

A RAPID ASSESSMENT OF THE LINKAGES

Between the Services offered for

SEXUAL AND REPRODUCTIVE HEALTH (SRH)

AND

HUMAN IMMUNODEFIENCY VIRUS (HIV)

IN

ST. VINCENT AND THE GRENADINES

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
BOEC	Basic Essential Obstetrical Care
CAREC	Caribbean Epidemiology Centre
CCM	Country Coordinating Mechanism
CCNAPC	Caribbean Coalition of National AIDS Programme Coordinator
CEOC	Comprehensive Essential Obstetrical Care
CFPA	Caribbean Family Planning Association
CRL	Caribbean Reference Laboratory
CSO	Civil Society Organizations
FBO	Faith-Based Organizations
FP	Family Planning
GNP ⁺	The Global Network of People Living with HIV/AIDS
GOSVG	Government of St. Vincent and the Grenadines
HBC	Home-based care
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug users
IEC	Information, Education and Communication
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
IPRSP	Interim Poverty Reduction Strategy Paper
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MCH	Maternal and Child Health
MCMH	Milton Cato Memorial Hospital
MERG	Monitoring and Evaluation Reference Group
MNH	Maternal and Newborn Health
MOHE	Ministry of Health and the Environment
MSM	Men who have Sex with Men
MTCT	Mother-to-child transmission
MTESP	Medium Term Economic Strategic Paper
NAS	National AIDS Secretariat
NGO	Non-Governmental Organizations
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children

PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PEP	Post-exposure Prophylaxis
PHC	Primary Health Care
PITC	Provider-Initiated testing and counselling
PLHIV	People living with HIV
PMTCT	Prevention of Mother-to-child Transmission
RTI	Reproductive Tract Infection
SRH	Sexual and reproductive health
STI	Sexually Transmitted Infection
SVG	St. Vincent and the Grenadines
SW	Sex workers
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

1. INTRODUCTION

1.1 Brief Profile of St. Vincent and the Grenadines

St. Vincent and the Grenadines (SVG) is a multi-island state in the Windward Island chain of the Lesser Antilles, consisting of thirty-two (32) islands, inlets and cays and a total land area of 345Km². Most of the land areas and ninety-one (91%) percent of the country's population are on the mainland St. Vincent. The Grenadines extend south, by forty-five (45) miles, and include seven (7) inhabited islands, Bequia, Canouan, Mayreau, Union Island, Mustique, Palm Island and Petit St. Vincent. Sea transport links all the islands, while airport facilities are present on the mainland St. Vincent and the four Grenadines islands of Bequia, Canouan, Mustique and Union Island¹.

The estimated population of St. Vincent and the Grenadines was 100,746 in 2005, a decline of 5.2 percent during the inter-censal period from 2001. The population is relatively young: in 2001, 30.7 percent of the population was younger than 15 years old. Approximately sixty two (62) percent of the population was between the ages fifteen (15) and sixty four (64). The sex distribution was even with males accounting for 50.5 percent while females accounted for 49.5 percent².

1.2 Overview of the Health Care Services

St. Vincent and the Grenadines has made remarkable achievement in health care over the past twenty years. Since the declaration of Health for all by the year 2000, at Alma Ata in 1978 the health indicators have shown significant improvement. The natural growth rate of the population has fallen over this period from 2.8 to 2.4, the total fertility rate is 2.4 and the population grows at a rate of 0.13% per annum with a dependency ratio of 61%. Life expectancy at birth has been estimated at 72 years and infant mortality rate is 16.3 percent per 1000 live births³.

¹UNFPA. Basic Indicators Sexual and Reproductive Health SVG Pg1

² GOSVG, Midterm Economic Strategy Paper, Pg4

³ MOHE, Draft Health Sector Strategic Plan, Pg.3

With respect to its major health problems, SVG resembles that of the developed countries. In 2008 the ten (10) leading health disorders were as follows:

1. Ischemic heart disease
2. Cancers
3. Cerebro-vascular disease
4. Diabetes
5. Hypertension
6. Other diseases of the circulatory system
7. Assault and intestinal injuries
8. Other endocrine, nutritional and metabolic diseases
9. Skin diseases – non intentional injuries
10. HIV related diseases

Health services in St. Vincent and the Grenadines are significantly state-owned and offered with little separation by population groups or gender. Private sector involvement in health care delivery over the past twenty years has shown some improvement in the provision of general practitioner and specialist consultancy services, but with very little changes with respect to the provision of inpatient care.

The Ministry of Health & the Environment provides Primary, Secondary and Tertiary Services through the following administrative structures and programmes;

- Medical Administration
- Medical Stores
- Central Pharmaceuticals Service
- Milton Cato Memorial Hospital (MCMH)
- Environmental Health Services
- Environmental Services Unit
- Lewis Punnetta Home / Geriatric
- Mental Health Centre/Rehabilitation Centre
- Community Health Services
- Integrated Vector Control
- Dental Services
- Health Promotion Unit
- Rural Hospitals and Health Centres
- Nutrition Support Programme
- Family Planning

- Nutrition Unit
- HIV / AIDS / STIs Prevention and Control
-

1.3 Primary Health Care Services

Primary Health Care (PHC) is the main strategy adopted for the delivery of health care at the community level. There are thirty-nine (39) Health Centres spreading over nine (9) health districts providing services to the populace. On an average, each health centre is equipped to cater to a population of 2,900. No one is required to travel more than three (3) miles to access health care. Most primary health care services in the public sector are offered free of charge to the entire population. Primary health care services have included services for Sexual and Reproductive Health (SRH) integrated into several of the programmes. An evaluation of the primary health care services was conducted by the Ministry of Health and the Environment, funded by the Pan American Health Organization (PAHO), in 2006. This stressed the need for modifications to the organization and delivery of services to include more intersceteral collaboration and integration for primary health care and secondary services within the state⁴.

1.4 Secondary Health Care Services

At the secondary level, the 211-bed Milton Cato Memorial Hospital (MCMH) is the country's only government acute care referral hospital providing specialist care. The delivery of care at MCMH is organized into seven departments; these are Accident and Emergency, Out-patient Department, Surgery, Medicine, Operating Theatre, Paediatric and Obstetrics/Gynaecology. There are five (5) district hospitals with a total of seventy one (71) beds. Other institutions offering secondary care are the Mental Health Centre and the Lewis Punnett Home. A small private hospital and several nursing homes also offer in patient care. These services are supplemented by private generalist and specialist medical services.

The HIV/AIDS/STI prevention and Control Programme was the last vertical programme to be included in the budgetary estimates in 1998. This programme was introduced to respond to the increased fatalities from AIDS

⁴ Montalvam, Jorge. Assessment of PHC SVG

and to stem the ever increasing presence and effects of the epidemic. It was therefore introduced as a secondary service.

The object of this paper is to report on whether linkages were established between the HIV services which have been introduced, and the services for sexual and reproductive health which have been part of the ongoing health services.

1.5 Policy Initiatives

Policy is defined as a standing decision characterized by behavioural consistency and repetitiveness on the part of both those who make it and those who abide by it⁵. Public policy, therefore, refers to government's action or inaction with respect to a specific phenomenon. The government of St. Vincent and the Grenadines has, through its various statements and actions, clearly demonstrated its commitment to programmes to combat HIV and AIDS and to promote and enhance the sexual and reproductive health of its population.

While there appears to be no written and approved policies to guide any of the national response strategies for SRH and HIV programmes, these have been guided by precedence, the evidence is overwhelming as to the level of commitment made by the government of SVG in both cases particularly HIV.

1.5.1 Constitution of SVG

The present Constitution of St. Vincent and the Grenadines, (1979) makes reference to 'health' only, in so much as it affects public safety. The draft Constitution (2009) states that "Every person has the right to the enjoyment of health. The State shall protect and promote public health, and shall establish and maintain appropriate sanitary measures to ensure to every Vincentian the highest attainable standards of health, to the extent feasible according to the resources available to the State." The constitution therefore, includes all ages, gender, vulnerable groups by the reference to use of the words "all" and "every" but only specifies "Vincentians".

⁵ Dye, Thomas. Understanding Public Policy. Pg2.

1.5.2 The Medium Term Economic Strategy Paper 2007-2009

This document emphasises the strengthening of the capacity of the country to fight against HIV/AIDS and its concomitant effects. The link between HIV/AIDS and STI was made as the document stressed the need for prevention and control programmes with priority given to youths and high risk and vulnerable groups.

1.5.3 Interim Poverty Reduction Strategy Paper (IPRSP)

This document also articulated the linkages between HIV and SRH, particularly in relation to family planning and the reduction of the rate of HIV/AIDS and advocated the focusing of poverty reduction strategies on the identification of population groups most at risk and the application of appropriate policy interventions. The new strategy document will soon be launched.

1.5.4 UNGASS Report 2008

The government of St. Vincent and the Grenadines subscribes to the unanimously adopted Declaration of Commitment of HIV/AIDS, acknowledging the epidemic to be a “global emergency and one of the most formidable challenges to human life and dignity” (the UNGASS declaration). St. Vincent and the Grenadines was also a full participant and contributor to the production of the Caribbean Regional Strategic Framework 2008-2012.

1.5.5 HIV/AIDS Strategic Plan

The government of St Vincent has been involved in Strategic Planning for HIV since 2001. The National Strategic Plan 2010-2014 is informed by the UNGASS Declaration and the Caribbean Regional Strategic Framework 2008-2012 and synchronizes with the CRSF.

The government of St. Vincent and the Grenadines remained committed to the prevention and control of the spread of HIV / AIDS along with the care and support of people already infected in the country. The Government intends to evaluate the socio-economic impact of HIV on the country and plans are at an advanced state to conduct this research.

2. SURVEY METHODOLOGY

2.1 Overview

Linkages are a relatively new approach to increasing universal access to SRH and HIV prevention and care. The importance of linking HIV and sexual and reproductive health is abundantly clear as the majority of HIV cases, about 85 %, are sexually transmitted and both HIV and many illnesses linked to SRH have the same root causes⁶. It is also clear that the Millennium Development Goals will not be achieved without ensuring universal access to SRH and HIV services. The achievement of ensuring bi-directional linkages between HIV and SRH was important enough to facilitate a partnership between IPPF, UNFPA, WHO, UNAIDS and other stakeholders in the development of a methodology and appropriate tools to assess the existence of, and provide for recommendations to strengthen these linkages.

2.2 Purpose of the Study

This paper reports on an examination of the linkages between services offered in Sexual and Reproductive Health (SRH) with those offered for Human Immunodeficiency Virus (HIV) in St. Vincent and the Grenadines. The study took the form of a rapid assessment survey adopting the methodology proposed by the IPPF, UNFPA, et al and therefore, a snapshot of the services offered for SRH and HIV in SVG. The findings are intended to give guidance to policy makers and programme planners with respect to policies and initiatives to improve the efficiency and effectiveness of these services.

2.3 Operational Definitions

The following operational definitions are used as guidelines in the study.

- Sexual and Reproductive Health Services – Policies and programmes related to and including family planning, maternal and newborn care, prevention and management of sexually transmitted infections,

⁶ UNFPA et al. Rapid Assessment Tool for SRH and HIV Services – A Generic Guide

prevention and management of gender-based violence, prevention of unsafe abortion and post-abortion care.

- Human Immunodeficiency Virus Services – Policies and programmes related to and including HIV counselling and testing; prophylaxis and treatment, Home-Based Care (HBC), psychosocial support; comprehensive primary and secondary prevention for and by people living with HIV (PLHIV); HIV prevention, information and services for general population; condom provision; prevention of mother to child transmission (PMTCT), 4 prongs; specific HIV information and services to key populations.
- Linkages – The provision of integrated services which may either be “One Stop” or those with efficient and effective referral systems, for both SRH and HIV clients. Services must be delivered in a sensitive, confidential, private and respectful manner which includes, in a meaningful relationship, the PLHIV, ongoing community participation and embodies a culture which seeks to reduce stigma and discrimination.
- Bi-directionality – This refers to both linking SRH with HIV related policies and programmes and HIV with SRH related policies and programmes.
- Dual Protection – This refers to protection against unintended pregnancy while at the same time providing protection against HIV and AIDS.
- Key Populations also called Most Population At Risk (MARP) – This refers to populations where risk and vulnerability converge. These include men who have sex with men (MSM), sex workers (SWs) and their clients and injecting drug users (IDUs)
- ‘One Stop’ Facility – This is a facility that offers multiple services including services for HIV and SRH.

2.4 Limitations of the Study

The main limitations to this study were time and resources. Being rapid and undertaken within a short period (6 weeks) there was not enough time to increase the sample size. This would have allowed for more responses from clinical care providers and users of the system. Time also posed a constraint to reviewing the available literature as both HIV and SRH have generated a tremendous number of documents that could have added to the richness of the data. It was also extremely challenging locating and obtaining information from some persons. Users of this study would, therefore, have to be careful when extrapolating information for future use.

2.5 Method of Data Collection

A perusal of the relevant documents related to SRH and HIV programmes was undertaken. This was followed by interviews with policy makers, programme managers and other stakeholders. This was done to determine the policy guidelines and programme organization for both SRH and HIV services. A mini survey of the health care delivery sites, services and the clients utilizing these was undertaken. A focused group session was also conducted involving identified respondents to the clinical care services survey. The tools used for data collection were those developed by the IPPF, UNFPA et al and are appendaged to the document.

2.6 Sampling Design

Since all health care facilities offer ongoing services in sexual and reproductive health while HIV services were relatively new, the sampling was done with a view to capture respondents who may be utilizing HIV services. To this end seven (7) 18% of the thirty nine (39) health centres, as well as the out-patient department of the MCMH were sampled as clinical delivery sites. Information was obtained from health care providers and a minimum of five (5) clients exiting from each site regarding the delivery and utilization of the services. These data were analysed and constitute the body of this study.

3. LITERATURE REVIEW

3.1 SRH Services

There is no programme entitled SRH within the Budgetary Estimates of St. Vincent and the Grenadines. However, SRH services are offered at all health facilities and have been incorporated into several health programmes for many years.

The Milton Cato Memorial Hospital is the main site for the delivery of pregnant women. The institution offers out and in patient services in Obstetrics and Gynaecology and accepts referrals for male sexual health problems.

Maternal and Newborn services also called Maternal and Child Health Services to include prenatal, intranatal, postnatal and newborn health care. These are offered at all community health centres and all hospitals. A Maternal and Child Health Committee performs oversight of the delivery of these services.

Family Planning (FP) Services are offered free of charge through the National Family Planning Programme, which is integrated into the primary health care system. The St. Vincent Planned Parenthood Association, a non governmental organization (NGO) offers family planning services for a nominal fee.

The prevention and management of sexually transmitted infections is incorporated in all relevant health care services at both the primary and secondary level.

Delivery of SRH services is guided by the following protocols and documents:

-
- Family Health Strategy for the Caribbean Community – PAHO
- Family Health Manual – Ministry of Health and the Environment, SVG 2002
- Advancing the Agenda for Adolescent Health and Development – 4 Step Strategy – PAHO, 2007
- Adolescent Health Programme in St. Vincent and the Grenadines

- Adolescent Survey Data Analysis St. Vincent – InERT 2002
- Pan-Caribbean Partnership Against HIV/AIDS Regional Model Condom Policy – 2008
- Behaviour Change communication and Comprehensive Condom Programming in 6 OECS countries – UNFPA, 2008
- Family Planning Medical Protocol East Caribbean Region 1989, adapted and revised in SVG 1998
- Draft National Policy on Health and Family Life Education – St. Vincent and the Grenadines
- Planning Appropriate Cervical Cancer Prevention Programs – Path, 2000
- Report on National Cancer of the Cervix Prevention and Control Programme for St. Vincent and the Grenadines
- Report on Framework for a National Cancer of the Cervix Prevention and Control Programme
- Caribbean Framework for Developing National Screening and Clinical Guidelines for Cervical Cancer Prevention and Control – CAREC, 2004
- Promoting Healthy Sexual Behaviour Among Young People in the Caribbean – UNFPA

Despite the absence of a policy document and an integrated programme for SRH there have been significant achievements. Recent demographic indicators show the following trends in the Sexual and Reproductive Health status of the population.

Table 1: Indicators – Sexual and Reproductive Health – St. Vincent and the Grenadines⁷

No	Indicators	2002	2003	2004	2005	2006	2007
1.	Total Fertility Rate	2.2	2.2	2.10	2.09	2.17	-
2.	Maternal Mortality Rate	57.05	172.61	0	0	57.80	114.48
3.	Antenatal Coverage (ANC)	-	-	99%	99%	99%	99%
4.	Births attended by skilled Health Personnel	99%	99%	99%	99%	99%	99%
5.	BEOC	-	3	3	2	2	2
6.	CEOC	-	1	1	1	1	1
7.	Perinatal Mortality Rate	20.3	21.84	27.16	18.9	30.62	23.20
8.	Prevalence of Low Birth Rate	-	6.4	5.24	7.0	7.9	6.75
9.	Prevalence of Positive Serology in pregnant women (15-24 years)	-	1.69	2.26	2.95	2.33	1.25
10.	Percentage of Obstetric and Gynaecological admissions owing to abortion	7.15	7.14	-	7.79	6.17	6.63
11.	Prevalence of HIV infection in pregnant women (Aged 15-24)	0.5	0.7	2.0	0.9	1.3	1.4
12.	Teenage Pregnancy Rate	22%	20%	21%	17%	16%	16.4%

3.2 HIV Services

St. Vincent and the Grenadines like the rest of the world has not been exempted from the impact of the HIV/AIDS pandemic. The HIV epidemic is driven by a number of factors including socio-cultural, behavioural and economic.

The most commonly recorded form of HIV transmission is through heterosexual contact accounting for approximately 70% of all HIV infections. Recorded homosexual or bisexual and vertical transmissions account for 10% and 4% of cases respectively⁸. The male to female ratio of HIV has, over the past 20 years, been decreasing from a high of 4.5:1 in 1987 to 1.4:1 in 2008. Cumulative cases of HIV from 1984 to 2008 show that there have been more females in the age groups: less than 5 years, 15 – 24 years and 65 – 69 years. The majority of the male HIV cases have

⁷ UNFPA. Basic Indicators Sexual and Reproductive Health SVG Pg2

⁸ SVG MOHE. HIV and AIDS National Strategic Plan 2010-2014

occurred within the ages of 20-49 years while the female cases have occurred within the ages of 20-39 years. Cumulative AIDS cases, 1984 – 2008, show a similar sex-specific age distributions of HIV distributions. The majority of male AIDS cases have been in the age range of 25-49 whereas the female cases have been in the age range of 20 – 39 ages. Since then, the epidemic has become generalized with a prevalence of just over 1% among pregnant women receiving antenatal services⁹. There was a general decrease in the HIV incidence, of approximately 37% by the end of 2008, from the peak of 2004. This decrease may be attributed to the interventions that the country has been implementing¹⁰.

The government's response has been aggressive, recognizing the fact that this epidemic has serious developmental implications if left unchallenged. Although there appears to be no written policy document with respect to HIV/AIDS the national response to the epidemic has been targeted. This was evident by the introduction of a programme with budgetary allocations for HIV and AIDS prevention and management in 1998.

A significant progress indicator was the development of a strategic plan which was launched in December 2001 and included the following strategic objectives:

- Strengthened inter-sectoral management, organizational structures and institutional capacity.
- Design and implement care, support and treatment programmes for PLWHA and their families.
- Develop and implement HIV/AIDS/STI and control programmes with priority given to youth and high-risk / vulnerable groups.
- Conduct research and training programmes
- Upgrade surveillance systems
- Implement advocacy programmes.

The time frame of the first strategic plan was 2002 – 2006, and oversight was in the hands of a designated body called the Country Coordinating Mechanism (CCM).

The Government of St. Vincent and the Grenadines in its mission to scale up the HIV/AIDS prevention and control programme negotiated with the World Bank in 2003 to finance the programme. This led to the establishment of a National AIDS Council and its Secretariat (NAS), co-chaired by the Prime

⁹ SVG MOHE. HIV and AIDS National Strategic Plan 2010-2014

¹⁰ Ditto

Minister and the Minister of Health and the Environment, to provide multi-sectoral coordination.

The World Bank funded project totalling US\$8.75m/EC\$23.5m¹¹, part grant and part loan, 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 multi-sectoral implementation approach.

This revised strategic plan covered the period 2004 – 2009 and included HIV prevention strategies. These have been guided by the objective of developing, strengthening and implementing HIV/AIDS/STI prevention and control programmes with priority given to youths, high risk and vulnerable groups. The NAS's coordination of the national response has resulted in the establishment of focal points in nine (9) non-health ministries and a number of civil society organizations (CSO) as partners, actively contributing to the national response.

3.3 Key Initiatives With Respect to HIV

Several initiatives have been introduced to combat the HIV epidemic. This study highlights only the major ones and recognises the inputs and contributions of all the concerned persons who have contributed.

3.3.1 Care and Support

The treatment, care and support response includes treatment with highly active antiretroviral therapy services provided, since August 2003, at the care and treatment clinic of the Milton Cato Memorial Hospital (MCMH). There are plans to establish three additional ART accredited sites within the next two years and three more eventually. The number of persons enrolled annually for care and treatment has been fairly uniform at about 60 per year, by the end of 2008 there were 259 people enrolled. From 2003 to the end of 2008, of the 177 patients enrolled at ART only 9 were children under 15

¹¹ World Bank, Project Appraisal Document SVG – Report No 28236 Pg4

years and 82 (46.3%) were women and 95 (53.7%) men¹². These statistics do not include patients treated in private clinics that may include individuals from other Caribbean islands, seek anonymity, who decide to be treated in St. Vincent and the Grenadines.

3.3.2 PMTCT

PMTCT began in St. Vincent and the Grenadines as a caring intervention in October 1998. In January 2000, the Ministry of Health and the Environmental assumed exclusive responsibility for a national PMTCT Programme offering counselling and HIV testing to all pregnant mothers and providing anti-retroviral treatment to mothers and babies as necessary, as well as, replacement feed for the babies up to six months.

There are three (3) reporting sources to support data collection for PMTCT; namely the health centres, public and private laboratories and the care and treatment centre.

This programme has several strengths which are attributable to its success. Some of these strengths include:

- a) The inclusion of HIV testing as routine for all pregnant women.
- b) A PMTCT Committee overseeing the PMTCT Programme.
- c) A PMTCT Protocol to effectively manage HIV positive pregnant women.
- d) Offering of drug therapy to interrupt HIV transmission from mother to infant.
- e) The provision of adequate staff to support follow-up of mothers and infants.
- f) An organized programme for early detection of HIV in babies.

The Mother to Child Transmission Programme (PMTCT) has progressed significantly over the last four years with 98-100% of pregnant women now accepting PMTCT services during pregnancy¹³.

¹² SVG MOHE. HIV and AIDS National Strategic Plan 2010-2014

¹³Ditto

3.3.3 Condom Distribution

Family Planning services which began as a vertical programme many years ago has been successfully integrated into primary health care. The main objective was to prevent pregnancy and STIs. The National Family Planning programme is the main supplier of contraceptives including condoms.

According to the data on condom distribution for 2007, a total of 305, 879 condoms were distributed. Of these, 297,369 (92.2%) were male condoms and 8,510 (2.8%) were female condoms. The National Family Planning Programme distributed 275,334((90%) of condoms (male and female) and the SVG Planned Parenthood Association distributed 30, 545 (10%). The data revealed a 35% reduction in condom distribution in 2007 when compared with the data of 2006 (472,014)¹⁴.

The data on condom distribution for 2008 realized a total of 352,182. Of these, 348,843 (99%) were male condoms and 3,339(1%) were female condoms. The National Family Planning Programme distributed 217,803 ((62%) of condoms (male and female), the SVG Planned Parenthood Association distributed 26,631 (7%) and HIV/AIDS Alliance distributed 107,748(31%). The cumulative total of condoms distributed from 2004 – 2008 amounted to 1.616140, which is approximately 81% in reaching the 2009 target of 2 million¹⁵. A total of thirty one (31) condom dispensers have been placed in public places¹⁶. Condom provision has placed significant financial burden on the Ministry of Health and the Environment.

¹⁴SVG MOHE. HIV and AIDS National Strategic Plan 2010-2014

¹⁵ Ditto

¹⁶ Ditto

Table 2 Data from the project coordination coordinating unit of the Ministry of Finance and Planning indicated the following expenditure for the period 2005 – 2009

Nos.	Expenditure on Provision & Distribution of Condoms in EC Dollar					
1	Provision & Distribution of Condoms	2005 & 2006	2007	2008	2009	Total as at 30 June
		456,089.00	41,031.00	27,941.00	121,719.00	646,780.00

Notes:

1. The figure for female condoms is included in the figure for the provision and distribution of condoms.
2. The total for the provision and distribution of condoms also includes the following (in EC\$):

- Female Condom (EC \$ 194,498 in 2005/2006 and EC \$ 4,899 in 2007)	199,397.00
- Condom vending machines	57,606.00
- Computer Equipment	7,800.00
- Shelving	8,797.50
- Female demonstration models	<u>22,767.66</u>
	<u>296,368.56</u>

3. The figure for the amount spent on male condoms should therefore be:

EC \$ (646,780 – 296,368.56)	<u>350,411.44</u>
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The HIV programme has also expended funds, amount unknown in the purchase of other contraceptive and STI medications. Figures can be obtained from the Central Medical Stores

3.3.4 Counselling and Testing

Counselling and testing was introduced in SVG in 2001 as an adjunct to the PMCTC programme.

Voluntary Counselling and Testing (VCT)

VCT is one of the main interaction strategy used to control the spread of HIV in St. Vincent and the Grenadines. The programme began in 2003 with the appointment of Counsellors for the specific purpose of reaching HIV infected persons. The programme then intensified in 2007-2008 when it was integrated into the PHC services. This was facilitated by the training of

health care providers in voluntary counselling and rapid testing and later provider initiated counselling.

According to the financial report of the PCU/MOFP the government has at the end of June 2009 spent \$19,814.72 EC on VCT training and \$239,331.04 EC on the purchasing of HIV Test Kits. The focus of this training has been mainly nurses in the community health centres who also have the responsibility for delivering SRH programmes, mainly Maternal and Newborn Care and Family Planning. District Medical Officers who have responsibility for delivering services for STI are still to receive training although some private practitioners and hospital doctors have been trained in PITC.

Provider Initiated Testing and Counselling

This has been recently introduced, whereby individuals attending health centres are offered counselling and either opt to have the rapid test done at the health centre or are referred to the MCMH laboratory for testing.

3.3.5 Laboratory Support/Testing for HIV

Testing for HIV is the prerogative of the three laboratories in SVG, these being the MCMH Laboratory, the Caribbean Reference Laboratory (CRL) and the John's Medical Laboratory. Automated testing for HIV, ELIZA commenced in SVG in 1992, CD4 count analysis commenced at the MCMH laboratory in 2002 while samples are sent to the CAREC for viral load testing. A study on the sero-prevalence for prison inmates was conducted in 2005 and all persons diagnosed with Pulmonary Tuberculosis (PTB) are routinely tested for HIV. Recently nursing personnel have been trained in rapid testing which can be carried out at specific health centres.

3.3.6 Education Programmes

Education programmes for HIV and AIDS were of high priority since the introduction of the disease in SVG. This was seen in the introduction of Peer education programmes to target 'Youths on the block' and taxi drivers. This

continued when community animators introduced a model of Behaviour change Communication (BCC) programme in 2006 to target key populations such as MSM, SW's and PLHIV. A national Communication Strategy to address Behaviour Change was developed and disseminated in 2008.

Several health departments viz Health Promotion Unit, Community Nursing Service, National AIDS Secretariat, Nutrition Programme and School of Nursing have all been involved in imparting information to their staff as well as the public to encourage behaviour modification. The Young Leaders groups from the Ministry Of Education have focused on awareness and training of adolescents. The Health Promotion Unit has maintained HIV as one of its priority areas in its radio and community focused programmes. The Nursing Division of the SVG Community College has added HIV and its prevention and management, to the three major programmes while the Ministry of Education has added HIV issues to its Health and Family Life Education (HFLE) curricula for secondary and tertiary programmes. These curricula reflect the linkage between SRH and HIV.

Whereas previously both HIV and SRH programmes only recognized the disparity in gender with respect to persons accessing services, the NAS Strategic Plan 2010-2014 has as one of its expected results an improved target behaviour change communication programmes to address specified groups including men forty (40) years and over.

3.3.6 Antiretroviral Therapy (ART)

The provision of ART commenced in SVG in the year 2003. The main site for clinical staging is the out patients department at the MCMH. At the end of 2008 there were two hundred and fifty nine (259) persons enrolled in the programme.

3.3.7 Post Exposure Prophylaxis (PEP)

PEP was one of the first HIV service to be introduced in SVG. A treatment protocol for needle sticks and other injuries was developed in 1991 for the MCMH and revised in 2001. This was extended to cover HIV and AIDS.

3.3.8 Stigma and Discrimination

Stigma and Discrimination associated with HIV present a challenge to universal access to HIV prevention, treatment and care services. SVG has taken several steps to address these issues even at the highest level of Government. Several political speeches have been made in support of the call for termination of stigma and discrimination against PLHIV.

A Human Rights Desk was established in January 2007, financed by the Caribbean Coalition of National AIDS Programme Coordinator (CCNAPC), to provide an opportunity for PLHIV to report instances of discrimination. This desk was managed by an individual who is living positively with HIV and who advocated on behalf of that population. The activity was suspended in December 2008. The NAS is presently dialoguing with the Human Rights Association to re activate this activity.

National and regional training in Human Rights matters was organized for the Manager of the Human Rights Desk to enhance knowledge and skills. There was close collaboration and cooperation with the care and treatment centre which allowed for prompt referrals of complaints from clients to the Human Rights Desk.

With the assistance of the Pan Caribbean Partnership against HIV/AIDS (PANCAP), a law, ethics and human rights national assessment was undertaken in the country and two reports were prepared. The first report was a desk review of the laws and policies as they pertain to HIV/AIDS human rights issues. The second report was prepared following community consultations addressing the findings of the legal consultant. There is still much to be done. Departments and agencies addressing legal issues are not very well versed in these issues so they can discuss them with high degrees of confidence. The next steps in the process include discussions with Policy Makers and the Attorney General's Office.

Stigma and discrimination sensitization training sessions were conducted for Health Care Providers and staff of Line Ministries. Additionally, a number of Information, Education and Communication (IEC) activities were implemented to address this problem. These included: distribution of material from the regional 'Ouch' campaign, public sensitizations and

education sessions through radio and television advertisements, carnival mass band and live radio call-in discussions.

Stigma and discrimination was monitored under the HIV/AIDS monitoring and evaluation programme and the Community Outreach Officer/HIV Human Rights Advocate has been given the responsibility to collect, document and forward to the HIV/AIDS Secretariat, monthly data on stigma and discrimination.

The National AIDS Secretariat's Strategic Plan 2004-2009 had as one of its strategic objectives the promotion of advanced programmes to prevent stigma and discrimination. This activity will be scaled up in the 2010-2014 Plan period.

3.3.9 Key Populations

Some emphasis has been placed on addressing the following key populations: men having sex with men (MSM), female sex workers (FSW) and young people. This has been mainly through the effort of CSO's such as Population Services International and the Alliance. The National AIDS Secretariat 2010 – 2014 Strategic Plan advocates a strengthening of the social, legislative and policy issues regarding MSM, SW and Youths, through the establishment of friendly, comprehensive, gender sensitive and targeted prevention programmes. Because of the epidemiological and demographical profile of St. Vincent and the Grenadines little emphasis is being placed on migrants, refugees, displaced populations and injecting drug users (IDU's).

3.3.10. National Plans

As was previously mentioned an updated National AIDS Secretariat Strategic Plan for the period 2010-2014 has already been drafted. This identifies, as one of its strategic objectives, the development of policies, programmes and legislation that promote human rights including gender equity and reduced socio-cultural barriers in order to achieve universal access. It also identifies strategies to establish friendly, comprehensive, gender sensitive and targeted prevention programmes.

The Ministry of Finance and Planning in collaboration with the Ministry of Health and the Environment, is committed to formulating a policy on HIV and AIDS to guide future responses and to conducting research to determine the impact of the disease on the country. The Ministry of Health and the Environment has also decided to integrate clinical services for treatment and care into primary health care with the establishment of three (3) Polyclinics at Stubbs, Marriaqua and Buccament.

4. PROGRAMME ORGANIZATION

For the purpose of this study there were five (5) service providers. Four (4) of these, the National AIDS Secretariat (NAS), National Family Planning Programme, Community Nursing Services and the Milton Cato Memorial Hospital are government funded programmes. The other, the St. Vincent Planned Parenthood Association is a non-governmental organization (NGO), funded by International Planned Parenthood Federation (IPPF), the Ministry of Health and the Environment and Caribbean Family Planning Association (CFPA).

4.1 Partnerships

The programme for sexual and reproductive health is mainly a government programme with international and regional partners such as United Nations Fund for Population Activity (UNFPA), International Planned Parenthood Association (IPPA), Pan American Health Organization (PAHO) and local partnership between National Family Planning Programme, Community Nursing Service, Health Promotion, Milton Cato Memorial Hospital, District Medical Officers, National Aids Secretariat, Ministry of Education and Private Sectors.

St. Vincent and the Grenadines has, over the years, benefited from bilateral, regional and international support and cooperation in the fight against HIV and AIDS. International organizations including UNAIDS, World Health Organization, World Bank, Global Fund, UNFPA and IPPF have assisted in this effort. Regional organizations such as PANCAP, PAHO, CFPA, and Caribbean AIDS Alliance have made invaluable contributions. HIV/AIDS programmers have been trendsetters in ensuring the involvement of other sectors, ministries, CBOs, NGOs, and faith based organizations (FBOs) as well as civil society in the planning and programming for services.

Several groups are involved in outreach programmes for PLHIV. The SVG Alliance, SVG Plus, House of Hope and Care SVG are all partners of the HIV national programme. The extent to which their objectives are being achieved will have to be evaluated in the future.

4.2 Planning, Management and Organization

Planning, management and organization for SRH is not conducted at the strategic level. However, several of the Ministry of Health and the Environment programmes, mainly the National Family Planning Programme, the Community Nursing Service, the Milton Cato Memorial Hospital and the Health Promotion Unit all programme for SRH at the operational level.

As identified previously there is a national programme for the prevention and management of HIV. This programme operates as a vertical one with respect to planning, programming, budgetary allocations and monitoring and evaluation. With respect to implementation there are linkages as most of the services offered, viz condom provision and Voluntary Counselling and Testing (VCT), are threaded through SRH services in the primary health care system.

When asked if there is joint planning of HIV and SRH programmes, four programmes heads responded in the affirmative. One indicated that this task could be improved. Joint planning, it was felt, is only undertaken based on the goals or issues under discussion. In the development of the National Strategic plan for HIV and AIDS there was much collaboration including several departments. Collaboration occurs between the National AIDS Secretariat (NAS) and FPP in support of dual protection in condom provision.

There is inter-sectoral and inter-ministerial collaboration in preparation of the IPRSP and the MTESP. Planning at the operational level for programmes both SRH and HIV still however operate along vertical lines. There has been more inter-sectoral and intra-sectoral planning within the HIV/AIDS programme involving SRH personnel than vice-versa.

Collaboration between SRH and HIV programme managers and implementers has been limited and involves mainly coordination of activities and request for provision of services and supplies.

4.3 Staffing, Human Resources and Capacity Building

St Vincent and the Grenadines like most of its counterparts in the OECS suffers from a shortage of experienced staff to plan, programme and evaluate health programmes. Most of the available staff is engaged in the delivery of services. The sexual and reproductive health services are delivered by the staff of the primary health care services and secondary health care services where applicable. Although in-service training is ongoing and had included sexual and reproductive health and HIV issues, the high turnover of staff affects the continuity of these services. Health care providers are still even now requesting training in Rapid Testing, Voluntary Counselling and Testing, Behaviour Change Modification and Management and care of PLHIV.

TABLE 3. HEALTH WORKERS' CAPACITY TO PERFORM SRH AND HIV FUNCTIONS

CADRE OF HEALTH STAFF	NUMBER AVAILABLE			NUMBER AND % TRAINED IN SRH BY SKILLS								NUMBER AND % TRAINED IN HIV BY SKILLS					NO. &% TRAINED IN BOTH SRH AND HIV
	Hos	H C	Tot	1	2	3	4	5	6	7	8	9	10	11	12	13	
Physicians			101										41			5	
Registered Nurses			228									82	76	28	-	16	
Midwives																	
Administrative Staff																	
Health Educators			7														
Psychologists			1										10	5			
Sociologists																	
Counsellors			5														
Nutrition Officers			12														
Pharmacists & Pharmacist Asst.			36													21	
Lab Tech & Lab Asst.			13										3	3			
Nurse Assts / NA/PHN			239										19	1			
Peer Educators													4				
Community-Based Distribution Agent/CHWs													6	.			

1. Counselling (specify type, e.g. family planning, sexuality, etc.)	8. Gender-based violence counselling and related services	CHW - Community Health Workers
2. Family Planning methods (specify type)	9. HIV Prevention counselling	Tot - Total
3. Life-Saving skills and Emergency Obstetric Care	10. HIV pre and post-test counselling	H/Asst - Health Assistants
4. Adolescent/youth-friendly health services (AFHS)	11. HIV testing	HC - Health centre
5. STI syndromic management	12. PMTCT	Hosp. - Hospital
6. Antenatal care, labour and delivery	13. Antiretroviral provision	Lab Tech & Lab Asst. - Laboratory Technician and Assistants
7. STI Prevention Counselling	14. Condom provision	NA - Nursing Aides
	HC Health Centre	PHN - Primary Health Nurse

4.4 Monitoring and Evaluation (M & E)

The HIV programme has a built in mechanism for monitoring and evaluation. This commenced in mid 2005 and lasted until mid 2009. The monitoring and evaluation officer had to undertake several tasks in the design and implementation of the system. Some of these were as follows:

- a) The development of a monitoring and evaluation framework to include agreed targets for indicators and methods of data collection.
- b) The training of staff to utilize the system and to contribute to its upkeep.
- c) The development of a data base to organize and manage monitoring and evaluation data.
- d) The formation of a monitoring and evaluation reference group (MERG) to provide advice and approaches in monitoring and evaluation.

Despite the challenges faced, the monitoring and evaluation system achieved the desired results as stated in the relevant reports. A significant milestone was the completion of a National HIV/AIDS Monitoring and Evaluation Plan which has been designed to complement the HIV/AIDS Strategic Plan 2010-2014. The responsibility for Monitoring and Evaluation of HIV services will from henceforth lie with the Epidemiology unit within the MOHE.

5. ANALYSIS OF DATA

5.1 Clinical Care Delivery Services

Interviews were conducted at eight (8) clinical service delivery sites, seven (7) at health centres and one (1) at the Out-patient Department at the Milton Cato Memorial Hospital. This was done to determine the linkages between SRH and HIV services offered. Seven (7) of these service areas, representing all health centres offered services in FP, Maternal and Newborn care and prevention and management of STI's. Three (3) interviewees cited offering interventions including referrals for prevention of unsafe abortion and post abortion care. Prevention and management of gender-based violence was not offered at any of the facilities.

5.1.1 HIV Services Integrated into SRH Programmes

Table 4: Number of SRH sites offering HIV services

HIV SERVICES	NUMBERS	PERCENTAGE %
HIV Counselling and Testing	8	100 %
VCT	8	100 %
Provider Initiated	5	62.5 %
Prophylaxis	3	37.5 %
Home based care	3	37.5 %
Psychosocial Support	6	75 %
Comprehensive Prevention	6	75 %
HIV Prevention	8	100 %
Condom Provision	8	100 %
PMTCT	8	100 %

With respect to PMTCT four (4) prongs, whereas prong one (1) is being offered at all facilities, Prong two (2), three (3) and four (4) are not integrated at some health centres.

5.1.2 Family Planning Services

Family Planning Services are offered daily at all health centres through the state. HIV voluntary counselling and testing services for the general population are offered at all sites sampled. Voluntary counselling is provided at all sites but provider initiated testing is carried out in four (4) 50% of sites. HIV Prevention information and condom provision are integrated in all health centres included in the study. Five (5) facilities offer PMTCT (four prongs) and psychosocial support are offered at four (4), 50% of these facilities while three (3) 38% offer home based care and comprehensive primary and secondary prevention for and by people living with HIV (PLHIV). Only two (2) 25% facilities offer prophylaxis and treatment for HIV, two (2) service areas cited adolescents groups as key population.

Seven (7) 88% of the facilities are health centres offering family planning to include HIV. Services are offered in the same service site with the same provider on the same day. Only one (1) facility refers clients to a different provider within the same facility.

5.1.3 Prevention and Management of STI Services

Prevention and Management of STI services are offered at (100%) health care facilities included in the study. Within these services HIV prevention information and services for general population and condom provision are provided at all facilities. HIV counselling and testing are offered at seven (7) of the sites. VCT and provider initiated counselling are being offered in seven (7) 88% of the eight (8) 100% sites. Five (5) 63% of the health centres included the four (4) prongs method of PMTCT in their STI services. Four (4) 50% sites provide comprehensive primary and secondary prevention and home based care as caring interventions while three (3) 38% offer prophylaxis and treatment to HIV clients. Only (2) 25% sites indicated that they have so far offered psychosocial support. There is no emphasis on key populations and groups within the prevention and management of STI services.

Prevention and management of STI services including HIV services are offered at all health centres by the same provider on the same day. Clients may be referred to another provider on a different day. In cases where

services requested are not available persons are referred to another facility (Milton Cato Memorial Hospital, (MCMH)).

5.1.4 Maternal and Newborn Services

Seven (7) 88% of the eight (8) facilities, i.e. all health centres offer services in Maternal and newborn Care. All seven (7) 100% facilities offer both VCT and provide initiated testing and counselling, HIV prevention information and services for the general population and condom provision. Five (5) 71.4% offer PMTCT four prongs, home based care and prophylaxis and treatment for HIV.

All facilities offer psychosocial support and comprehensive and primary and secondary prevention for and by people living with HIV in the maternal and new born care services. The focus on key population with respect to HIV in the maternal and new born care programme is pregnant women. Maternal and New born care services including HIV, are offered in the same service site by the same provider on the same day at all Health Centres. Clients requiring testing are referred to Milton Cato Memorial Hospital (MCMH) laboratory services in keeping with established protocol.

5.1.5 Prevention and Management of Gender Based Violence

There is no organised service for the prevention and management of gender-based violence in the health centres or in our social welfare services. The agency which offer service for gender based violence is the Family Court which deals primarily with offenders. Health care providers at three (3) 38% facilities indicated having dealt with individual issues of gender based violence and offering appropriate interventions/solutions such as Information Education Counselling (IEC) and psychosocial support. These are offered by the same provider on the same day. Clients requiring additional support are referred to the appropriate agency.

5.1.6 Prevention of Unsafe Abortion and Post Abortion Care Services

Only one (1) 13 % health care facility was involved in the prevention of unsafe abortion and post abortion care services, and offered HIV/AIDS information as one of their interventions.

5.1.7 Referrals

All facilities have mechanisms in place to assess whether clients act on referrals. The methods used are telephone calls, home visits and the appointment system.

5.1.8 Reorientation of Services

The advent of HIV has led to the re-orientation of SRH services in order to accommodate clients living with HIV or vulnerable to HIV. Health Centres have been refurbished to include rooms for VCT. The personnel delivering SRH services have been trained to deliver HIV services. Equipment and supplies to include condoms and test kits have been supplied in greater quantities. According to the sample there is no structural collaboration (formal arrangement) between SRH services and community based HIV organizations.

5.2 SRH Services Integrated Into HIV Programmes

The organized HIV services offered at district health centres are VCT, condom provision, Prevention of Mother to Child Transmission (PMTCT) and HIV prevention and information. All of the health centres in the sample have initiated these services, fifty percent (50%) of them have designated clinic sessions while the others have a walk-in policy. The services are offered by the same provider within the same facility on the same day. Several clients, however, request referral to another facility (MCMH) for testing. Condom provision, while originally an SRH initiative now serves for dual protection and is offered at all sites.

While there are no other organized services, respondents indicated that HIV clients are included in their clientele for all available services at health centres and during home visits. They also indicated that in their quest to provide comprehensive primary and secondary prevention and support, they refer clients to district medical officers, specialist clinics, laboratory services, nutrition support services and social services.

When questioned on the provision of SRH services within the HIV prevention and information services for the general population seven (7) 88% of respondents indicated that there was an abundance of resources in the form of television programmes, videos, pamphlets and leaflets with respect to HIV and AIDS and that these included information on SRH issues. They indicated that this information was located in the same service site with the same provider on the same day. Fifty percent (50%) of them indicated the involvement of different providers in the dissemination of this information. Three (3) 38% indicated that clients were also referred to different facilities for additional information.

There is full integration of PMTCT into SRH services at all sampled sites. To the extent that HIV services are integrated into SRH services and vice versa there are guidelines facilitating different aspects of care.

National

- Family Health Manual, Ministry of Health and the environment - 2002
- HIV Voluntary Counselling and Testing (SVG) Ministry of Health & the Environment July 2005
- Care and Treatment Protocol.

Regional

- Family Health Strategy for the Caribbean Community PAHO - 2003
- Promoting Healthy Sexual Behaviour Among Young People in the Caribbean – July 2009
- Advancing the Agenda for Adolescent Health and Development – 4 step Strategy - WHO/PAHO et al – Barbados 2007
- PANCAP Against HIV/AIDS Regional Model Condom Policy – June 2008

Six (6) 75% of the eight sites visited indicated evidence of protocol/guidelines to support integrated service delivery. The documents available were the VCT Manual and the Family Planning Protocol.

5.3 Linkages in HIV and SRH Services

In assessing the linkages between SRH and HIV services the group felt that the most important policies and procedures facilitating linkages were:

1. The existence of strong, well established SRH services viz Maternal and Newborn Care, provision of condoms and other contraceptives and an integrated management of STI's service into primary health care services. The availability of these offered easier integration of HIV services into SRH services.
2. The policy guidelines of routine HIV testing of all pregnant women attending government health care institutions ensured a more effective PMTCT programme.
3. The training of health care providers, mainly those working in sexual and reproductive health programmes, for the delivery of HIV services including voluntary counselling and testing allowed for greater integration of both services.
4. The production and dissemination of the appropriate manuals enhanced care geared to support these linkages.
5. Referrals between SRH services and HIV services were also seen as methods of providing linkages between the programmes.

When asked to rate the extent of following constraints the respondents indicated the following:

Table 5: Constraints to Supporting Linkages between HIV and SRH

#	Constraints	No constraint	Small	Medium	Large
1	Shortage of Equipment for offering Integrated services	2 25%	1 13%	3 38%	2 25%
2	Shortage of space for offering private and confidential services	3 38%	0	2 25%	3 38%
3	Shortage of staff time	2	0	1	5

		25%		13%	63%
4	Shortage of Staff Training	2 25%	2 25%	2 25%	1 13%
5	Inappropriate / Insufficient staff supervision	4 50%	2 25%	0	2 25%
6	Low Staff Motivation	6 75%	2 25%	0	0

When questioned about policies and procedures that felt were challenges and constraints to strengthening linkages between SRH and HIV services respondents cited the following:

- Late receipt of HIV supplies-2 persons
- Stigma related to a dedicated site to VCT
- The absence of a comprehensive manual for sexual and reproductive health
- Absence of partner tracing-2 persons
- Heavy workload of health care providers
- Lack of confidentiality on the part of health care providers
- Lack of privacy
- Inadequate knowledge and skills

With respect to the likely impact of linking SRH and HIV services all respondents (100%) agreed that work load for providers and time spent per clients will increase. Seven (7) 88% saw increases in the cost of services at the facility level, the efficiency of services delivered, available space for delivery of services including privacy and the need for more equipment, supplies and drugs. Three (3) 38% respondents stated that there would be no change in the cost of services to clients while another three (3) 38% stated that these would increase. While five (5) 63% of respondents indicated that linking HIV and SRH services would likely decrease stigmatization of HIV clients, 37.5% indicated that this would likely decrease stigmatization of SRH clients. Only (1) 13% respondent saw this initiative as being likely to increase stigmatization with respect to both HIV and SRH clients.

5.4 Utilization of Services

Forty six (46) client interviews were conducted. The interviews were conducted in eight (8) of the nine (9) health districts. Clients were interviewed as they exited services. Twenty three (23) exited maternal and newborn care, fourteen (14) family planning, five (5) management of opportunistic or HIV infection, four (4) each from management of STI's and HIV counselling and testing. Three (3) exited from other , one (1) from Hep B vaccination, one (1) from pap smear and one (1) from District Medical Officer (DMO) clinic. Three clients did not know from which service they were exiting. Thirty six (36)/78% females and ten (10)/22% males were interviewed. The ages of clients interviewed are shown in the following table:

Table 6: Number of Clients interviewed, by Age Groups.

AGE GROUPS	NUMBERS
60+	0
50-59	3
40-49	7
30-39	7
20-29	22
Under 20	7
TOTAL	46

The clients visited the health centres for various services. Several clients requested multiple services.

Table 7: Services Requested By Clients.

N0	Services Requested	Number of Clients	Percentage
1	Maternal and Newborn Care	23	27.4
2	Family Planning	14	16.7
3	Routine Gynaecological Examination (Breast exam, Pap Smear, etc)	8	9.5
4	HIV Monitoring and Treatment	7	8.3
5	HIV Prevention	6	7.1
6	Condom Services	6	7.1
7	Nutrition Support	5	6
8	Prevention and Management of STI	5	6
9	HIV Counselling and Testing	4	4.7
10	Economic Assistance	2	2.4
11	Other	4	4.7
Total			100

Of the four (4) others, one (1) was requesting psychosocial support, one (1) PMTCT, one (1) Hepatitis B vaccine and one (1) investigation for fibroids. The majority of clients were requesting maternal and newborn care and family planning services. Services for prevention and management of gender based violence and prevention of unsafe abortion and post abortion care and treatment preparedness were not requested at any of the facilities.

Table 8: Services Received by Number of Clients

N0	Services Received	Number of Clients	Percentage
1	Maternal and Newborn Care	20	22
2	Family Planning	16	17.6
3	Routine Gynaecological Examination (Breast exam, Pap Smear, etc)	13	14.3
4	Condom Services	11	12.1
5	Nutrition Support	7	7.7
6	HIV Prevention	6	6.6
7	Prevention and Management of STI	5	5.5
8	HIV Counselling and Testing	4	4.4
9	HIV Monitoring and/or Treatment	4	4.4
10	Treatment Preparedness	2	2.2
11	Psycho-social Support	1	1.1
12	Other	2	2.2
Total		91	100

The two (2) “Other” received services for laboratory investigation and Hepatitis B vaccine.

Twelve (12) 26% clients were referred to other services than those that they were requesting. Thirty-four (34) 74% clients were not referred.

Thirty-nine (39) 85% clients indicated that they received service as requested while seven (7) 15% did not. Five (5) clients wanted services in HIV testing. One (1) was seeking nutritional support and ultra sound, while the other was requesting services for HIV monitoring and treatment, economic assistance and psychosocial support. The reasons cited by four (4) clients for not receiving the services, was the absence of trained health care personnel. The other persons did not feel comfortable requesting the service. Two (2) clients refused to answer.

Forty three (43) 93% of the clients interviewed preferred services for sexual and reproductive health and HIV at the same facility. Only two (2) preferred that they be offered at different facilities and one did not respond.

The reasons cited by clients for their preferences for having both services at the same facility were:

- | | | |
|---------------------------|---|----|
| 1. Confidence in staff | - | 22 |
| 2. Convenient | - | 11 |
| 3. Reduces discrimination | - | 6 |
| 4. Cost effective | - | 4 |
| 5. Limited crowd | - | 2 |
| 6. Allows for flexibility | - | 1 |

Some of the possible benefits of receiving multiple services from the same facility as cited by interviewees were:

- | | | |
|--|---|----|
| - Reduced transportation cost | - | 32 |
| - Good opportunity to access additional services | - | 22 |
| - Reduced number of trips to facility | - | 19 |
| - Reduced stigma for HIV | - | 9 |
| - Reduced waiting time | - | 8 |
| - Improved efficiency of services | - | 6 |

Some of the possible disadvantages of receiving multiple services at the same facility were:

- | | | |
|--|---|----|
| - Fear of less confidentiality | - | 24 |
| - Fear of stigma and discrimination | - | 17 |
| - Embarrassment to talk about HIV with providers in same village/neighbourhood | - | 15 |
| - Increase client waiting time | - | 11 |
| - Provider will be too busy | - | 5 |
| - Decrease quality of services | - | 2 |
| - Don't know | - | 3 |
| - None | - | 10 |

Thirty-eight (38) 82.6% clients preferred sexual and reproductive health and HIV services from the same provider. These persons cited confidence in the

staff, privacy and accountability for services as the main reason. Seven (7) clients preferred referral to another provider, one (1) client cited confidentiality, two (2) clients cited privacy, two (2) clients felt that it would be too heavy a workload on providers, and two (2) felt that it would allow for a more efficient system in that one thought that it would save time and the other (1) felt that it would allow for better record keeping.

The possible benefits of receiving all services from the same provider at the same time were cited by the clients as:

- Good opportunity to access additional services - 23
- Improvement of efficiency of services - 18
- Reduction in the number of trips to facility - 17
- Reduction of transportation costs - 17
- Reduction in waiting time - 9
- Reduction in fees - 4
- Reduction in HIV related stigma - 4
- Don't know - 2

The possible disadvantages of receiving all the services from the same facility at one time as indicated by the client were:

- Fear of less confidentiality - 24
- Embarrassed to talk about HIV with provider in same village / neighbourhood. - 15
- Increased client waiting time - 12
- Fear of stigma and discrimination - 12
- Provider will be too busy - 8
- Don't know - 6
- Decreased quality of services - 4
- None - 3

During delivery of services provider used the opportunity to discuss several services. Those services mentioned by the providers as stated by respondents were:

- Family Planning	-	21
- Use of condoms to prevent HIV/STI	-	19
- HIV Prevention	-	13
- Cervical Cancer screening	-	13
- Vaccination	-	13
- Use of condoms to prevent unwanted pregnancy	-	12
- Child Health Services	-	12
- Use of Female Condoms	-	9
- Counselling and Testing of HIV	-	9
- STI management	-	7
- Labour and Delivery	-	7
- Breast Cancer Screening	-	7
- Relationships	-	5
- HIV is treatable with ART	-	4
- Antenatal Services	-	4
- Care and support of PLHIV	-	3
- Sexuality	-	3
- Preventing Transmission of HIV to your baby	-	2
- Diabetic Counselling	-	2
- Care of Pregnant woman	-	1
- Breech Pregnancy	-	1
- Post Natal	-	1

When asked for suggestions about the integration of sexual and reproductive health and HIV services, eight (8) clients felt that services were already integrated, six (6) clients did not respond, eighteen (18) said they had no suggestions. Suggestions emanating from the other fourteen (14) clients were:

The need for community Education in the form of:

- Workshop and distribution of leaflets	-	5
- More information on HIV and AIDS	-	3
- Continuing Education of Nurses	-	1
- Dedication of a day to deal with integrated services	-	1
- Availability of a doctor for HIV testing	-	1
- Include more information on men's health	-	1
- Services should be kept separate	-	3
- Stress condom usage	-	1

When asked for suggestions for improving services at their facility, clients responded as follows:

- Provide resident nursing staff - 4
- Provide more nursing staff - 3
- Provide equipment for emergency procedures - 4
- Improve client facility by making rooms larger - 3
- More seating accommodation - 2
- Provide more staff - 2
- Offer prompt services - 1
- Ensure more privacy - 1
- Increase variety of condoms - 1
- Offer HIV medication - 1
- Provide a television for teaching sessions - 1
- Introduce an appointment and numbering system - 1
- Trained health care workers - 1
- Provide daily medical services - 1

When asked how satisfied with the services received on that day, thirty-six (36) 78% of the clients were very satisfied, six (6) 13% were mostly satisfied, three (3) 6.5% were somewhat dissatisfied and one (1) did not wish to answer.

Reasons cited for their dissatisfaction were:

- The need to have HIV/AIDS test done - 2
- Need for more information - 2
- Lack of privacy - 2
- Unavailability of medication - 1
- Unavailability of specific health care provider - 2
- Quantity and quality of condom - 1

6. CONCLUSIONS

It is a well known fact that for as many answers as research provides it raises the equivalent number of queries. Nevertheless some conclusions are more definitive in their findings while others imply and assume inferences. With respect to this the following conclusions have been made.

The government of St. Vincent and the Grenadines has no formulated policy to guide the services of either SRH or HIV. However, the government has implemented aggressive programmes for both these areas. These have been supported in their endeavours by many local, regional and international partners.

The sexual and reproductive health services are being offered in several of the Ministry of Health and the Environment health programmes at both the primary and secondary health levels. Sexual and reproductive health services offered are mainly family planning, prevention and management of sexually transmitted infections, maternal and newborn services and referrals. The prevention and management of gender-based violence and the prevention of abortion and post abortion care services are not organized services offered in the primary health care programme.

The existence of a well established Primary Health Care Programme offering SRH services allow for easier integration of HIV services into SRH programming. Primary health care services are offered to all age groups and gender but age specific services have been organized and time tabled. These services, however, are utilized by more females than males.

Programming for HIV was introduced in St. Vincent and the Grenadines in a vertical manner but is now being integrated into primary health care services. The inclusion of routine HIV testing of all pregnant women can be seen as a best practice in ensuring effective PMTCT. The production of manuals/protocols coupled with the training of staff and an established system of referrals allow for more integration of services.

HIV interventions/services have been introduced and integrated into sexual and reproductive health services at the primary health care level for all services but this is more evident in voluntary counselling and testing, condom distribution, prevention of mother to child transmission and HIV prevention.

Testing for HIV is done primarily at the three local laboratories. Rapid testing, which had been done mainly at the Maternity Unit of the MCMH, is being introduced at district health centres.

Integration of most at risk populations (MARPs) into main stream programmes for SRH and HIV is still a huge challenge.

The strong aspects of the linkages of HIV into SRH programme are in the area of HIV counselling and testing, mainly VCT, HIV prevention programmes condom provision and PMTCT. Comprehensive prevention, psychosocial support, and provider initiated counselling need strengthening. Primary health care services have been deficient in providing prophylaxis for HIV home based care.

The strongest linkages of HIV into SRH programming can be found in the maternal and newborn programme.

Most persons (78%) exiting the programme were satisfied with the services they received. It is important to note that the five (5) of seven (7) persons who did not receive services were requiring HIV testing, and that 93% of the clients would have preferred a “One stop” facility. The main reasons were that it would reduce transportation costs, allow for the opportunity to access additional services, confidence in staff, it would be convenient and would reduce the number of trips to the facility.

The main disadvantages of a “One stop” facility were seen as fear of less confidentiality, fear of increased stigma and discrimination and embarrassment on the part of the clients.

Eighty three percent (83%) of the clients preferred services for SRH and HIV to be done by the same provider. Indeed 17% of the clients felt that these services were already integrated and 30% offered positive suggestions for integration.

This study explored the policy issues, programme planning and implementation strategies used to deliver SRH and HIV services. The purpose being, to identify the linkages where possible between these services. The study revealed that in ST. Vincent and the Grenadines HIV services are being integrated into SRH services.

The integration of services however is not without its challenges; shortage of staff and space for offering services were seen as the main constraint. Most respondents felt, however, that if these services were combined the cost of services and the workload would increase.

7. RECOMMENDATIONS

The following recommendations are offered to strengthen the linkages between HIV and SRH services in St. Vincent and the Grenadines.

1. Policy makers should stress the relatedness between SRH and HIV. The policy document to be prepared by the MOHE should address SRH including the integration of HIV services. The Strategic Plan should therefore address the wider issue, SRH, and should span a period of ten years. This will offer opportunities for the inclusion of a wider range of services and allow HIV to become more accepted as a condition within SRH, thus lessening stigma and discrimination. This emphasis stressing the linkages between these two components should begin at the macro level (MOFP) be included in all relevant policy documents including the MTESP 2010-2012 and the PRSP soon to be launched.
2. Programme planning at the corporate level should be more consultative and bi-directional and include all stakeholders with vested interests in SRH and HIV.
3. The MOHE should seek to combine budgetary resources into one programme for Sexual and Reproductive Health to encompass HIV. Every effort should be made to maximise cost efficiency and cost effectiveness.
4. Government continues with its plan to decentralize Care and Support of PLHIV with the establishment of the three polyclinics as “one stop” facilities for primary health care services to include SRH and HIV services.
5. A vibrant sensitization programme be launched emphasising the benefits of having “one stop” services for Primary health care delivery while de-emphasising HIV to prevent stigma and discrimination.
6. The MOHE seek to re-organise and re-orient services for SRH to include services for the prevention and management of gender based violence and the prevention of unsafe abortion and post abortion care.

7. Continued emphasis be placed on reaching Most at Risk Populations particularly MSM, FSW and PLHIV, and addressing their sexual and reproductive health needs. This will necessitate the development of charters, standards, protocols, checklists and the concerted strengthening of partnerships and therapeutic relationships. The time has come to introduce Contact Tracing and Partner Notification in the Public health system for all communicable diseases
8. Health care providers seek innovative ways to actively involve the “Male Population” in programmes for SRH including HIV.
9. Attention be given to the delineation of the legal aspects affecting and affected by SRH and HIV issues. Once this is addressed, the Ministry of Health and the Environment (MOE) should seek to institute an in-service programme focussing on Medico- Legal-Ethical issues for health care providers.
10. Efforts continue with respect to the reduction of stigma and discrimination and to greater involvement of people living with HIV/AIDS into mainstream society.
11. The full range of services encompassing SRH and HIV services be offered through the development of, modification where necessary and the utilization of the appropriate manuals all linked to a monitoring and evaluation System.
12. The reach of educational programmes, are made extensive to involve health care providers other stakeholders as well as all members of the population.

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