St. Vincent and the Grenadines

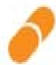
GLOBAL AIDS RESPONSE PROGRESS REPORT

2014

REDUCE SEXUAL TRANSMISSION

PREVENT HIV AMONG DRUG USERS

ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN


15 MILLION ACCESSING TREATMENT

AVOID TB DEATHS

CLOSE THE RESOURCE GAP

ELIMINATE GENDER INEQUALITIES

ELIMINATE STIGMA AND DISCRIMINATION

ELIMINATE TRAVEL RESTRICTIONS

STRENGTHEN HIV INTEGRATION

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LIST OF ACRONYNS & ABBREVIATIONS

AIDS	Acquired Immuno-deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
CHAA	Caribbean HIV and AIDS Alliance
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use
IEC	Information, Education, Communication
MARP	Most at Risk Population
M&E	Monitoring and Evaluation
MCMH	Milton Cato Memorial Hospital
NCPI	National Commitments and Policy Instrument
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
OECS	Organization of the Eastern Caribbean States
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PEPFAR	United States President's Emergency Plan For AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSI/C	Population Services International / Caribbean
STI	Sexually Transmitted Infection
SVPPA	St. Vincent Planned Parenthood Association
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

I. STATUS AT A GLANCE

(a) The inclusiveness of the stakeholders in the report writing process:

Stakeholders from the public sector and civil society were engaged in the report preparation process for St. Vincent and the Grenadines. The National Commitments and Policy Instrument questionnaire was distributed to stakeholders for completion. Data were gathered from the relevant stakeholders and a face-to-face consensus meeting was convened. Participating stakeholders were drawn from the Ministry of Health, Wellness and the Environment, Department of Labour; Non-Governmental Organizations such as St. Vincent Planned Parenthood Association, Caribbean HIV/AIDS Alliance, Population Services International, House of Hope Society, Human Rights Association, Marion House; and regional and international partners including the President's Emergency plan for AIDS Relief (PEPFAR), Pan American Health Organization and the Organization of Eastern Caribbean States/ HIV/AIDS Project Unit.

(b) The status of the epidemic:

During the reporting period 2012-2013, the number of reported cases of HIV for 2012 and 2013 remained unchanged when compared to the previous reporting period, 2010 and 2011.

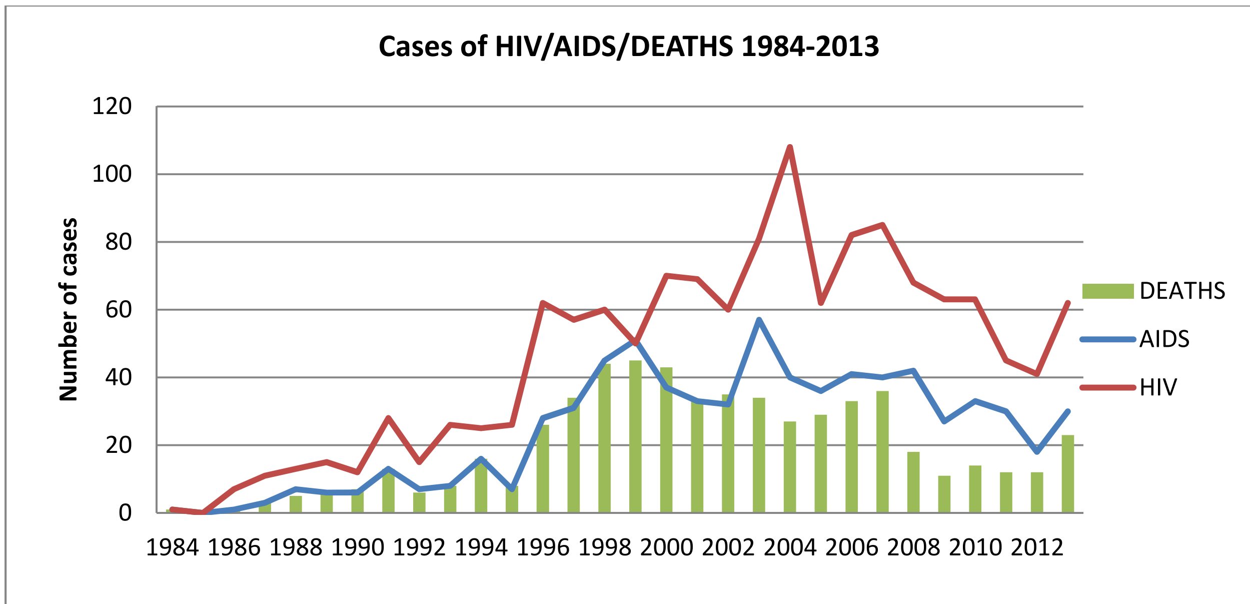

Figure 1: HIV, AIDS, AIDS-related Deaths, 1984 - 2013

The reported number of clients diagnosed with AIDS has continued to decline, from 63 cases in 2010-2011 to 48 in the 2012-2013 reporting period, a 25% reduction. AIDS related deaths are coded based on the International Classification of Disease-10 (ICD-10) coding system of all death certificates. There was a 35% increase in the number of deaths as a result of the complications of AIDS for the 2012-2013 reporting period (35 deaths), compared to the 2010-2011 reporting period (26 deaths). The increase in deaths occurred mainly in 2013, with a 92% increase over the 2012 number of 12 cases, and further analysis and investigations will be conducted to determine the causes of this increase. For the current reporting period, an effort was made to incorporate the private sector care and treatment data.

(c) The policy and programmatic response:

The 2012 - 2013 reporting period was very active, with respect to the development and implementation of policies. The St. Vincent and the Grenadines National Tripartite Workplace Policy on HIV and AIDS was adopted by Cabinet in November 2012 and launched in June 2013. The policy was developed by a consultant, in collaboration with the Department of Labour, the International Labour Organization, the Employers' Federation, the National Labour Congress and the Ministry of Health, Wellness and the Environment.

The Policy will be used by the private and public sectors as a best-practice precedent for responding to HIV in and through the workplace. While it does not have the force of a law made by Parliament, except where expressly stated, where appropriate, existing law should be used to guide the consequences for the non-compliance with the provisions of the Policy.

The Policy applies to all workers, their families and their dependents:

1. Current and prospective workers in the private and public sectors;
2. All workers working under all forms or arrangements and at all workplaces;
3. All sectors of economic activity, including the private and public sectors and the formal and informal sectors;
4. All employers and/or contractors of labour in the private and public sectors;
5. Persons in any employment or occupation, including uniformed services.

As part of the launch, eleven of the largest enterprises signed a memorandum of understanding with the Government, pledging to adapt/adopt and implement the resultant policies in their workplaces. Over the period, June to December 2013, the International Labour Organization supported a pilot project where the enterprises conducted trainer of trainers' workshops for focal points and peer educators. For World AIDS Day 2013, several of the enterprises implemented prevention interventions.

During the latter part of 2013, the Ministry of Health, Wellness and the Environment developed a National HIV/STI/TB Policy Framework, 2014-2025. This was accomplished through a PAHO-supported consultancy. This policy is currently awaiting adoption by Cabinet.

The purpose of the National HIV/STI/TB Policy is to establish a super-arching, rights-based policy, legislative and ethical framework that will direct the development of a holistic and sustainable HIV/STI/TB response in St. Vincent and the Grenadines. In turn, the success of this policy-directed response will contribute directly and substantially to the achievement of the strategic goal of enabling increased human and social development, as stated in the National Economic and Social Development Plan 2013-2025 of the Government of St. Vincent and the Grenadines.

The vision of the National HIV/STI/TB Policy Framework is that St. Vincent and the Grenadines will become a nation in which new HIV infections are rare and where all persons infected and affected by HIV/STI/TB will have unfettered access to high-quality care and support, free from stigma and discrimination regardless of age, gender, sexual orientation or socio-economic status. The national strategy will revolve around four (4) discrete but inter-related objectives:

1) Reduce new HIV infections, including co-infections
2) Increase access to treatment, care and support and improve health outcomes for people living with HIV/STI/TB
3) Advance HIV/STI/TB-related human rights and gender equality
4) Invest human and technical resources strategically

The process was very inclusive and included the formation of a committee, interviews and consultations. The government was able to advance the programmatic response, guided by the HIV and AIDS National Strategic Plan 2010-2014, with the strategic objectives of policy development and legislation; multi-sectoral involvement and decentralization; prevention services; care, treatment and support services; and strategic information, M&E and research. The government was able to make progress on all strategic objectives despite challenges.

(d) Indicator data in an overview table:

<table>
<tr><th>TARGETS</th><th colspan="2">INDICATORS</th><th colspan="4">2012-2013</th></tr>
<tr><td rowspan="17">Target 1
Reduce sexual transmission of HIV by 50 percent by 2015

General population</td><td rowspan="3">1.1</td><td rowspan="3">Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission [OECS BSS 2005]</td><td>Age (yrs)</td><td>Male (%)</td><td>Female (%)</td><td>Both (%)</td></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>
<tr><td>1.2</td><td>Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15</td><td colspan="4">Both Sexes: 22%
Males: 31%
Females:14% [OECS BSS 2005]</td></tr>
<tr><td rowspan="4">1.3</td><td rowspan="4">Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months [OECS BSS 2005]</td><td>Age (yrs)</td><td>Male (%)</td><td>Female (%)</td><td>Both (%)</td></tr>
<tr><td>15-19</td><td>41 (16)</td><td>29 (10)</td><td>70 (13)</td></tr>
<tr><td>20-24</td><td>101 (52)</td><td>36 (15)</td><td>137 (32)</td></tr>
<tr><td>25-49</td><td>38 (13)</td><td>15 (5)</td><td>53 (9)</td></tr>
<tr><td rowspan="4">1.4</td><td rowspan="4">Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse [OECS BSS 2005]</td><td>Age (yrs)</td><td>Male (%)</td><td>Female (%)</td><td>Both (%)</td></tr>
<tr><td>15-19</td><td>26 (62)</td><td>16 (55)</td><td>42 (59)</td></tr>
<tr><td>20-24</td><td>63 (62)</td><td>18 (50)</td><td>81 (49)</td></tr>
<tr><td>25-49</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>1.5</td><td>Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results</td><td colspan="4">Not Available</td></tr>
<tr><td>1.6</td><td>Percentage of young people aged 15-24 who are living with HIV</td><td colspan="4">2013: 0.76 % (7/919)</td></tr>
<tr><td>Sex workers</td><td>1.7</td><td>Percentage of sex workers reached with HIV prevention programmes</td><td colspan="4">Not Available</td></tr>
</table>

TARGETS	INDICATORS		2012-2013
Sex workers	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	Not Available
	1.9	Percentage of sex workers who have received an HIV test in the past12 months and know their results	Not Available
	1.10	Percentage of sex workers who are living with HIV	Not Available
Men who have sex with men **Source:** Health Information Unit, Ministry of Health & the Environment; Men who have Sex with Men Behavioural and HIV Seroprevalence Pilot Survey 2010	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	**90.5%** **[2010]**
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	**73.3%** **[2010]**
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	**32.4%** **[2010]**
	1.14	Percentage of men who have sex with men who are living with HIV	**29.5%** **[2010]**
Target 2 Reduce transmission of HIV among people who inject drugs by 50% by 2015	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes.	Not Applicable
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Not Applicable
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected.	Not Applicable
	2.4	Percentage of people who inject drugs that received an HIV test in the past 12 months and know their results	Not Applicable
	2.5	Percentage of people who inject drugs who are living with HIV	Not Applicable
Target 3 Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths **Source:** HIV/AIDS/STI Clinic, Milton Cato Memorial Hospital	3.1	Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother -to-child transmission	**2012:** 89.47% (17/19) **2013:** 80% (12/15)
	3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	**2012:** 100% (1/1) **2013:** 100% (2/2)
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	**2012:** 73.68% (14/19) **2013:** 87% (13/15)

<table>
<tr><th>TARGETS</th><th colspan="2">INDICATORS</th><th colspan="4">2012-2013</th></tr>
<tr><td></td><td>3.3</td><td>Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months</td><td colspan="4">-</td></tr>
<tr><td rowspan="2">Target 4
Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015</td><td>4.1</td><td>Percentage of adults and children currently receiving antiretroviral therapy</td><td colspan="4">2012: 91.82 % (202/220)
2013: 93 % (269/289)
2013: 37.8 % (269/710) NEW*</td></tr>
<tr><td>4.2</td><td>Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy</td><td colspan="4">2012: 75 % (24/32)
2013: 68% (25/37)</td></tr>
<tr><td>Target 5
Reduce tuberculosis deaths in people living with HIV by 50% by 2015</td><td>5.1</td><td>Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV</td><td colspan="4">2012: 6 (66.7%)
2013: zero cases</td></tr>
<tr><td>Target 6
Close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low and middle income countries</td><td>6.1</td><td>Domestic and international AIDS spending by categories and financing sources</td><td colspan="4">Eastern Caribbean Currency

2012: 3, 959, 854
2013: 4, 267, 142

See Table in Annex</td></tr>
<tr><td>Target 7
Eliminating gender inequalities</td><td>7.1</td><td>Proportion of ever married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months</td><td colspan="4">Not Available</td></tr>
<tr><td rowspan="5">Target 8
Eliminating stigma and discrimination

Source: Ministry of Health Wellness & the Environment
[OECS BSS 2005]</td><td rowspan="5">8.1</td><td rowspan="5">Respondents with accepting attitudes towards people living with HIV. General population aged 15 – 49 years.

A. Buy food from a shopkeeper or food vendor with HIV
B. Allow an infected student to go to school

Sample size for 15-24: Male 439, Female 526
Sample size for 25-49: Male 282, Female 295</td><td>Age (yrs)</td><td>Male (%)</td><td>Female (%)</td><td>Both (%)</td></tr>
<tr><td>15-24</td><td>16</td><td>14</td><td>15</td></tr>
<tr><td>25-49</td><td>20</td><td>15</td><td>18</td></tr>
<tr><td>15-24</td><td>72</td><td>74</td><td>73</td></tr>
<tr><td>25-49</td><td>73</td><td>70</td><td>71</td></tr>
<tr><td>Target 9
Eliminate travel restrictions</td><td></td><td>Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed</td><td colspan="4">Not Applicable</td></tr>
<tr><td rowspan="2">Target 10
Strengthening HIV integration</td><td>10.1</td><td>Current school attendance among orphans and non-orphans aged 10-14</td><td colspan="4">Not Available</td></tr>
<tr><td>10.2</td><td>Proportion of the poorest households who received external economic support in the last 3 months</td><td colspan="4">Not Available</td></tr>
</table>

NEW* New Definition for Denominator Used

II. OVERVIEW OF THE AIDS EPIDEMIC

The number of HIV reported cases for the last two reporting periods (2010/2011 and 2012/2013) has remained comparatively constant. There were 103 HIV reported cases for 2012/2013, which was 5 less than the previous reporting period 2010/2011, when 108 HIV cases were reported. This computes an average of 50 HIV reported cases annually for the last 4 years. Since the annual number of reported cases peaked in 2004 (108 reported cases - see chart below), there has been steady progress in reducing the number of HIV reported cases.

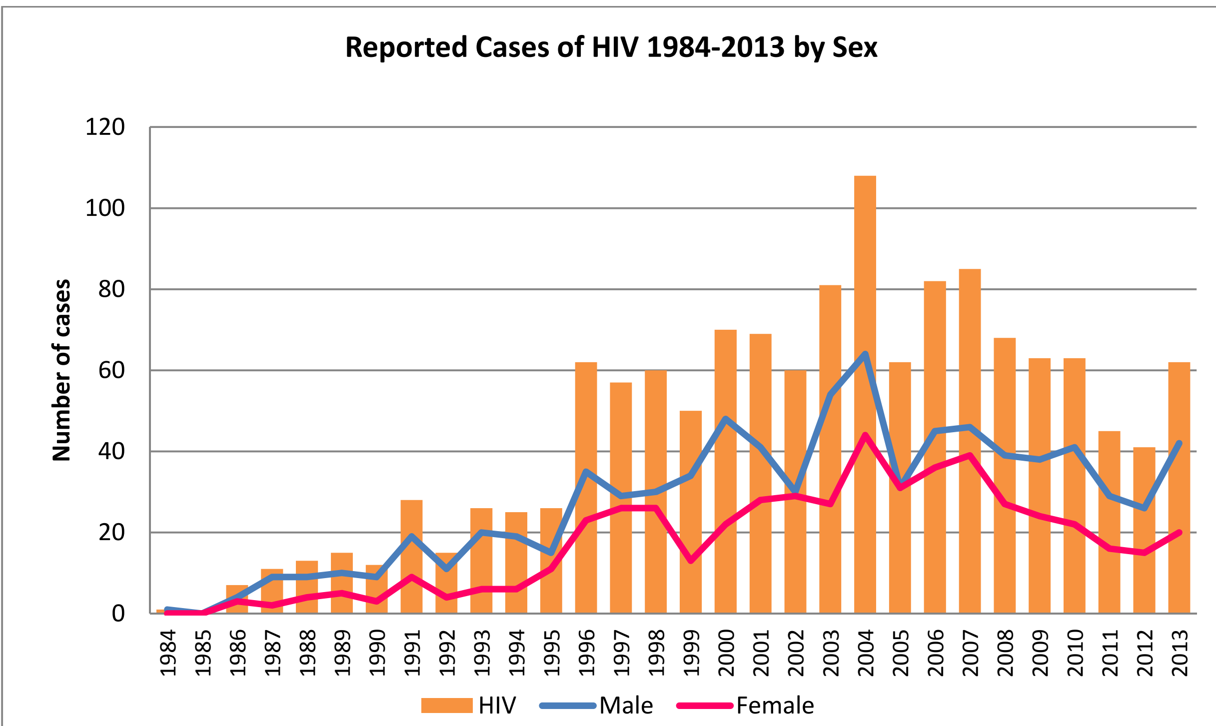

Figure 2: Bar Chart / Line Graph shoving HIV reported cases by sex

There are a number of reasons why it may be difficult for countries to see drastic reductions in reported cases at this stage of the epidemic. These include the global challenge of changing sexual behaviour and the pool of undiagnosed HIV infected individuals who do not yet know their status and are reluctant to be tested.

The latter reason may have been demonstrated during the reporting period 2012 to 2013. Over three-quarters of the reported cases (3/4) were diagnosed at 30 years and older, and were

predominantly males. Approximately one third of the reported cases were diagnosed as a result of voluntary counselling and testing and contact tracing activities.

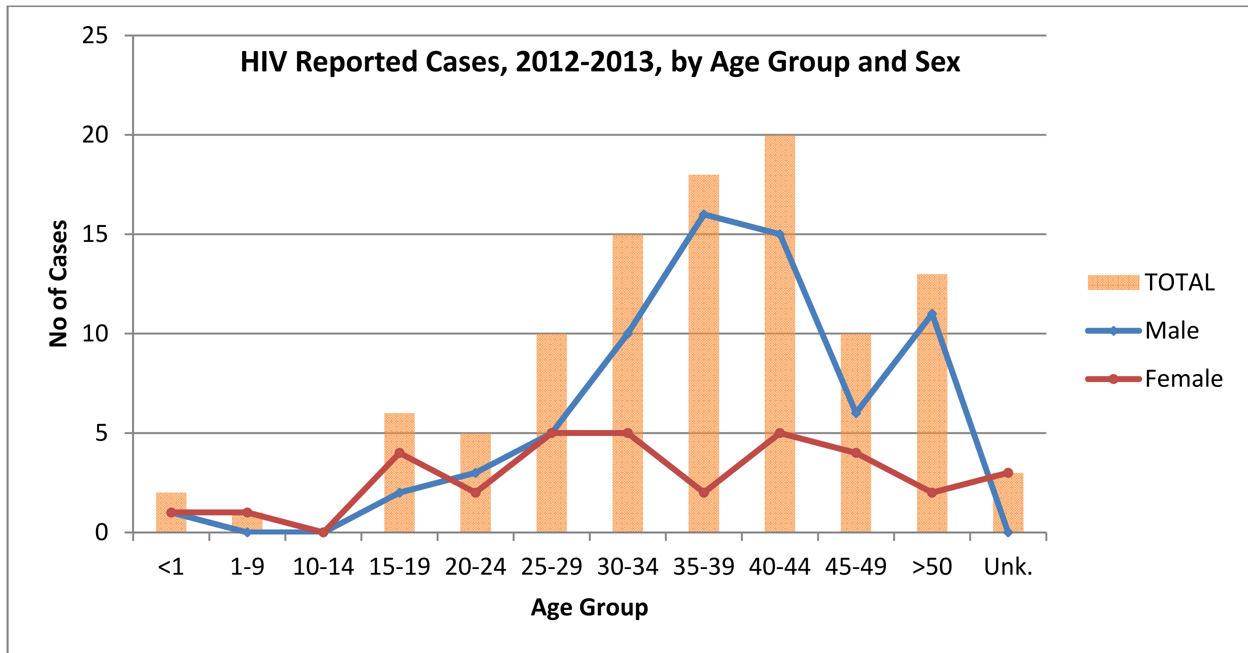

Figure 3: Bar Chart / Line Graph showing HIV reported cases by age and sex

With respect to mode of transmission, 77 reported cases or 75 percent stated that they were engaging in heterosexual relationships, 3 reported cases or 2.9 percent were infected as a result of mother-to-child transmission. The remaining 22 percent did not state a risk factor. However, it is noteworthy that most of these cases were males. Approximately one third of the reported cases were unemployed.

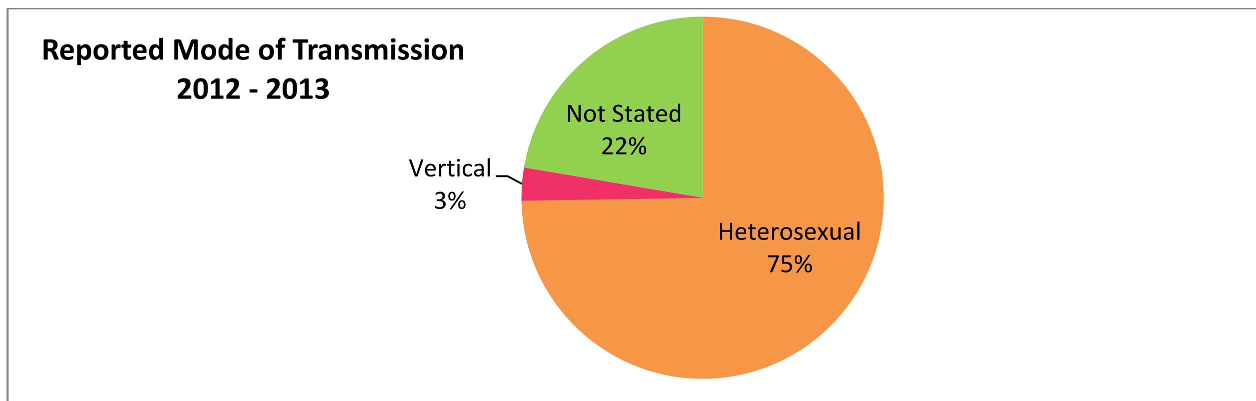

Figure 4: Pie Chart showing HIV mode of transmission, 2012-2013

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

PREVENTION

During the reporting period, the Ministry of Health, Wellness and the Environment and its partners forged ahead with the national prevention efforts. The prevention efforts included: **biomedical interventions** - condom distribution and promotion; continued care and treatment programme utilising the ART as a prevention strategy; **behavioural interventions** - stakeholders engaged in community-level, and interpersonal interventions with high-risk groups to disseminate behavioural messages; and **structural interventions** - policies were developed and other interventions implemented to reduce stigma and discrimination against people living with HIV, and marginalized groups. The multi-sectoral response was strengthened to address issues such as gender inequality, gender-based violence and economic empowerment.

The prevention of mother to child transmission programme continued over the reporting period, despite challenges. Approximately 85 percent of HIV positive pregnant women received antiretroviral to prevent mother to child transmission of HIV. An average of 80 percent of infants born to HIV positive mothers received an HIV virologic test within two months of birth. HIV positive pregnant women are provided with HIV antiretroviral therapy during pregnancy, and whereas in the past the ARV was discontinued after the birth of the baby, the mother is now offered treatment for life, which is called the Option B+. Replacement milk is provided for one year to mothers who decide not to breastfeed. A number of challenges remain, including the fact that some women do not access antenatal care, while others access care late in pregnancy and had poor adherence to medication. The country continued to strengthen its interventions towards achieving elimination of mother to child transmission of HIV and congenital syphilis.

Voluntary Counselling and Rapid Testing: During the reporting period, 2012 to 2013, there was a fifty percent increase in the number of voluntary HIV rapid tests offered to clients. During the reporting period, 5067 HIV rapid tests were done compared to 3380 provided in 2010-2011. The trend, however, continued, where twice as many females accessed the service. VCT continues to be a significant activity, as seen previously, where approximately 30 percent of reported cases were diagnosed through the provision of this service.

Total number of VCT clients by age group and sex, 2012 – 2013

Sex	2012				2013				
	<15	15-24	25+	Total	<15	15-19	20-24	25+	Total
Male	2	217	565	**784**	3	79	175	676	**933**
Female	6	677	1054	**1737**	12	327	503	1065	**1907**
Total	**8**	**894**	**1619**	**2521**	**15**	**406**	**678**	**1741**	**2840**

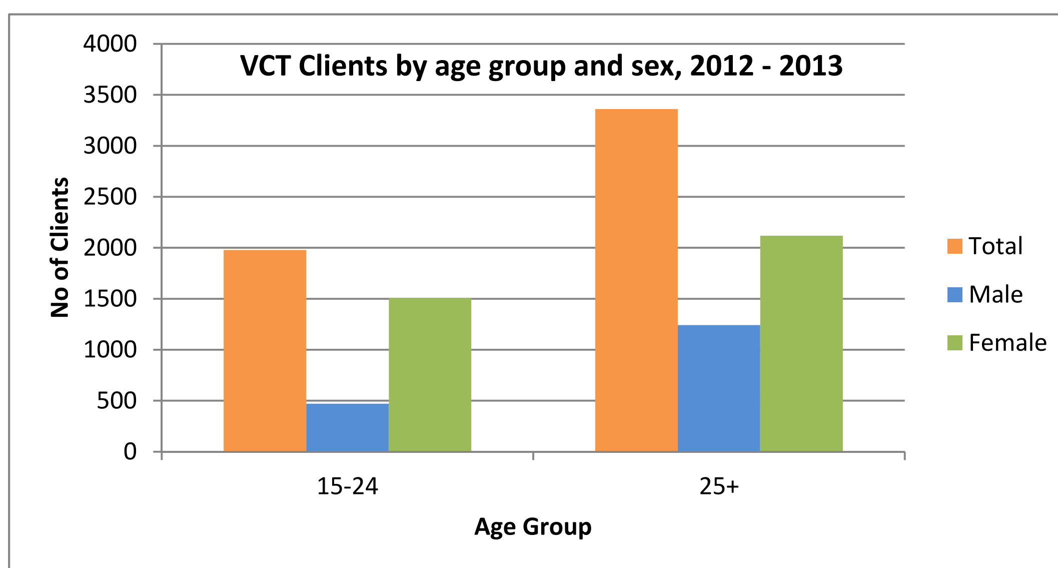

Figure 5: Bar Chart showing voluntary HIV rapid testing by age group and sex

The Caribbean HIV/AIDS Alliance (CHAA) continued to play a vital role in the national response to HIV through sustainable partnership with the Ministry of Health, Wellness and the Environment, Community Based Organizations, Non-Profit Organizations and other local partners working to mitigate the impact of HIV/AIDS in St. Vincent and the Grenadines.

CHAA during this period continued to work aggressively through a dynamic team of Peer Community Animators (CA), with key populations such as men who have sex with men, sex workers and persons living with HIV, to reduce their risk of contracting HIV through the provision of individualized targeted interventions, distribution of free commodities such as condoms, lubricants and IEC materials as reinforcement to support behaviour change. The total

number of prophylactics distributed during this period included, 38,547 male condoms, 1411 female condoms, 435 dental dams, 1215 lubricants and approximately 871 IEC materials.

During the 2013 reporting period, CHAA provided various services to a total of 1,094 individuals within the key populations. Of the total number persons reached, 397 were MSM, 396 sex workers and 304 PLHIV. Also during this period, a total of 269 persons within the key populations were referred for several HIV related services, and out of this total, 151 persons were reported to have uptake services. The team of Community Animators also supported the various testing sites, including Infectious Disease clinic, by providing confidential counselling service for persons receiving HIV rapid testing. During the reporting period, approximately 586 persons received counselling services, 208 males and 378 females.

Caribbean HIV/AIDS Alliance also provided technical assistance and expertise through training for Faith Based Organization leaders and selected peer educators within the workplace. The training was intended to equip persons with skills required to make the various work places and places of worship more conducive, tolerant and stigma-free environment for members of the key populations. Finally, CHAA further supported the national response by providing human resources as well as funding for some aspects of the World AIDS Day activities.

St. Vincent Planned Parenthood Association (SVPPA): During 2013, the St. Vincent Planned Parenthood Association saw an increase in the number of persons accessing sexual and reproductive services, as well as HIV and STI screening, over the 2012 figures. The association continued to target young persons and males in addition to its female clients. See table below for the counselling and testing services provided:

SERVICE/CLIENT	<25 YRS	>25YRS
Family Planning Service	326	617
Youth Clients	1187	N/A
Male Clients	171	271
HIV Rapid Testing Service	523	658
Sexually Transmitted Infections	707	885

Condom distribution continued to be the main biological prevention intervention, with close to half a million condoms distributed over the reporting period.

Population Services International (PSI) is a global health organization specializing in the social marketing of HIV prevention, family planning and maternal and child health products and services. The organization's platform oversees the implementation of a regional social marketing programme which aims to strengthen and complement existing HIV prevention activities, and increase the uptake of sexual and reproductive health services. This objective is achieved through collaboration with key stakeholders and partners, both public and private, to increase safer sexual practices among identified vulnerable populations through peer education, Behaviour Change Communications (BCC), mass media and social media.

PSI, through educators, has implemented its BCC programme amongst target populations such as 'Males at Risk', 'Females at Risk' and 'Youths at Risk'. Through interactive activities, educators have engaged persons in various physical environments such as on the streets, community centres, bars, clubs etc.

PSI through its mass and social media campaigns has promoted the 'Got IT? Get IT!' brand appeal, which provide persons with information about condom availability. Through this campaign, outlets (shops, bars, clubs, supermarkets, gas stations etc.) are branded with 'Got It? Get It!' apparels. This aspect of the project is coordinated by a Condom Sales Promotion Agent. In St.Vincent and the Grenadines, there are over 150 branded 'Got It? Get It!' outlets that sell condoms to the public. The private sector continued to be actively involved in this campaign during the reporting period.

In 2012 PSI implemented a referral card system, where participants though BCC activities were encouraged to access Sexual and Reproductive Health (SRH) services. This programme has been very successful, and as a result, the SVPPA (PSI local umbrella organization) has seen an increase in the number of clients at its clinic. The services sought by the referred clients included HIV testing, STI screening, pap smears and prostate examinations. PSI has been involved in community outreach activities, Carnival events, World AIDS Day activities, etc. PSI continued

to collaborate with various stakeholders during 2012-2013 with focus on HIV prevention, access to STI screening and accessing SRH services.

CARE, TREATMENT & SUPPORT

The number of adults receiving ART continued to increase over the reporting period. The estimated number of adults (15+) needing antiretroviral therapy, based on 2010 WHO guidelines, using spectrum estimation was 358 for 2013. The actual number of adults (15+) receiving antiretroviral therapy as at December 2013 was 264, with 85 percent of clients on first line therapy. Since the introduction of the HAART programme in 2003, 508 clients have been enrolled in the care and treatment programme. More clients are being placed on Fixed Dose Combination (1 pill a day) and approximately 70% of clients on ARVs are on fixed dose combination. Stavudine based regimens were phased out in 2012. The recent WHO recommended CD4 threshold of 500 is being implemented. Viral load testing available in Barbados is offered to the clients and more Health Care Providers have been trained in the clinical management of HIV.

Several challenges continued to affect the care and treatment programme, including adherence to medication; poverty and social issues, including homelessness and drug abuse and lost to follow up. During the midterm review conducted in 2013, the stakeholders identified the following key programmatic actions necessary to ensure that more individuals receive care and treatment services.

- There is need for formalized collaboration with other stakeholders, such as the Caribbean HIV and AIDS Alliance and faith based organizations at the community level, to further encourage clients to access care and treatment services especially those clients lost-to-follow-up.

- The adherence strategy needs to be fully implemented at the clinic level, with the support of all stakeholders, to address the social issues facing some clients.

- Stigma and discrimination associated with being HIV-infected must be addressed so that the fear of being tested and accessing care and treatment would be reduced or eliminated.

- Provider initiated testing and counselling services, as well as partner notification and referral services must be strengthened.

- Decentralization and integration of HIV services must be advanced.

Treatment & Support Indicators 2010-2013

CARE & TREATMENT PROGRAMME INDICATORS	2010	2011	2012	2013
Total number of CD4 counts	**457**	**375**	**698**	**546**
Total number of days of hospitalization for HIV/AIDS and related conditions	**1135**	**1069**	**1107**	**1449**
Total number of new HIV clients enrolled in care (Public)	**52**	**35**	**25**	**47**
Total number of new HIV clients who commenced ARV treatment	**36**	**32**	**37**	**50 + 4 transferred In**
Total number of adults and children receiving ARV treatment (Public and Private)	**175**	**186**	**202**	**269**
Total number of **males** receiving ARV treatment	95	103	102	141
Total number of **females** receiving ARV treatment	80	83	100	128
Total number of clients **<15 yrs** receiving ARV treatment	2	3	2	5
Total number of clients **≥15 yrs** receiving ARV treatment	173	183	200	264
Total number of clients receiving 1st Line ARV treatment	**149**	**157**	**176**	**229**
<15 yrs	**2**	**3**	**1**	**4**
≥15 yrs	**147**	**154**	**175**	**225**
Total number of clients receiving 2nd Line ARV treatment	**26**	**29**	**26**	**40**
<15 yrs	**0**	**0**	**1**	**1**
≥15 yrs	**26**	**29**	**25**	**39**
Percentage of clients receiving 2nd Line ARV treatment	15	16	13	15

Source: Infectious Disease Clinic (MCMH)

The number of males placed on antiretroviral therapy is comparable with the number of females demonstrated by a 1:1 ratio. The following comparison of four male to female ratios points to the fact that more interventions are needed with respect to encouraging male clients living with HIV to know their status, access care and treatment services and adhere to medication. It is a well established fact that females are more proactive in seeking health care services compared to males. The ratios below show that although more males have been diagnosed (1.6 male to1 female), approximately the same number of males and females are on ARV therapy. Also, the number of males who have died almost doubles that of the number of females.

Male to Female Ratio of cumulative reported cases, 1984-2013	***1.6 : 1***
Male to Female Ratio of estimated number of PLHIV	***1.3 : 1***
Male to Female Ratio of PLHIV on ARV Therapy	***1.1 : 1***
Male to Female Ratio of cumulative deaths, 1984-2013 (all causes)	***1.9 : 1***

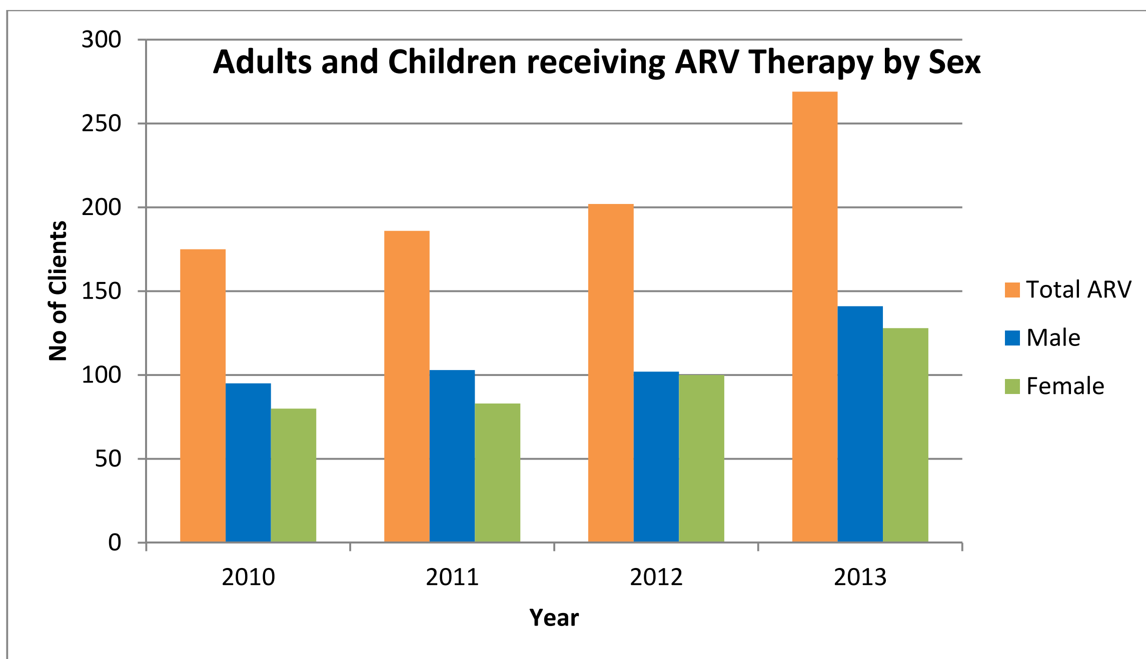

Figure 6: Bar Chart showing adults and children on ARV therapy by sex

On a positive note, the majority of the clients on therapy (85 percent) are on first line therapy. It is important that clients remain on first line therapy as long as possible, as this results in a lower cost to the country. It now costs less than two hundred US dollars per patient per year for first line therapy compared to second line which is much more expensive.

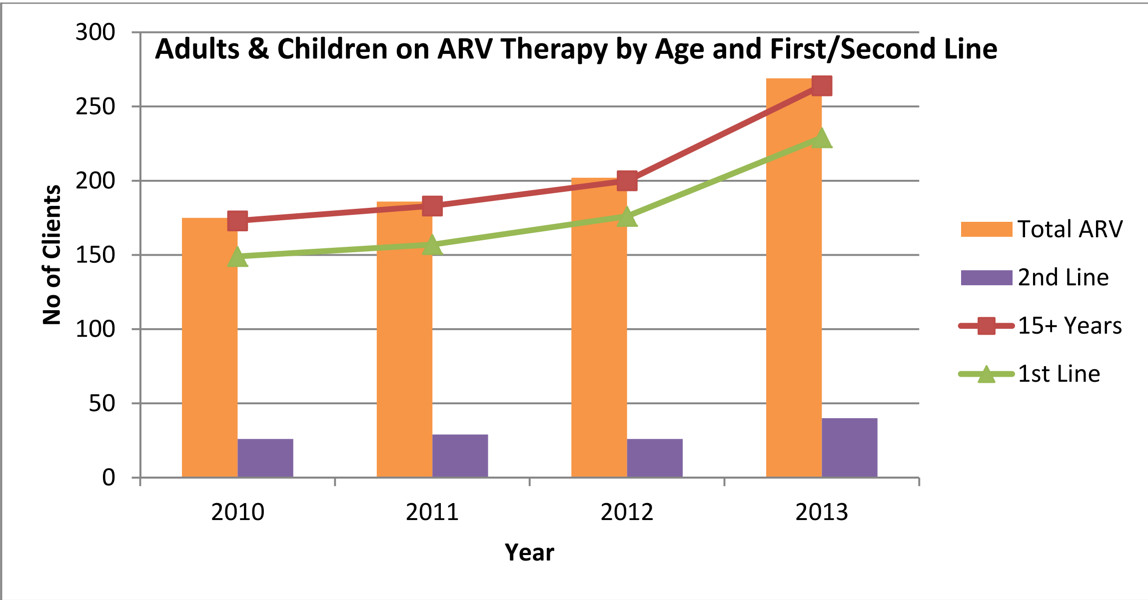

Figure 7: Bar Chart and Line Graph showing adults and children on ARV therapy by age and regimen

The House of Hope Society is a legally registered Faith-based Charity in St. Vincent and the Grenadines. This charity was organized by Anglican, Methodist and Roman Catholic Churches and the Salvation Army, which form the SVG Christian Council. The mission is to serve all people with empathy, compassion, and dignity. The Society's main aim is to offer hospice and home-based care to terminally ill persons, especially those infected with HIV, by offering care, spiritual guidance, medication, and counselling so that PLHIV can spend their last days comfortably, with dignity and die peacefully.

The main goals of the House of Hope Society are to help control and decrease the spread of HIV; to increase the use of health services by individuals, particularly those living with HIV; to address the myths and misconceptions regarding HIV and AIDS; and to increase the acceptance of PLHIV.

In order to reach these essential goals, the House of Hope Society is working in four main areas: extending the House of Hope headquarters to provide accommodation for caregivers with family members in the hospital; to provide hospice care at the headquarters; to provide home- based care to people living with HIV/AIDS; and to implement ongoing educational programme for primary and secondary school students.

Since its inception, the Society has achieved many successes. These include acquiring the headquarters and increasing the staff complement, development of a constitution and by-laws, development of a promotional video, erection of several bill boards at strategic locations, procurement of equipment for the hospice and home-based care, and the development of home-based care protocol and training manual. The Society has also developed a Strategic Plan for 2014 – 2019 to provide guidance in achieving its mission of treating all with empathy, compassion, and dignity.

The Society works in partnership with the Ministry of Health, Caribbean HIV/AIDS Alliance, the Infectious Disease Clinic at Milton Cato Memorial Hospital, and other agencies to increase the number of persons receiving home-based care. Through this programme the Society was able to provide support for the most vulnerable persons by providing them with care to relieve suffering in a dignified and respectful manner. During the year 2012, the Society offered home based care and other assistance to those in need and provided training to volunteers. The volunteers participated in a week-long training on HIV/AIDS and hospice care conducted by the Florida Association for Volunteer Action in the Caribbean and Americas. Additionally, through two one-day training sessions, 16 volunteers were trained to go into the homes of patients to provide care, affection, practical support, and to help clients deal with their existing circumstances. These sixteen volunteers visited twelve clients on a weekly basis in Clare Valley, Kingstown, Calliaqua, and Biabou. Through the home-based care programme, volunteers give clients and their caregivers hope and support through counselling, personal hygiene, exercise, massaging and other assistance.

The Society developed a Home-based Care Manual to provide guidance for volunteers. The manual contains information on benefits of home-based care, counselling, HIV/AIDS care and treatment, care for bed-ridden clients, record keeping, living positively with AIDS, and simple exercises for clients. Volunteers are trained on an on-going basis to ensure they provide high

quality care to clients. Currently, there are fifteen active volunteers that provide care and also go into schools for the educational programme which is designed to reduce stigma and discrimination and create positive behavioural change towards people living with HIV/AIDS among students. A number of volunteers are also living with HIV. This allows them to remain active in the community and learn about proper care for themselves. They offer additional insight and positive support to clients and volunteers.

The Society collaborates with the Ministry of Health, Wellness and the Environment's Nutrition Support Programme and also the Nutrition Unit to provide monthly food packages to approximately one hundred persons living with HIV/AIDS in St. Vincent and the Grenadines.

IV. BEST PRACTICES

Political Leadership and Supportive Policy Environment

During the reporting period, significant progress was made with respect to the integration of the national HIV response. At the policy level, the national HIV response has been incorporated into the St. Vincent and the Grenadines National Economic and Social Development Plan, 2013 – 2025. The following are the objectives and interventions as stated in the development plan:

Strategic Objective 5:

To reduce the incidence of HIV/AIDS and improve the quality of life for people living with the disease

Strategic Interventions:

- Strengthen inter-sectoral management, organizational structures and institutional capacity.
- Strengthen HIV/AIDS prevention and control programmes.
- Strengthen care, support and treatment programmes for people living with HIV/AIDS, and their families.

Within the Ministry of Health, Wellness and the Environment, the HIV response has been fully integrated at all levels. At the administrative level, the HIV response is no longer a vertical programme; it has become part of the newly formed Department of Wellness, Disease Prevention and Management. This initiative provides the opportunity for lessons learnt over the years from implementing the HIV national response to be used to guide the programmes for other diseases, such as chronic non-communicable diseases. On the other hand, as resources to fund the HIV response dwindle, opportunities can be seized to utilize scarce resources to continue HIV prevention and control efforts, thus ensuring that gains are not lost.

At the service delivery level, efforts were made to decentralize and integrate HIV care, treatment and support services within the primary health care structure. These initiatives were complemented by the implementation of an HIV Workplace Policy and the completion of the national HIV/STI/TB policy framework 2014 – 2015.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

(a) Progress made on key challenges reported in the 2012 Country Progress Report or during the Mid-Term Reviews of the Political Declaration performed in June 2013.

The following were the major challenges highlighted in the previous report for St. Vincent and the Grenadines and remedial actions implemented.

1) ***Sustainability of Services –***

The strategies to sustain the provision of HIV services were two-fold: 1. Preventing the pool of individuals requiring the services from expanding out of control and 2. Ensuring efficient and equitable use of human, financial and material resources. These were accomplished through the following:

a. Promoting adherence to ARV therapy
b. Providing routine antenatal screening for HIV
c. Implementing a robust prevention of mother to child transmission programme, including early infant diagnosis and treatment
d. Providing psychosocial and nutritional services for PLHIV
e. Decentralizing and integrating HIV services
f. Increasing access to HIV screening by providing point of care rapid testing

2) ***Difficulty reaching some target populations –***

This challenge has been addressed through collaboration with specific stakeholders and by implementing the following:

a. More targeted combination prevention programmes for various MARPs.
b. Effective use of social marketing tools
c. Reducing stigma and discrimination by the adoption and implementation of work place policies and programmes in the private sector
d. Strengthening partner notification and referral services
e. Providing voluntary counselling and testing services in settings where MARPs are more comfortable accessing services

3) ***Resistance to behaviour change –***
   a. Continued condom promotion and distribution
   b. Continued educational activities and public service announcements that target special population
   c. Continued campaigns including the provision of pamphlets and brochures, as well as the use of print, electronic and social media by PSI
   d. Behaviour Change Communication/peer communication training and appropriate interventions were implemented

(b) Challenges faced throughout the reporting period (2012–2013) that hindered the national response.

1. Individuals have the information about HIV transmission and prevention. However, they do not perceive that they are at risk and, therefore, do not practise safer sex.

2. Behaviour change interventions are very costly and reduction in donor funding has hampered some programmes.

3. Limited data on high risk groups; and outdated data on youth and general population

(c) Concrete remedial actions that are planned to ensure achievement of agreed targets.

1. Mobilize technical assistance and financial resources to conduct data collection for high-risk groups, including prison survey.

2. Strengthen the case-based surveillance system for HIV

3. Strengthen collaborative work with stakeholders to improve behaviour change activities

4. Fully implement the recently developed national HIV/STI/TB policy framework to guide interventions with MARPs

VI. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Over the reporting period, the United States President Emergency Plan for AIDS Relief (PEPFAR) was the country's main development partner. St. Vincent and the Grenadines is a signatory to PEPFAR Caribbean Regional HIV and AIDS Partnership Framework which provides technical assistance to national and regional entities in HIV prevention, strategic information strengthening, laboratory strengthening, and health systems strengthening to improve the capacity of government and civil society to implement an effective and sustainable HIV response.

Strategic Information

The activities implemented strengthened the capacity of the Ministry of Health, Wellness and the Environment and civil society to increase the availability and use of quality, timely HIV and AIDS data to better characterize the epidemic and support evidence-informed decision-making for improved programmes, policies and health services. The activities included training in surveillance and M&E methodologies; support for the use of disease surveillance and M&E data for decision-making and planning, including strengthening systems for HIV case reporting and updating minimum datasets for the collection of routine HIV program monitoring data

Laboratory Strengthening

The National Reference Laboratory registered and participated in EQA proficiency testing (PT) for HIV serology, CD4, hematology and chemical pathology. Training workshops were conducted on quality assurance for HIV testing for the Dried Tube Specimen (DTS) technology. Standardized logbooks for use at all HIV testing sites were printed and disseminated. Laboratory personnel participated in regional training sessions to enhance in-country capacity.

The government of St Vincent and the Grenadines has been assisted in the implementation of the ISO 15189 Quality Management System (QMS) towards accreditation of the National Reference Laboratory. The SchuyLab Laboratory Information System was installed and commissioned.

Health Systems Strengthening

Health care workers participated in CHART/I-TECH training activities, in the following technical areas: clinical management of HIV, counselling and testing, blood safety, prevention of mother to child transmission, strategic information, palliative care, psycho-social services and stigma and discrimination.

Prevention

The main support under the prevention goal was provided through the Caribbean HIV and AIDS Alliance and the Peace Corps' Men As Partners programme.

The activities implemented through the Caribbean HIV and AIDS Alliance were:

1) HIV behaviour change interventions for most at risk populations
2) Community-based HIV Counselling and Testing
3) Care and support for people living with HIV/AIDS

VII. MONITORING AND EVALUATION ENVIRONMENT

(a) An overview of the current monitoring and evaluation (M&E) system

The following provides a synopsis of the status of the basic monitoring and evaluation core components for the Ministry of Health, Wellness and the Environment.

Core Components	Status
Trained human resource to support the M&E system	In place
Multi-disciplinary M&E team or unit responsible for coordinating M&E actions	In place
Strategic and operational plans to determine the activities that will be implemented and the results to be obtained	In place
Sufficient budget to support M&E activities	Inadequate
Concise, manageable and measurable indicators to measure the progress and impact of the interventions in terms of the outlined goals and objectives	In place
Informatics system that will organize and manage the collected data, maximizing efficiency of data management and use	In place
Sustainable systems for data collection, processing and analysis	Being developed
An information dissemination and data use system	In place
Operations research to fill information gaps not addressed through routine data collection	Conducted periodically – needs to be strengthened
Surveillance system to describe the epidemiological situation in the country	In place

(b) Challenges faced in the implementation of a comprehensive M&E system

- Budget allocation is inadequate as M&E is a relatively new paradigm within the health sector.
- Further M&E advocacy for health is required.
- Information and objectives in the strategic plan were not consistent with programme level activities.
- Late submission of data remains a challenge.

(c) Remedial actions planned to overcome the challenges

- M&E budgets are included in annual Corporate Plans that are submitted to Cabinet for approval.
- Sensitization of M&E concepts has taken place among the majority of departments in 2013 by the Health Information Unit.
- A new Health Strategic Plan is being developed which will align objectives and priorities of the Ministry with departmental/programme activities.

(d) Highlight, where relevant, the need for M&E technical assistance and capacity-building.

- Sufficient capacity building in monitoring and evaluation has been completed to accomplish the Ministry's objectives.

ANNEXES

ANNEX 1: CONSULTATION/PREPARATION PROCESS

- The Surveillance Officer and Surveillance Assistant were given the responsibility to coordinate data collection for the preparation of St. Vincent and the Grenadines fourth Global AIDS Response Progress Report.

- NCPI questionnaires were printed and distributed to government and civil society representatives.

- Meetings were convened to determine the sources of data

- Development partners were contacted and requested to provide spending data for the country.

- Desk review of relevant documents was conducted.

- The data were validated, analysed and interpreted.

- Data were entered online in the AIDS reporting tool.

- A narrative report was prepared and reviewed by the Chief Medical Officer and Permanent Secretary.

- A stakeholder workshop was convened to validate and finalize the country's data and narrative report.

- One major challenge was the inability to gather some data due to the illness of a critical member of staff.

ANNEX 2: AIDS SPENDING DATA, 2012

St. Vincent and the Grenadines AIDS Spending Categories (2012)	TOTAL (Eastern Caribbean Currency)	Public Sub-Total	National	International Sub-Total	UN Agencies	Global Fund	All Other Multilateral	Private Sub-Total	For-profit institutions / Corporations	All Other Private
1. Prevention (sub-total)	1,123,121.82			1,122,121.82	10,456		1,111,665.82	1,000	1,000	
1.03 Voluntary counselling and testing (VCT)	5,025.00			4,025.00	4,025			1,000	1,000	
1.99 Prevention activities not elsewhere classified	6,431.00			6,431.00	6,431					
2. Care and Treatment (sub-total)	625,307.72	92400	92400	452,907.72		224,688.12	228,219.60	80,000		80,000
2.01.03 Antiretroviral therapy	111,789.51			111,789.51		111,789.51				
2.01.04 Nutritional support associated to ARV therapy	92,400.00	92400	92,400							
2.01.05 Specific HIV-related laboratory monitoring	112,878.61			112,878.61		112,878.61				
2.01.09 Home-based care	80,000.00							80,000		80,000
3. Orphans and Vulnerable Children (sub-total)	540,000.00	540000	540000							
3.03 OVC Family/home support	540,000.00	540000	540,000							
4. Program Management and Administration Strengthening (sub-total)	1,540,064.65	919253	919,253	620,811.65		16,301.40	604,510.25			
4.01 Planning, coordination and programme management	914,044.00	914044	914,044							
4.03 Monitoring and evaluation	16,301.40			16,301.40		16,301.40				
4.99 Program Management and Administration Strengthening not-	609,719.25	5209	5,209	604,510.25			604,510.25			

ANNEX 2: AIDS SPENDING DATA, 2012

St. Vincent and the Grenadines AIDS Spending Categories (2012)	TOTAL (Eastern Caribbean Currency)	Public Sub-Total	National	International Sub-Total	UN Agencies	Global Fund	All Other Multilateral	Private Sub-Total	For-profit institutions / Corporations	All Other Private
elsewhere classified										
5. Incentives for human resources (sub-total)	11,150.70			11,150.70	3000	8,150.70				
5.03 Training					3000	8,150.70				
6. Social Protection and Social Services (excluding OVC) (sub-total)	110,000.00	110000	110000							
6.99 Social protection services and social services not elsewhere classified	110,000.00	110000	110,000							
7. Enabling Environment (sub-total)	10,209.00			10,209.00	10209					
7.98 Enabling Environment and Community Development not disaggregated by type	10,209.00			10,209.00	10,209					
TOTAL	**3,959,853.89**	1,661,653	1,661,653	2,217,200.89	23,665	249,140.22	1,944,395.67	81,000.00	1,000.00	80,000.00

ANNEX 2: AIDS SPENDING DATA, 2013

St. Vincent and the Grenadines AIDS Spending Categories (2013)	TOTAL (Eastern Caribbean Currency)	Public Sub-Total	National	International Sub-Total	UN Agencies	Global Fund	All Other Multilateral	Private Sub-Total	For-profit institutions / Corporations	All Other Private
1. Prevention (sub-total)	1,599,837.00	12,000	12,000	1,587,837.00	31,025		1,556,812.00			
1.03 Voluntary counseling and testing (VCT)	4,025.00			4,025.00	4,025					
1.05 Prevention - Youth in School	9,000.00			9,000.00	9,000					
1.99 Prevention activities not elsewhere classified	39,000.00	12,000	12,000	27,000.00	27,000					
2. Care and Treatment (sub-total)	402,488.12	92400	92400	230,088.12	5,400	224,688.12		80,000		80,000
2.01.03 Antiretroviral therapy	111,789.51			111,789.51		111,789.51				
2.01.04 Nutritional support associated to ARV therapy	97,800.00	92400	92,400	5,400.00	5,400					
2.01.05 Specific HIV-related laboratory monitoring	112,878.61			112,878.61		112,878.61				
2.01.09 Home-based care	80,000.00							80,000		80,000
3. Orphans and Vulnerable Children (sub-total)	540,000.00	540000	540000							
3.03 OVC Family/home support	540,000.00	540000	540,000							
4. Systems Strengthening Program Coordination (sub-total)	1,331,691.40	1004028	1,004,028	327,663.40		16,301.40	311,362.00			
4.01 Planning, coordination and programme management	1,004,028.00	1004028	1,004,028							

ANNEX 2: AIDS SPENDING DATA, 2013

St. Vincent and the Grenadines AIDS Spending Categories (2013)	TOTAL (Eastern Caribbean Currency)	Public Sub-Total	National	International Sub-Total	UN Agencies	Global Fund	All Other Multilateral	Private Sub-Total	For-profit institutions / Corporations	All Other Private
4.03 Monitoring and evaluation	16,301.40			16,301.40		16,301.40				
4.99 Program Management and Administration Strengthening not-elsewhere classified	325,362.00			325,362.00		14000.00	311,362.00			
5. Incentives for human resources (sub-total)	225,725.70			225,725.70	10000	8,150.70	207575			
5.03 Training					10000	8,150.70	207,575			
6. Social Protection and Social Services (excluding OVC) (sub-total)	110,000.00	110000	110000							
6.99 Social protection services and social services not elsewhere classified	110,000.00	110000	110,000							
7. Enabling Environment (sub-total)	57,400.00			57,400.00	57,400					
7.98 Enabling Environment and Community Development not disaggregated by type	57,400.00			57,400.00	57,400					
TOTAL	**4,267,142.22**	1,758,428	1,758,428	2,428,714.22	103,825	249,140.22	2,075,749.00	80,000.00	0.00	80,000.00