted Infections (HIV/STIs) and to provide guidance to the Minister of Health and the Environment.

The clinical laboratory, then the lone facility on island had already established routine screening programmes for blood donors. However, the capabilities of the laboratory required expansion to facilitate the conduct of needed tests to diagnose and manage this new condition. By 1985 the laboratory was using the first generation Elisa. By 1995, this was upgraded to the third generation Elisa, and in 1999 the decision was taken to perform confirmatory tests locally, a task previously done through Caribbean Epidemiological Centre. The incidence of HIV among blood donors in St. Vincent and the Grenadines remains very low; at about 0.2%. Blood safety remains a high priority for the Ministry of Health and the Environment. Seroprevalent studies were undertaken on antenatal patients to determine the prevalence of HIV among that population. These studies have been ongoing. Many of these studies indicated a 0.1% incidence. A policy decision was made to have all VDRL samples as well as positive TPHA individuals screened for HIV.

The development of policies became essential if a coordinated, human rights compliant, gender sensitive, non-discriminatory approach was to be consistently applied in the provision of all services, especially HIV/AIDS/STI care and treatment. The need for confidentiality was one of the critical elements needed to foster trust in the operations of the health care delivery system at a time when an incurable sexually transmitted disease was to be efficiently managed. A coding system was instituted to minimize inappropriate disclosure of seropositive status by non-health care workers. Laboratory forms were used to collect what was considered essential epidemiological data. Mechanisms to ensure pre and post- test counselling were put in place, as well as a system of follow-up and referral. The government wished to make it abundantly clear to patients and employees alike that it was committed to providing a satisfactory service for all HIV positive clients. A working group

with members from the advisory Committee was therefore identified to enunciate policy and a policy document was the outcome. This document proved useful for Health personnel who were also encouraged to document HIV related policies and procedures at the various levels of the Health service.

Information, Education and Communication (IEC) was another of the pillars on which the HIV/AIDS/STI response was built. IEC activities targeted the general public as the second line of attack. The role of the media was recognized as significant in the implementation of this strategy, so efforts to brief the media and identify just how they could provide support was discussed with media representatives. This proved useful and so many on-going briefing and feed-back sessions were conducted and more importantly, the general public was given the opportunity to view many educational programmes utilizing films, drama, poetry, calypso, talk–shows, panel presentation and interviews. Pamphlets, bill boards, posters, public service announcements, all complemented the educational thrust. Community out-reach programmes took centre stage in an effort to keep all informed and to obtain feedback on the level of understanding of the messages provided. Focus group discussions were conducted to obtain more behavioural knowledge and attitudinal type information, useful for targeting specific population sub-sets. The private sector, the Health Promotion and Education Unit, the church, the service and non-governmental organizations all committed themselves to the IEC action Plan.

Frequent feed-back was a requirement in the implementation of most programmes, and efforts in so doing revealed that many persons had received the many HIV/AIDS/STI prevention and control messages, but the picture was unclear as to the extent to which the information given was internalized with the resultant positive behaviour change. Given the fact that sexual issues could not be adequately dealt with in public forums, different programmes aimed at bringing individuals and groups into closer dialogue with IEC workers was the new approach in the growing arsenal of HIV/AIDS/STI prevention and control strategies. It was the consensus of both the planners and the public that, one on one, counselling and in-depth discussions afforded a better opportunity for the counsellor to assess the individual client and identify needs. It would also allow the client to be provided with a more conducive environment in which discussions could be geared to personal needs, demystifying HIV/AIDS/STI, providing information on sexual developmental issues, matters of gender and roles, condom use, negotiating safer sexual practices, abstinence, and the development of good interpersonal and social skills.

As the epidemic unfolded, it was observed that no new cases were identified in 1985 after the first case in 1984. In 1986, 4 male and 3 female HIV positive persons were identified. Thereafter, the number increased to an approximate average of 50 new positive cases per year up to 1999. The year 2000 saw an unprecedented 70 new HIV positive cases. The major mode of spread was

heterosexual and the male female ratio ranged from 2:1 to 1:1. It seemed somewhat perplexing that although women were more at risk than men, men seemed more at the fore in this condition. In the early phase of the epidemic, many of the cases were identified in the late stage of the disease and were classified as AIDS according to the Caracas definition. An analysis of AIDS deaths showed that between 1984 and 2000, 65% of AIDS deaths occurred within less than one year. (Note table).

| LIFE SPAN FROM DIAGNOSIS TO TIME OF DEATH FOR HIV POSITIVE /AIDS CLIENTS | | |
|---|---|---|
| **TIME PERIOD** | **NUMBER** | **PERCENTAGE** |
| <1 Year | 173 | 65 |
| 1 - 5 | 81 | 30.5 |
| 6 - 10 | 12 | 4.5 |

Persons Living with AIDS (PLWHA) often found it difficult to accept their HIV positive status and there were many violent reactions to the knowledge of their seropositive status. Some found it difficult to disclose their status to partners, friends, close relatives, or supervisors at their work places. Relocation and change of names were not uncommon occurrences and follow-up closely resembled a complete detective investigation with outcomes which often ended at a dead end. Follow-up however was important and many health care workers persevered. They identified that many clients initially found it difficult to speak on sexual issues and taking a sexual history required much tact, patience, sensitivity and time on their part. They also recognized the need to possess more than routine counselling skills and thus the need for in-depth counselling skills became part of the continuing education programme for Health Care Workers (HCWs).

Antiretroviral therapy has been shown to reduce mortality among those infected by HIV. A formalized system of care and treatment offering antiretroviral to HIV/AIDS clients commenced nationally in August 2003. In support of this programme the clinical laboratory of the Milton Cato Memorial Hospital (MCMH) increased its capacity to perform and analyze CD4 counts through immunomagnetic separation technology. A Becton- Dickens FACS count flow cytometer became operational in March 2003. In addition, a Clinical Care Coordinator, and Counsellors assigned to the programme provide invaluable support. Up to the end of May 2005, a total of 144 clients were registered on the Care and Treatment Programme with 55 or 38% on antiretroviral medication.

Voluntary Counselling and Testing (VCT) is another major step in the HIV/AIDS Prevention and Care Strategies. It allows persons to make

appropriate HIV prevention decisions if they are aware of their HIV status. Couples about to be married can use VCT to know their HIV status before deciding on marriage. It also allows people who are infected to learn about their HIV status early enough to receive adequate care and support which can lead to a better quality of life.

In the Scaling–up of the HIV Prevention and Control Programme in St. Vincent and the Grenadines in 2001, Voluntary Counselling and Testing Service delivery was seen as a viable strategy. In preparation for this service delivery, VCT Providers and Trainers have been receiving overseas training which commenced in 2003. Since then, several national VCT workshops have been organized and approximately 55 health care workers and other appropriate personnel have been locally trained to deliver VCT services. Plans are afoot to establish a total of 18 VCT sites at various locations throughout St. Vincent and the Grenadines.

In conclusion, individuals must accept responsibility for their own sexual health, and this does not come naturally, they must be taught. While many planned activities were put in place and the desired awareness among all sectors of the society was attained, there is still much work to be done in reducing the incidence and prevalence of the disease; implementing support programmes for PLWHA and their families; developing and administering behaviour modification programmes; and addressing gender issues as they relate to the epidemic.

## INDICATORS OF SUCCESS

Decline in the transmission of new HIV infection

Decline in syphilis and other STI rates

Increase in condom use and condom availability

VCT services operational in at least 18 Health Centres

Monitoring and Evaluation have become well entrenched in the programme

Most line Ministries are actively involved in the programme

## PRIORITY AREAS FOR HIV/AIDS/STI PROGRAMME DEVELOPMENT

**STRATEGY 1** - STRENGTHEN INTERSECTORAL MANAGEMENT, ORGANIZATIONAL STRUCTURES AND INSTITUTIONAL CAPACITY

**STRATEGY 2 -** DEVELOP, STRENGTHEN AND IMPLEMENT HIV/AIDS/STI PREVENTION AND CONTROL PROGRAMMES WITH PRIORITY GIVEN TO YOUTH AND HIGH RISK/VULNERABLE GROUPS

**STRATEGY 3 -** STRENGTHEN CARE, SUPPORT AND TREATMENT PROGRAMMES FOR PEOPLE LIVING WITH HIV/AIDS AND THEIR FAMILIES.

**STRATEGY 4 -** CONDUCT HIV/AIDS RELATED RESEARCH

**STRATEGY 5 -** UPGRADE SURVEILLANCE SYSTEMS

## STRATEGY 1

## STRENGTHEN INTERSECTORAL MANAGEMENT, ORGANIZATIONAL STRUCTURES AND INSTITUTIONAL CAPACITY

| STRATEGIC OBJECTIVES | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTORS | EXPECTED OUTCOME |
|---|---|---|---|---|
| 1.1 Restructure National machinery for management of HIV/AIDS | 1.1.1 Establish National AIDS Council (NAC). | • National AIDS Council established by May 2004 | Cabinet/MOHE | Membership in HIV/AIDS management committee expanded to include other sectors, stakeholders, and interest groups by 2004. |
| | 1.1.2 Recruit technical staff: (HIV/AIDS unit)<br>° Director<br>° 2 counsellors<br>° others as appropriate | • Technical staff recruited by June 2004 | Chief Personnel Officer<br>Ministry of Finance and Planning<br>Line Ministries | Staff recruited and functional |
| | 1.1.3 Conduct job analyses for all staff positions. | • Jobs redesigned, job descriptions available by June 2004. | Ministry of Health and the Environment<br>Public Sector Reform | Officers informed about jobs and functional |
| | 1.1.4 Strengthen Non-Governmental Organization network. | • Representative membership of all Civil Society Organizations implementing HIV/AIDS activities collaborating by year end 2004 | Non-Governmental Organization coordinator<br>Ministry of health and the Environment<br>National AIDS Council. | Heightened involvement of Non-governmental organisations |
| | 1.1.5 Establish a committee of focal points from each ministry and private sector organization. | • Public/Private sector working committee in place by August 2005 | Ministry of Health and the Environment / National AIDS Secretariat (NAS) | Multisectoral approach to HIV/AIDS management |

| STRATEGIC OBJECTIVES | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTORS | EXPECTED OUTCOME |
|---|---|---|---|---|
| | 1.1.6 Establish HIV/AIDS hotline service | • Hotline service functional by March 2006 | Ministry of Health and the Environment / National AIDS Secretariat Non-governmental Organisation Network | Increased accessibility to information on HIV/AIDS. A well informed general public |
| 1.2 Improve institutional capacity to deliver relevant quality health and social services. | 1.2.1 Conduct needs assessment for the following areas. | • Study report available by: | Ministry of Health and the Environment / NAS Line Ministry and CSO Coordinator | Needs assessments done. Findings recorded and reports available |
| | ° Public / Private sector | • Annually 2005 - 2009 | Committee of focal point | |
| | ° Non-governmental Organizations | • December 2005 | Non-governmental Organization Network | |
| | 1.2.2 Develop sector plans including private/ public and Non-governmental Organizations. | • By end of strategic period 2005 – 2009, all sectors have developed and implemented HIV/AIDS sector plans. | National AIDS Secretariat, Non-governmental Organisation | Increased number of programmes for HIV /AIDS. The Public is saturated with HIV/AIDS prevention & control programmes |
| | 1.2.3 Implement programmes utilizing information from needs assessment. | • No of Programmes implemented by public/private sector annually 2005 - 2009 | Focal points Ministry of Health and the Environment / NAS Non-governmental Organization | Number of persons reached increased |

| STRATEGIC OBJECTIVE | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTORS | EXPECTED OUTCOME |
|---|---|---|---|---|
| | 1.2.4 Increased budgetary allocations through Ministry of Finance and Planning to relevant ministries and agencies for HIV/AIDS programmes. | • Budgetary allocations 2005-2009 | Ministry of Finance and Planning<br>Ministry of Health and the Environment / NAS Focal points Line Ministries | Prudent and efficacious use of funds |
| | 1.2.5 Expand capacity of clinical lab to include estimation of viral load and other tests. | • Machinery and equipment purchased by 2007/8.<br>• Technical lab staff increased by 2005. | Ministry of Finance and Planning<br>Ministry of Health and the Environment / Chief Lab Technologist MCMH | Tests available and accessible |
| | 1.2.6 Develop monitoring and evaluation indicators for various service areas. | • Monitoring and Evaluation indicators developed by December 2005 | Ministry of Health and the Environment, National AIDS Secretariat, Monitoring and Evaluation Advisor | Indicators achieved, Services provided improved |
| | 1.2.7 Strengthen social support for people living with HIV/AIDS and their families. | • No of Social support programmes for people living with HIV/AIDS and families strengthened over the period 2004-2009. | Ministry of Finance and Planning, Ministry of Health and the Environment, Ministry of Social Development, Non-governmental Organisation | Vibrant social programme<br>Social welfare needs of people living with HIV/AIDS and families met |

| STRATEGIC OBJECTIVE | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTOR | EXPECTED OUTCOME |
|---|---|---|---|---|
| | 1.2.8 Conduct ongoing monitoring and periodic evaluation of HIV/AIDS programme | • Mechanisms for monitoring and evaluation in place by December 2005.<br>• Mid-term/end of year evaluation reports available 2006-2009 | National AIDS Secretariat, Monitoring and Evaluation Consultant, Ministry of Finance and Planning | Information on status of programme available. |
| | 1.2.9 Construct a building to house HIV/AIDS secretariat. | • Building constructed by 2006 | Ministry of Finance and Planning<br>Ministry of Health and the Environment<br>Ministry of Transport Works and Housing | Functional user friendly secretariat |
| | 1.2.10 Expand primary Health Care Centres to facilitate counselling services. | • Twelve counselling rooms constructed by 2007<br>• Six counselling rooms refurbished by 2006 | Ministry of Finance and Planning<br>Ministry of Health and the Environment<br>Ministry of Transport Works & Housing | Decentralized counselling services |

## STRATEGY 2

## DEVELOP, STRENGTHEN AND IMPLEMENT HIV/AIDS/STI PREVENTION AND CONTROL PROGRAMMES WITH PRIORITY GIVEN TO YOUTH AND HIGH RISK/VULNERABLE GROUPS

| STRATEGIC OBJECTIVES | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTORS | EXPECTED OUTCOME |
|---|---|---|---|---|
| 2.1 Produce a cadre of personnel capable of sustaining programmes for HIV/AIDS in the areas of clinical care management, ARV, OI, STI syndromic approach, nutrition, PMTCT, VCT, PEP, M&E, IT, ARV adherence, contact tracing, HIV rapid test and stigma and discrimination as well as basic HIV/AIDS information. | 2.1.1 Conduct training programmes for Medical Officer and District Medical Officers in clinical care management, ARV, OI, STI syndromic approach, PMTCT, VCT, PEP, M&E, ARV Adherence and stigma and discrimination. | • No of Medical Officers and District Medical Officers trained annually in the listed areas. | Ministry of Finance and Planning<br>Ministry of Health and the Environment / NAS<br>CAREC/PAHO | Quality client care |
| | 2.1.2 Training programme for other health care providers, including nurses, laboratory staff, pharmacists, community health aides in all relevant programme areas. | • No of persons trained annually by staff category and programme areas. | Ministry of Finance and Planning, Ministry of Health & Environment<br>CAREC/PAHO | Quality client care |
| | 2.1.3 Train selected personnel in VCT. | • No of VCT service providers trained annually according to national standard | Ministry of Finance and Planning<br>Ministry of Health and the Environment / NAS<br>CAREC/JHPIEGO/FHI | Decentralization of services/changes in lifestyle behaviours. |

| STRATEGIC OBJECTIVES | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTORS | EXPECTED OUTCOME |
|---|---|---|---|---|
| | 2.1.4 Conduct Trainer of trainers for various sectors on HIV/AIDS related areas. | • No of persons trained annually. | Ministry of Finance and Planning<br>Ministry of Health and the Environment / NAS<br>CAREC | Sectors gained knowledge on HIV/AIDS |
| | 2.1.5 Train focal points from various sectors on programme planning as well as other relevant HIV/AIDS areas | • No of Focal points trained 2005-2009 | Ministry of Finance and Planning<br>Ministry of Health and the Environment / NAS | Efficiency and effectiveness in programme delivery |
| | 2.1.6 Train selected personnel on Information Technology. | • No of persons trained in Information Technology for the period 2005-2009 | Ministry of Finance and Planning,<br>Ministry of Health and the Environment,<br>/Ministry of Technology. | Efficient network system |
| | 2.1.7 Train selected management officers on management Issues. | • No of management officers trained 2004-2009 | Ministry of Finance and Planning<br>Ministry of Health and the Environment<br>CAREC/PAHO/UWI | Effective and efficient programme delivery for HIV/AIDS |

| STRATEGIC OBJECTIVES | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTORS | EXPECTED OUTCOME |
|---|---|---|---|---|
| 2.2 Strengthen prevention and control programmes to target adolescents, young adults, and high risk Vulnerable groups | 2.2.1 Conduct needs assessment of vulnerable groups which will focus on behavioural patterns, e.g. STI, life skills, sexuality, decision making etc. | • Group profiles collected and documented and available by 2005. | Ministry of Health and the Environment, Private Sector, Non-governmental Organizations, Public Sector | Data collected, compiled and utilized. |
| | 2.2.2 Developed behavioural change communication programmes. | • Behavioural change Communication (BCC) Programme plans available by 2006 | Ministry of Health and the Environment, Ministry of Education, Non-governmental Organizations, Private Sector Consultant | Increase in condoms sales, reduction in teenage pregnancy. Increased VCT counselling |
| | 2.2.3 Conduct HIV/AIDS training for tourist sector workers and hotel industry workers. | • No of tourism industry workers trained annually | Ministry of Tourism & Culture, Ministry of Health and the Environment, Ministry of Finance and Planning, CAREC | Knowledgeable tourism industry workers |
| | 2.2.4 Develop a peer education/counselling programme for the following groups:<br>◦ CSW<br>◦ PLWHA<br>◦ MSM<br>◦ Youth<br>◦ Women in union | • Peer counselling programme by 2006<br>• No of peer educators/ counsellors trained by listed groups in multiple aspects of HIV prevention.<br>• No of counselling sessions conducted according to the listed categories | Non-governmental Organizations, Ministry of Health and the Environment, Faith-Based organisations | Peer education/ counselling service provided |

| STRATEGIC OBJECTIVES | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTORS | EXPECTED OUTCOME |
|---|---|---|---|---|
| | 2.2.5 Place condom dispensers in strategic locations | • Condom dispensers available by 2006.<br>• No of male condoms distributed during the preceding 12 months | Ministry of Health and the Environment Non governmental organization private sector. Funding agency | Condoms are readily available. Utilization increased |
| | 2.2.6 Utilize mass media programme focusing on high risk groups, promoting safer sex and condom use, benefits of accessing care and treatment programmes, benefits of knowing HIV status etc. | • No of media programmes conducted annually in the form of radio spots, television spots, newspaper articles and special events | Ministry of Education, Ministry of Health and the Environment / NAS Communication Consultant. | No. of persons reached increased |
| | 2.2.7 Erect communication (Billboard). | • Electronic communication Billboard erected by 2007. No of billboards erected annually | Ministry of Health and the Environment / NAS Non governmental organization | HIV/AIDS information disseminated, lifestyle behaviour changes noted |
| | 2.2.8 Develop teaching manual for HIV/AIDS education. | • Teaching manual available by 2005 | Ministry of Health and the Environment, Non government Organization | Consistent information provided at all levels |
| | 2.2.9 Formulate HIV/AIDS policy document | • Policy document available by 2006 | Ministry of Health and the Environment, Non government Organization, Ministry of Finance | Policy document utilized. Standards maintained |

## STRATEGY 3

## STRENGTHEN CARE, SUPPORT AND TREATMENT PROGRAMMES FOR PEOPLE LIVING WITH AIDS AND THEIR FAMILIES.

| STRATEGIC OBJEVTIVES | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTOR | EXPECTED OUTCOME |
|---|---|---|---|---|
| 3.1 Strengthen treatment, care and support network system for people living with AIDS and their families | 3.1.1 Review composition of CCM broad-based sub- committee for care and treatment. | • Broad based sub committee re-established by May 2004 | HIV/AIDS unit and Non-governmental Organisation network | Inclusive/collaboration approach to care |
| | 3.1.2 Develop HIV/AIDS operational manuals for the following:<br>° Management protocols<br>° Standard of care<br>° Treatment protocols<br>° Referral and follow-up systems<br>° Social welfare policy<br>° PMTCT | • Manuals completed by December 2005 | Country Coordinating Mechanism Broad based sub committee for care and treatment<br>Ministry of Health and the Environment / NAS | Operational guidelines available, distributed and utilized by relevant personnel |
| | 3.1.3 Train families of people living with AIDS in home care and universal precaution. | • No of family members of people living with HIV/AIDS trained annually | Ministry of Health and the Environment / NAS, Non Governmental Organizations | Informed body of caregivers |

| STRATEGIC OBJECTIVES | STRATGEIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTOR | EXPECTED OUTCOME |
|---|---|---|---|---|
| | 3.1.4 Extend counselling to all people living with HIV/AIDS including adherence counselling | • No of counselling sessions conducted for PLWHA annually.<br>• No of PLWHA who would have received counselling. | Ministry of Health and the Environment / NAS<br>Non-governmental Organizations | Increased compliance rate/decreased case fatality rate. |
| | 3.1.5 Strengthen condom distribution and use through family planning programme. | • Increased condom distribution annually through public and private sector. | Ministry of Health and the Environment<br>National Family Planning Unit<br>Non-governmental Organizations | Decreased in HIV incidence by 2009 |
| | 3.1.6 Strengthen Prevention of Mother To Child Transmission(PMTCT) programme | • 100% compliance rate in PMTCT programme by 2009. | PMTCT Broad based committee | Zero tolerance to mother to child transmission by 2009 |
| | 3.1.7 Strengthen diagnostic capacity of laboratory services to measure CD4 counts. | • Diagnostic CD4 functional by 2005<br>• No of CD4 tests performed annually | Ministry of Health and the Environment, Ministry of Finance and Planning | Diagnostic services available and utilized. |
| | 3.1.8 Conduct needs assessment of People Living with AIDS and Families | • Study completed and documented by 2005 | Ministry of Health and the Environment | Needs identified |

| STRATEGIC OBJECTIVES | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTOR | EXPECTED OUTCOME |
|---|---|---|---|---|
| | 3.1.9 Extend antiretroviral therapy to all People Living with AIDS. | • No. of persons receiving ART annually | Ministry of Health and the Environment<br>CAREC/PAHO | Case fatality decreased |
| | 3.1.10 Extend community nursing service to include home based care. | • No of Health Districts offering home-based care | Ministry of Health and the Environment, Non Governmental Organizations | Home based care available to people living with HIV/AIDS |
| | 3.1.11 Provide support for Non-governmental Organizations<br>° House of Hope<br>° Bread of Life (orphans).<br>° Planned Parenthood Association | • No of NGO projects funded annually.<br>• Amount allocated per organization annually 2005 - 2009. | Ministry of Finance and Planning<br>Ministry of Health and the Environment | Capacity building in Non-Governmental Organizations achieved.<br>PLWHA benefit from support. |
| | 3.1.12 Promote advocacy programmes against stigma and discrimination. | • Advocacy programmes developed and implemented by 2006 | Attorney Generals Office, Human Rights Association, Ministry of Health and the Environment, Non Governmental Organizations. | Reduced complaints by people living with HIV/AIDS and families |
| | 3.1.13 Conduct HIV/AIDS LEHR national assessment & Enact relevant legislation | • Legislation and workplace policies completed by 2007 | | |
| | 3.1.14 Strengthen mechanism for Contact Tracing. | • Training provided 2005 - 2009<br>• Develop Contact Tracing protocol for HIV | Ministry of Health and the Environment | Early diagnosis and intervention for PLWHA |

## STRATEGY 4

## CONDUCT HIV/AIDS RELATED RESEARCH

| STRATEGIC OBJECTIVE | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTOR | EXPECTED OUTCOME |
|---|---|---|---|---|
| 4. Establish a framework and mechanism for the conduct of HIV/AIDS related research. | 4.1 Establish a ministerial research committee. | • Committee functional by 2004. | Ministry of Health and the Environment, Focal point committee, National AIDS Council, Non-governmental organization. | Mechanism developed to monitor research |
| | 4.2 Train selected personnel in the science of research. | • Personnel trained in research by 2007-2008. | Chief Personnel Officer, Ministry of Health and the Environment, UWI | Personnel available to conduct research. |
| | 4.3 Conduct KABP on selected groups. | • Study reports available by 2006. | All sectors | Information available to guide programme planning. |

## STRATEGY 5

## UPGRADE SURVEILLANCE SYSTEMS

| STRATEGIC OBJECTIVE | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTOR | EXPECTED OUTCOME |
|---|---|---|---|---|
| 5.1 Strengthen the structure and mechanism within the HIV/AIDS/STI surveillance system. | 5.1.1 Evaluate existing HIV/AIDS/STI surveillance system. | • Evaluation completed by 2004 | Ministry of Health and the Environment, Ministry Of Finance and Planning | Deficiencies of system identified. |
| | 5.1.2 Upgrade operational surveillance system by upgrading HIV/AIDS data template to reflect data consistent with 3rd generation surveillance system. | • 3rd generation surveillance system implemented by 2005. | Ministry of Health and the Environment | Systems functional and required data generated |
| | 5.1.3 Continue to strengthen the surveillance of HIV/AIDS STI through development of sentinel strategy in collaboration with private sector. | • Prepared reports collected by 2004 and ongoing | Ministry of Health and the Environment | Reports available |
| | 5.1.4 Introduction of clinical management information system | • Clinical management information system introduced by 2006. | Ministry of Health and the Environment | System available and functional |

| STRATEGIC OBJECTIVE | STRATEGIC ACTIVITIES | INDICATORS | RESPONSIBLE SECTOR | EXPECTED OUTCOME |
|---|---|---|---|---|
| 5.2 Strengthen epidemiological surveillance through prevalence studies conducted for:<br>• Pregnant women<br>• STI clients<br>• Etiological STI study<br>• Prisons | 5.2.1 Conduct orientation sessions to ensure that all physicians and health care workers understand the purpose of prevalence studies. | • Sessions completed by 2004 | Ministry of Health and the Environment | Sessions completed<br>Reports available<br>Resources available |
| | 5.2.2 Ensure that adequate supplies and staff available to support the study. | • Resources evident by 2004 | Ministry of Health and the Environment | Study conducted. |
| | 5.2.3 Develop implementation phases of studies. | • Studies completed by:<br>2005<br>2007<br>2009 | CAREC/Ministry of Health and the Environment | Bottlenecks addressed |
| | 5.2.4 Monitor and evaluate studies. | • Programme monitoring and evaluation undertaken 2004-2008 | CAREC/Ministry of Health and the Environment | Data published in national and regional magazines |
| | 5.2.5 Analyze and disseminate study information. | • Study reports available by:<br>2006<br>2008<br>2010 | CAREC, FHI<br>Ministry of Health and the Environment | Study reports available |

| STRATEGIC OBJECTIVE | STRATEGIC ACTIVITIES | INDICATORS | RESPONSBLE SECTOR | EXPECTED OUTCOME |
|---|---|---|---|---|
| | 5.3.1 Conduct behavioural surveillance study for:<br>◦ MSM<br>◦ CSW<br>◦ Youths on the block<br>◦ General population | • Behavioural surveillance study studies completed by:<br>2005<br>2007<br>2009 | Ministry of Health and the Environment, CAREC | Study reports available and utilised in programme planning, implementation and evaluation |
| 5.3 Strengthening capacity of surveillance team. | 5.3.1 Procure fellowships for training<br>◦ systems analyst<br>◦ research officer | • Persons trained by 2007 | Ministry of Health and the Environment | Trained persons |
| | 5.3.2 Recruit data entry personnel | • Recruitment by 2005 | Ministry of Health and the Environment Finance | Persons recruited |
| | 5.3.3 Training for software application/ development of networks at peripheral level. | • Training conducted by 2005 | Network system developed and persons trained 2005-2007 | Persons trained<br>System operational |