

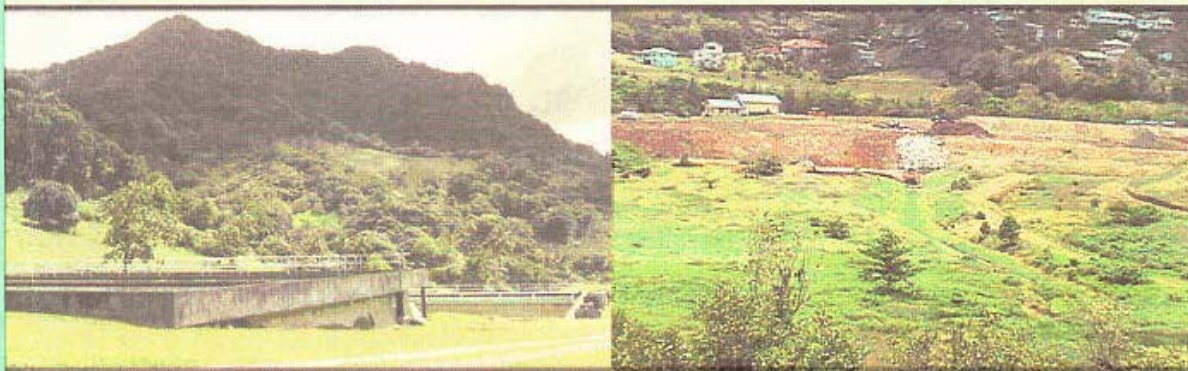
***A HEALTHY VINCENTIAN
IS A WEALTHY VINCENTIAN***

STRATEGIC PLAN FOR HEALTH

2007 - 2012



St. Vincent & the Grenadines



Prepared by:
Ministry of Health and the Environment
May 2007

ACKNOWLEDGEMENT:

This **National Strategic Health Plan 2007-2012** was made possible through the collective efforts of many persons, whose contributions are most appreciated.

- The many health care workers, who developed the system, facilitated them and delivered the care over the years thus achieving the results.
- The persons who recorded, entered, retrieved, analysed or disseminated data or information.
- The many persons who attended the consultations and workshops and gave of their time and expertise.
- The technical working team who worked diligently to produce, edit and complete this document.
- The clerks and typists who painstakingly corrected and modified several copies over an extended period of time to ensure a high quality product.
- The Pan American Health Organisation (PAHO) who partnered with us.
- To all who would have assisted in one way or another.

A HEARTY THANK YOU!

| TABLE OF CONTENTS | PAGES |
|--|--------------|
| <i>Minister of Health Message</i> | 4 |
| <i>Chief Medical Officer Message</i> | 5 |
| <i>Executive Summary</i> | 6 |
| <i>List of Figures</i> | 7 |
| <i>List of Tables</i> | 7 |
| <i>List of Abbreviations</i> | 8 |
| | |
| Chapter 1: THE CONTEXTUAL FRAMEWORK | 10-18 |
| ▪ Introduction | 10 |
| ▪ Determinants of Health | 12 |
| | |
| Chapter 2: SITUATIONAL ANALYSIS | 19-39 |
| ▪ Mortality Profile | 19 |
| ▪ Morbidity Profile | 21 |
| ▪ Family Health | 29 |
| ▪ Mental Health | 34 |
| ▪ Environmental Services | 36 |
| ▪ Institutional Capacity | 37 |
| | |
| Chapter 3: OVERVIEW OF HEALTH SERVICE | 40-49 |
| ▪ Organisation of Services | 40 |
| ▪ Primary Health Care | 40 |
| ▪ Secondary Services | 43 |
| ▪ Human Resources | 48 |
| | |
| Chapter 4: STRATEGIC DIRECTIONS | 52-77 |
| ▪ Log Frame 2007-2012 | 52 |
| ▪ Programme Indicators Strategies | 58 |
| | |
| APPENDICES | 78-79 |
| 1. Matrix showing collaboration of stakeholders in planning process | 78 |
| 2. Map of St. Vincent and the Grenadines depicting location of Health Facilities | 79 |
| | |
| REFERENCES | 80 |

MINISTER OF HEALTH AND THE ENVIRONMENT (MOHE)

MESSAGE:

As our nation moves into the new millennium, the delivery of an appropriate quality of health care remains a priority of our Government, in order to deliver on a continued basis to meet the challenges of ongoing disease conditions such as Chronic Non-Communicable Diseases and probably more so the new emerging ones such as AIDS, Avian Flu, SARS and others.

These challenges are compounded by the sometimes-daunting task of effectively financing health care in an environment of ever increasing expectations, demands and the spiraling cost of the various components of the health care industry.

In St. Vincent and the Grenadines we are fortunate to have a solid team of dedicated health care workers and administrators who have surmounted many of the challenges despite our many inherent limitations. We have been able to maintain health indices that are exemplary and comparable with societies endowed with more resources than us. We must try our utmost to continue with this trend and to always strive for excellence.

The various stakeholders such as the State, NGOs, CBOs, Private Sector and the citizenry in general need to be full participants in the process. The Government is fully supportive of all efforts to develop and maintain the highest standard of health care possible.

I sincerely thank all those involved in developing this National Strategic Health Plan and pledge my personal and Government's support to facilitate its implementation.

.....
Hon. Dr. Douglas Slater

CHIEF MEDICAL OFFICER OF HEALTH (CMO)

MESSAGE:

I am delighted that we have accomplished the production of the National Strategic Health Plan 2007-2012. Thanks indeed to all the members of the hard working team who laboured dedicatedly to produce this important document.

The plan is a comprehensive one. I am confident that once the necessary resources both human and financial are committed, the strategies and activities outlined in the plan will augur well toward the realization of health for all our people. There is much here to be accomplished, I believe by the grace of God that we will realise our dreams of healthy living for all our citizens.

T.S Elliot once wrote:-

“Where is the life we have lost in living?

Where is the wisdom we have lost in knowledge?

Where is the knowledge we have lost in information?

And Harland Cleveland asked: “Where is the information we have lost in data?”

In formulating this Strategic Health Plan 2007-2012, we have gathered the necessary data and arranged them with relevance and structure to produce the pertinent information. It is my hope that the human mind will internalize and integrate this information into knowledge and that the wisdom derived from knowledge refined will form the basis for our actions in relation to health and healthy living.

As Chief Medical Officer of Health, I commend this Strategic Health Plan 2007-2012, to the government and people of our wonderful nation of St. Vincent and the Grenadines.

.....
Dr. St. Clair Thomas

EXECUTIVE SUMMARY:

The vision of the health sector is “to have a healthy population living in environmentally sound communities empowered with a holistic knowledge of health, developmental and environmental issues.” To achieve any vision there must be strategic planning; which embodies a sense of purpose and direction and encompasses the ideals and belief of a people as a collective entity. The goal of this National Strategic Health Plan 2007-2012 is to improve the health status of the people of St. Vincent and the Grenadines. This can be achieved through the development of an efficient, equitable, effective and sustainable quality oriented health system that seeks to enable people to live richer, healthier and more productive lives.

St. Vincent and the Grenadines has made noteworthy achievements in the health status of its population over the past twenty years. The Infant Mortality Rate is now 18.1 per 1000 live births, Immunization against selected childhood diseases is 100%, the Fertility Rate now stands at 2.4 and the average Life expectancy rate is 74.4. Notwithstanding these, the challenges faced by the lifestyle diseases including Non-communicable diseases and HIV/AIDS, place considerable cost burdens on individuals, families and communities, necessitating critical decision-making.

The plan was developed based on consultations with other government departments, Statutory Corporations as well as the private sector including non- governmental, faith based and community based organizations. The Ministry of Health and the Environment is the lead executor of the plan but relies on the collaborative effort of all stakeholders, especially as the role of the MOH will change significantly over the planned period. The Plan encapsulates the hopes and aspirations of the people and is divided into three chapters; chapter one outlines the contextual situation in which health care is provided, chapter two describes the health status of the country, while chapter three gives an overview of the organization of health services within the state.

The Log Frame is used to highlight the Strategic Direction of health services development over the next five years. These directions are; 1) the strengthening of the health information system and the organization and management of human resource for health, 2) The promotion and improvement of prevention and management strategies of chronic disease and other priority health needs, 3) the articulation of policies to promote universal coverage, equity and sustainability of the health system, and 4) the strengthening of the steering role of the Ministry of Health and the Environment. To complement the strategic directions a number of indicators and programme strategies have been included to guide operational planning. Appendices, including a map of St. Vincent and the Grenadines depicting the location of health facilities, a matrix showing collaborating partners and a list of references, complete the document.

LIST OF FIGURES

1. A Multicausal Concept of Health
2. Population by age group and sex 2001
3. Population by Age Group and Sex 1991.
4. Distribution of Deaths by Communicable and Non- Communicable Diseases 2004.
5. Infant Mortality Rate per 1000 Live Births- 1995 – 2004
6. Leading Health Conditions Reported in 2003-2004.
7. Diabetic Visits to Public Health Care Services 1999 – 2004
8. HIV/AIDS Cases and Deaths in St Vincent & the Grenadines 1984 – 2004
9. HIV Cases by Age Groups and Sex 1984 – 2004
10. AIDS Cases by Age Groups and Sex 1984 – 2004
11. HIV Cases by Transmission Categories 1984 – 2004
12. Summary of Health Issues in SVG 2004.

LIST OF TABLES

1. Ten Principal Causes of Death in Rank Order 1999 – 2003
2. Infants Death and Infant Mortality Rate 1995 – 2004
3. Ten Leading Health Conditions 2003 – 2004
4. Number of Communicable Diseases 2000 – 2003
5. Reported Cases of Acute Respiratory Infections (ARI) 1999 – 2003
6. Reported Cases of Gastro-enteritis 1999 – 2002
7. Immunization Status at age group 0 – 5 years 1999 – 2003
8. Nutritional Status of Children under 5 years, 2001- 2002
9. Contraceptives Distribution by Year and Cost 2000 – 2004
10. Deaths from Prostate Cancer 1996 – 2002
11. Population 50 years and over by Sex and percentage, 2001 Census
12. Admissions to the Mental Health Centre 2002 – 2004
13. Common Mental Health Disorders 2002 – 2004
14. Essential Public Health Functions
15. Health Districts by Health Centres and population
16. Priority Conditions seen at Accident and Emergency Unit, MCMH 2000 – 2004
17. Vital Indicators at MCMH 2000 – 2004
18. Budgetary Allocation for the MOHE 2000 – 2004
19. Health Professions by Discipline, Numbers and percentage population

ABBREVIATIONS

| | | |
|-------|---|---|
| SVG | - | St. Vincent and the Grenadines |
| MOHE | - | Ministry of Health and the Environment |
| PHC | - | Primary Health Care |
| PAHO | - | Pan American Health Organisation |
| CCHII | - | Caribbean Cooperation in Health |
| EPHF | - | Essential Public Health Functions |
| ESPH | - | Expansion of Social Protection in Health |
| STIs | - | Sexually Transmitted Infections |
| HIV | - | Human Immune Virus |
| AIDS | - | Acquired Immune Deficiency Syndrome |
| CMO | - | Chief Medical Officer |
| EHS | - | Environmental Health Services |
| EHSU | - | Environmental Health Services Unit |
| MCH | - | Maternal and Child Health |
| MHC | - | Mental Health Centre |
| CWSA | - | Central Water and Sewerage Authority |
| CD | - | Cluster of Differentiation |
| PSA | - | Specific Antigen |
| TFT | - | Thyroid Function Test |
| EU | - | European Union |
| WHO | - | World Health Organisation |
| CAREC | - | Caribbean Epidemiology Centre |
| OECS | - | Organisation of Eastern Caribbean States |
| NCD | - | Non-Communicable Diseases |
| PPS | - | Pharmaceutical Procurement Service |
| DMFT | - | Decayed, Missing and Filled Teeth |
| CPI | - | Community Periodontal Index |
| VCT | - | Voluntary Counseling and Testing |
| MTCTP | - | Mother to Child Transmission program |
| ARV | - | Antiretroviral |
| DARE | - | Drug Abuse Resistance Education |
| ISAAC | - | International Study of Asthma and Allergens in Children |
| DRGs | - | Diagnosis related Groups |
| NIS | - | National Insurance Services |
| IDA | - | Iron Deficiency Anaemia |
| CNCD | - | Chronic Non Communicable Disease |
| KAPB | - | Knowledge Attitude Practice and Behaviour |
| HACCP | - | Hazard Analysis Critical Control Point |
| GDP | - | Gross Domestic Product |
| MCMH | - | Milton Cato Memorial Hospital |
| CMH | - | Caribbean Minister of Health |
| CCH | - | Caribbean Cooperation in Health |

| | | |
|---------|---|--|
| UNDP | - | United Nations Development Programme |
| GEF | - | Global Environmental Facility |
| CPA | - | Country Poverty Assessment |
| EC | - | East Caribbean |
| CDB | - | Caribbean Development Bank |
| MOFP | - | Ministry of Finance and Planning |
| ENT | - | Ear, Nose & Throat |
| ICU | - | Intensive Care Unit |
| PHLIS | - | Public Health Laboratory Information Systems |
| NEMO | - | National Emergency Management Organisation |
| ICD | - | International Conference & Development |
| IMR | - | Infant Mortality Rate |
| PLWHA | - | Persons living with HIV and AIDS |
| BMI | - | Body Mass Index |
| UNCCD | - | United Nation Convention to Combat Desertification |
| NBSAP | - | National Bio-diversity Strategy and Action Plan |
| MOAF | - | Ministry of Agriculture, Forestry and Fisheries |
| COP | - | Conference of the Parties |
| CPACC | - | Caribbean Planning for Adaptation to Climate Change |
| UNFCCC | - | United Nation Framework Convention on Climate Change |
| MACC | - | Mainstreaming Adaptation to Climate Change |
| ESU | - | Environmental Services Unit |
| NEAB | - | National Environmental Advisory Board |
| CRIC | - | Committee for the Review of the Implementation of the Convention |
| CARICOM | - | Caribbean Community |
| MDG | - | Millennium Development Goals |

Chapter 1:

CONTEXTUAL FRAMEWORK

INTRODUCTION

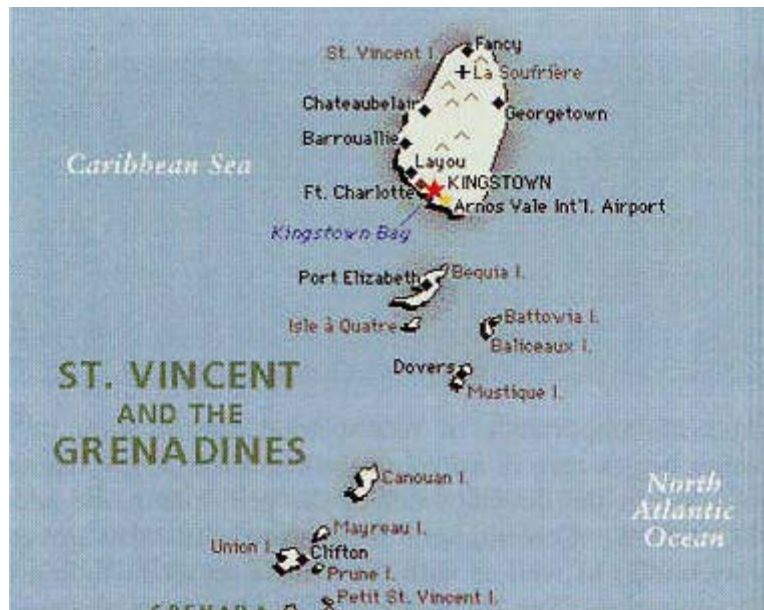
The policy of the Government of St Vincent and the Grenadines is to provide universal health care that reflects the principles of equity, affordability, quality and cultural acceptance.

The Ministry of Health and the Environment (MOHE) is the state agency responsible for the coordination of health issues in the country and therefore led and will lead in the preparation and implementation, respectively, of the health sector plan. The mission of the Ministry of Health and the Environment is: “To provide equitable, quality, sustainable, comprehensive, primary, secondary and tertiary health care, health promotion, nutrition and health education services to the population and to promote the protection and preservation of the environment and its natural resources, through a process of health services delivery, environmental assessment/research and dynamic management within the context of available resources, thus contributing to a healthier nation living in environmentally safe and friendly communities.”

The Ministry appreciates the importance of intersectoral coordination in ensuring that the population receives quality health care in an equitable and sustainable manner. This has been reflected in the process used in the development of the priorities to be addressed during the period of this plan (2007 – 2012). Consultations took place with other government ministries, departments and statutory bodies as well as with the private sector including non-governmental and community based organisations. Structures and processes are necessary to facilitate a more effective working relationship between the major stakeholders in health care delivery and the plan reflects this added emphasis on continued close collaboration.

The plan outlines the contextual framework in which health care is provided in the state, gives an overview of the health care problems within the country, and describes how health care is organized and offers broad strategic directions to be focused on over the next five years. These directions should form the core basis of operational planning and the entry point for regional and international partners in the development of the health care delivery services.

St. Vincent and the Grenadines (SVG) is a multi-island state in the Windward Island chain of the Lesser Antilles. It consists of thirty-two (32) islands, inlets and cays and has a total land area of 345km². Most of the land area and ninety-one (91%) percent of the country's population of 106,253 (2001 census) 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 four of the Grenadines islands- Bequia, Canouan, Mustique and Union Island.



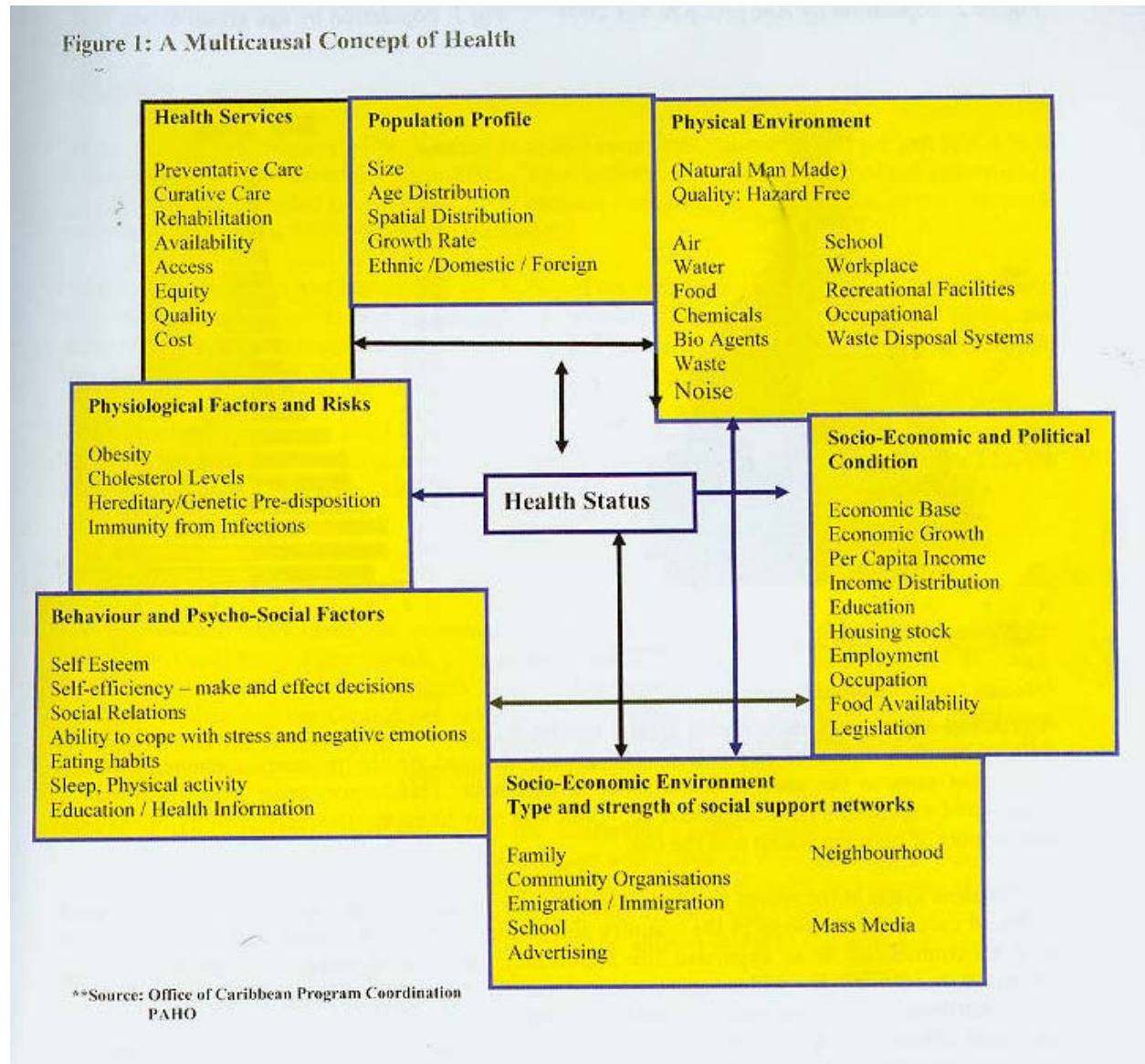
Mainland St. Vincent is volcanic in origin with a central chain of mountain peaks and ravines. The La Soufriere volcano located at the north of the island last erupted in 1979. The smaller islands that make up the Grenadines are primarily of coral formation. SVG is susceptible to hurricanes, tropical storms, volcanic eruptions and earthquakes.

SVG attained political independence from Great Britain in 1979, and inherited a Westminster Parliamentary Democracy system of Government with elections every five years. The next election is constitutionally due in 2010.

St. Vincent and the Grenadines has made remarkable achievements in Health Care over the past twenty years. The health indicators have shown significant improvement since the declaration of Health for All by the year 2000, at Alma Ata in 1978. The natural growth rate of the population has fallen over this period from 2.8 to 2.4 %. Today, some 7.3% of the population is over the age of 65 years, the total fertility rate is 2.4 and the population grows at a rate of .13% per annum with a dependency ratio of 61%. Infant Mortality has decreased by twenty percent (20%) from 22.4 to 18.1 per 1000 live births, life expectancy has risen by 7.8 years from 68.6 to 74.4 over the last 20 years and access to drinking water is now at 95 % households as against 51 % in 1980. Despite these improvements, Chronic Non-Communicable Diseases have become the leading health problem together with drug abuse, violence and HIV/AIDS.

DETERMINANTS OF HEALTH

The factors that determine our health status are as diverse as they are sometimes unapparent. The causal relationship between health status of populations and individuals, and the interplay of varying social, economic, environmental, biological and psycho-social factors has as an underpinning thread, the understanding that one disease has different determinants, and that these determinants impact negatively or positively on the health status of the population.

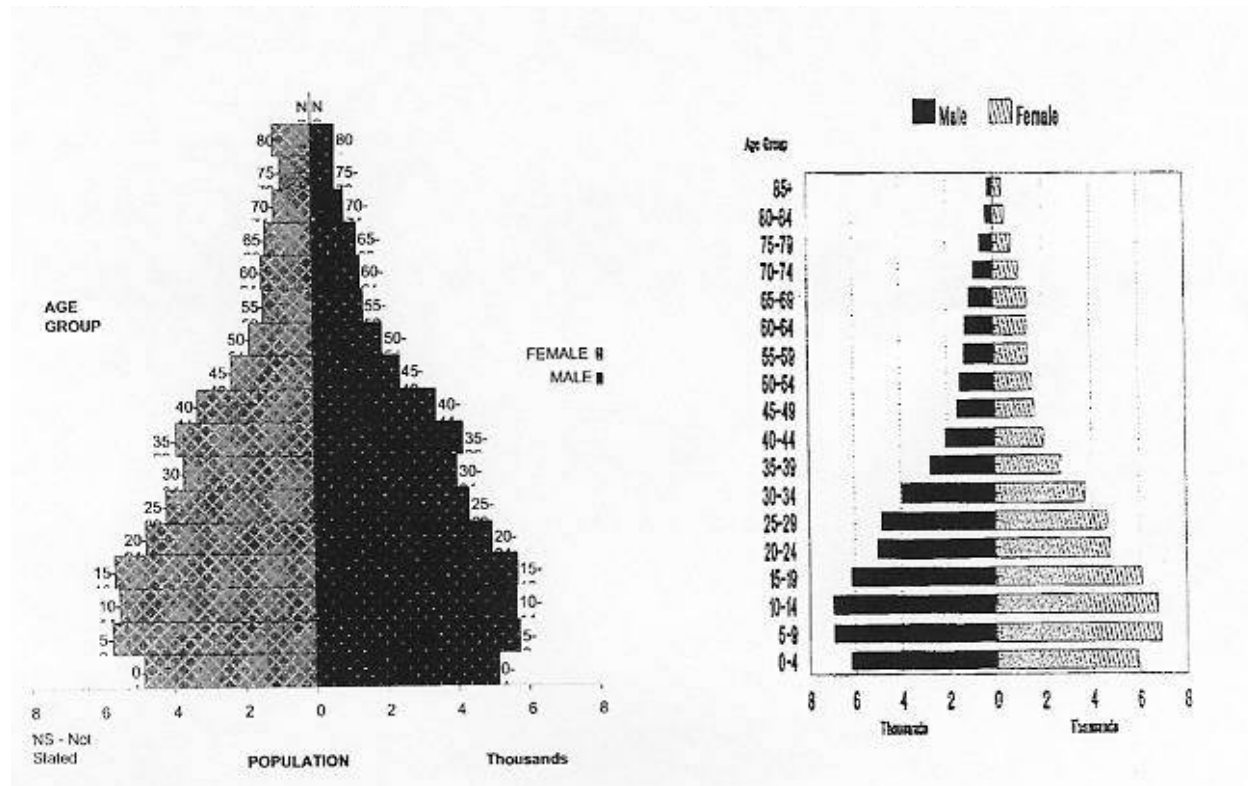


Demography

The demographic changes noted in St. Vincent and the Grenadines over the last two decades are not unlike those in the developed world. St. Vincent and the Grenadines is going through a demographic transition, which is seeing an increase in the elderly population, a decline in the fertility rate, a growing dependency ratio and a decline in the rate of population growth. The 2001 population was 106,253, a decline by 246 persons from 1991.

Figure 2: Population by Age group & Sex 2001

Fig 3: Population by age group & Sex 1991



Source: Central Statistical Department

A growing dependency ratio places greater burden on the social support structures available, as well as on the productive population. The greater demand on the productive elements of the population goes to the core of sustainable development. This sector, apart from fulfilling both its social and economic dreams and aspirations, has now to accept the responsibility of the care and support of both the young and the old.

Health gains made in the recent past have significantly influenced these developments. Increased access to care, improvements in the quantity and quality of staff and health promotion activities have all contributed to an expanded life expectancy. Migrations, as well as family planning initiatives, resulting in the wider acceptance and use of varying contraceptives by the population, have contributed to reduced birth rates and declining population growth.

Increased life expectancy has contributed to the predominance of chronic non-communicable diseases including various cancers. The demographic changes observed recently require significant reorientation of health services. Institutional and non-institutional care must be made available to an ageing population. There are also emerging and re-emerging infections/conditions offering serious challenges to health care delivery.

The growing phenomenon of urbanization and the attendant situation of informal settlements place great pressures on health and social infrastructures. Overcrowding in some less than ideal conditions leads to the easy spread of infectious diseases, low productivity, under-employment, poverty and other social problems. The social pressures placed on health facilities and other systems in these situations require continuous adjustments to health infrastructures and delivery systems, since the health needs of these populations are to be met.

Economics

The economic performance of St. Vincent and the Grenadines registered real growth of 5.4 % in 2004 compared with 3.4 % in 2003. This growth rate was the result of the construction industry, which expanded by 14.7%, a 5.5% increase in tourism, 9.8% increase in the wholesale and retail sector and a 7.8% increase in transport.

Output in Agriculture has contracted by 5.2%. This reduction in the Agriculture sector was influenced primarily by the non-performance of other crops, which declined by 11.1% notwithstanding a 5.7% increase in bananas. Although a programme on agricultural diversification was introduced, this has not yet realized its true potential.

The Government, between 2000 and 2004, spent 4.37% of the Gross Domestic Product on this sector. Expenditure increased from EC \$54.50 to EC \$ 58.17 million, an average of 12.4% of the total budget. This is an indicator of Government's commitment to the nation's health.

Poverty

The health sector welcomes the government's emphasis on poverty reduction and education reform. It is well known that an association between economic deprivation and ill health has been found wherever and whenever it has been examined. Poverty begets illness and illness begets poverty. The Poverty Assessment Study Report of 1996 for Saint Vincent and the Grenadines identified 37% of households and 42 % of the population as poor. This vicious cycle continues to negate the effects of even the most ambitious public health interventions.

Poverty is associated with poor environmental conditions, nutrient deficiencies, excess energy intake, unemployment, poor care-seeking tendencies and increased risky behaviors. Any health intervention in the context of poverty must go beyond the realm of health and develop strategies aimed at alleviating poverty and subsequently ill health by providing safety nets for the under-privileged and the indigent. The health sector must be able to quantify the economic cost of ill health and effectively use this in its advocacy.

At present, preparatory work is ongoing for the implementation of another Country Poverty Assessment (CPA), which should be completed by the end of 2007. Discussions are also ongoing regarding the introduction of a social safety net to safeguard the population's health.

Education

Education has long been recognized as an important social determinant of health. It is estimated that some 21% of the population over 15 years in St. Vincent and the Grenadines is illiterate. The less educated people are the least likely to be gainfully employed, and as such, least economically productive. This tends to give rise to poor life choices and conditions resulting in disease, disability and death. The uneducated utilize health facilities less often than is necessary and usually not in a timely fashion, notwithstanding the fact that their needs are significantly greater than other population subsets. They are also unable to make maximum use of information, intended to produce positive behaviour modification.

The government has embarked on a National Literacy Crusade, which is aimed at addressing the problem of illiteracy. Mainstream education programmes have modified their curricula, over the years, to include family life education with more content on the effects of individual behaviors, emerging infections and appropriate public responses. The move to compulsory secondary education will in time be manifested in better health practices and status of the population.

Gender

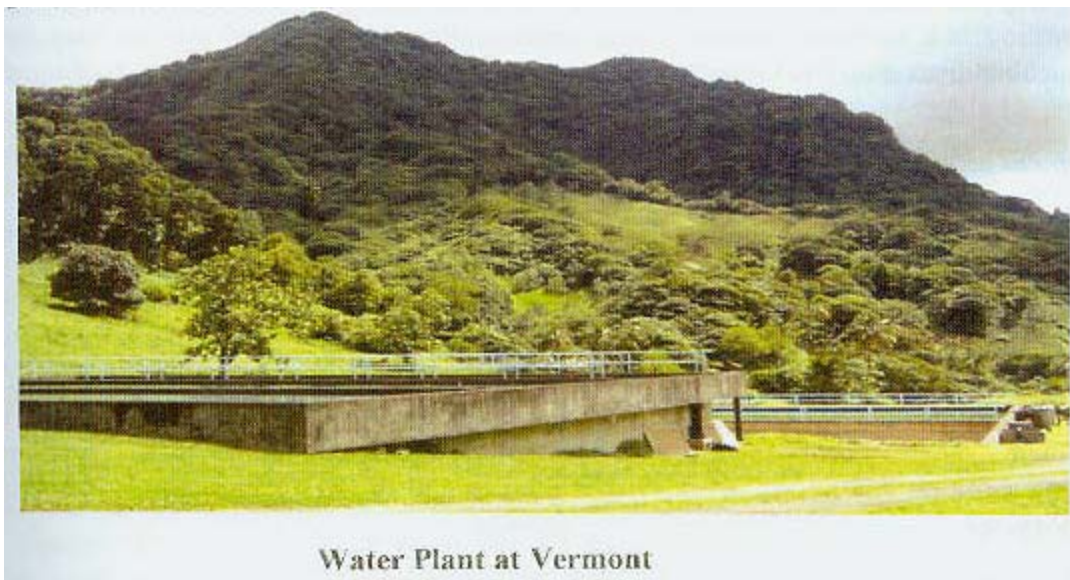
Notwithstanding the strides made in empowering females to take control of their health, there continues to be inequities and dysfunctional gender relations denying females the right to control and make choices, which can affect their sexual and reproductive health. Although there has been significant decrease in parity of births, there are risks associated generally with childbearing especially in the teenage years. Among the STIs, female infection rates double that of males, with the exception of HIV where the ratio is 2:1.

Physical and emotional abuse continues to be of concern to both genders. The burden of NCDs is borne predominantly by females. Fifty-nine percent (59%) of all cancers occur in females and the vast majority of diabetics are women. Economically and socially deprived females are particularly vulnerable.

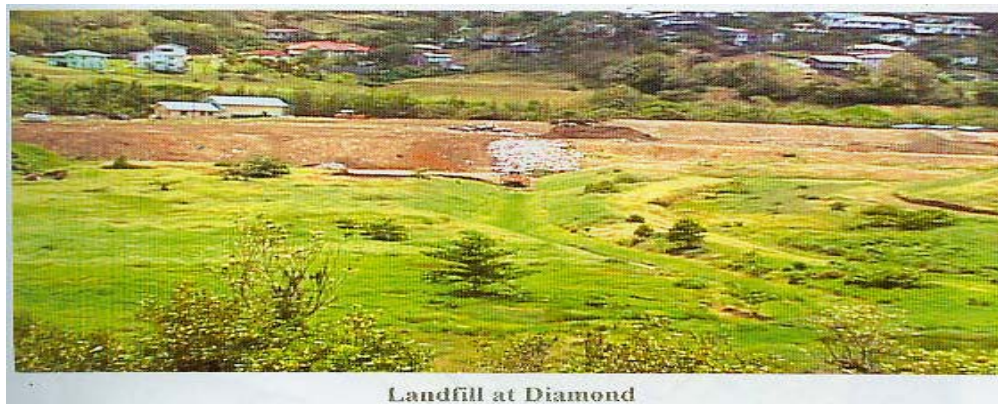
Male health continues to pose a huge public health challenge. The health-seeking habits of males are different from those of females. Men are less likely to access the health care facility early for illnesses. In the last five years the leading cause of death has been malignant neoplasm, and the greatest burden of mortality from cancers occurs in males as a result of prostate cancer.

Environment

The role of the environment as an important determinant of health has become more prominent over the last decade. The recent decline in agricultural activities has seen greater focus being placed on tourism as a viable alternative and as such, an engine for economic growth and development. While St. Vincent and the Grenadines possesses a tourism product of excellent quality, there is need to pay greater attention to the physical and social environment. Apart from enjoying sand, sea and sunshine, tourism product consumers need to know that adequate facilities are available for the disposal of liquid and solid waste, that safe food is being offered for consumption and potable and coastal waters present no health risk and that they can receive quality health care if necessary. The Ministry of Health and the Environment needs to assume a greater role in the monitoring and regulation of environmental conditions and adopt standards relating to these conditions.



Significant strides have been made in the area of solid waste management over the last five years. Two of these include the transfer of the responsibility for the collection and disposal of garbage from the Public Health Department to the Central Water and Sewerage Authority (CWSA) and the establishment of two landfills: one at Belle Isle and the other at Diamonds.



Although commendable, there is still much to be done. Activities aimed at increased social participation in waste management have not borne maximum fruit. Vector borne diseases have become endemic in the country. National household and Breteau indices continue to be above and beyond internationally accepted levels. Dengue Fever and Leptospirosis continue to present some concern. Strategies aimed at building capacity at the community and household levels, to exercise public health safety need to be developed with full participation of communities.

Housing space and living conditions present some environmental concerns. Squatting continues to be widespread. Areas used for squatting are usually without potable water and sanitary facilities and are usually overrun with vermin, rodents and other diseases-carrying organisms. Overcrowding is a common feature within these settlements. This allows for easy spread of communicable diseases. The Government is making an effort to address the issue of squatting.

Employment and Working Conditions

The right to work refers not only to gainful employment, but employment through decent work. This implies that work must not be degrading and present no serious threat and social risks to workers' health. Although adequate data are not available, it is thought that work related injuries contribute significantly to the morbidity profile of St. Vincent and the Grenadines simply because some workplaces are unsafe or provide an unhealthy environment. Some laws relating to the content, conditions and layout of work fall outside the ambit of the Ministry of Health and the Environment. There needs, therefore, to be intersectoral collaboration in regulating and monitoring working conditions, work related injuries and in the development of relevant work safety measures.

Recreation, although of higher prominence, is still not an important enough part of the Vincentian lifestyle. There is need for more emphasis on health promotion through the development of recreational activities, fitness programmes and other self-care initiatives.

Food and Nutrition Security



Food and nutrition security exists when “all people at all times have physical and economic access to sufficient safe, nutritious and culturally-acceptable food for a healthy, active and economically productive life”. It captures the ideal of safe, high quality food including dietary diversity to meet the physiological need for energy and nutrients at all stages of the lifecycle. Good nutritional status is an essential prerequisite for optimal reproduction, growth and development and protection from disease, reduced risk of mortality, adequate learning, economic activity and social well-being. Food availability, food access and biological food utilization reflect food and nutrition security at the national, household and individual levels respectively.

An assessment of food availability at the national level suggests a trend in oversupply of daily per capita energy but does not describe household food security or the nutritional status of individuals based on what they consume. Household food access depends not only on an adequate and sustainable national food supply but also on the ability of different households to produce or purchase food determined by income and price levels, livelihoods, market infrastructure and access to land space.

Individual nutritional status reflects household care and feeding practices, food preparation methods determined by nutrition knowledge and skills; intra-household food distribution; hygiene and health care practices; access to clean water and safe food; health and sanitation services; type of labour and recreation; and the absence or presence of communicable and non-communicable disease.

The government has established a National Food and Nutrition Security Council to coordinate and monitor the implementation of the National Food and Nutrition Policy and Plan of Action in seven thematic areas. It has also approved the development of National Dietary Guidelines to improve food choices. These guidelines have implications for agricultural production; food manufacturing and retail; trade policy and food price regimes; physical planning; education curricula at all levels; government feeding programmes and nutrition promotion programmes for the next five years. Strategies for food and nutrition improvements at the national, community and household levels need to be developed with full participation of communities.

Chapter 2

SITUATIONAL ANALYSIS

Mortality Profile

The mortality profile of St. Vincent and the Grenadines (SVG), mirrors that of a developed country in some respects, in that its crude death rate is sustained at an average of 5.8 per 1000 population and the principal causes of death are mainly the non-communicable diseases.

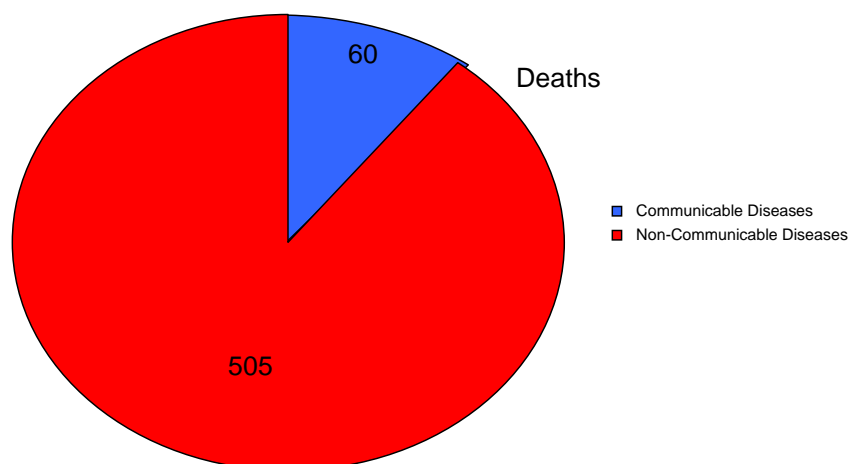
Table 1: The Principal Causes of Deaths in Rank Order 2000 -2004

| Principal Causes | 2004 | 2003 | 2002 | 2001 | 2000 |
|--|---------|---------|--------|----------|---------|
| Diabetes | 1 (125) | 1 (120) | 2 (89) | 29 (103) | 1 (153) |
| Malignant Neoplasm (All forms) | 2 (116) | 2 (119) | 1(122) | 1 (132) | 2 (116) |
| Heart Disease | 4 (58) | 3 (102) | 4 (58) | 4 (45) | 4 (98) |
| Hypertension | 4 (58) | 4 (101) | 9 (26) | 6 (33) | 6 (54) |
| Cerebrovascular Disease | 3 (64) | 5 (51) | 3 (89) | 3 (60) | 3 (11) |
| Accidents | | 7 (25) | | | |
| HIV/AIDS | 6 (33) | 6 (34) | 6 (36) | 5 (34) | 3 (46) |
| Respiratory Infection | 9 (27) | 7 (25) | 5 (47) | | 5 (63) |
| Signs, symptoms & ill defined conditions | 7 (29) | 9 (24) | | 8 (21) | 8 (29) |
| Conditions of the Perinatal Period | 10 (26) | 10 (20) | 7 (29) | 8 (24) | 9 (21) |
| Homicide | 7 (29) | | | | |

***Source: Digest of Health Statistics, Health Planning and Information Unit, 2003
Statistical Office, Central Planning Division – June 2005

*****Figures in brackets represent number of deaths

Figure 4: Distribution of Deaths by Communicable and Non-communicable Diseases 2004



Source: Digest of Health Statistics, Health Planning and Information Unit

Non- communicable diseases accounted for more than eighty percent (80%) of deaths in both males and females.

Infant Mortality

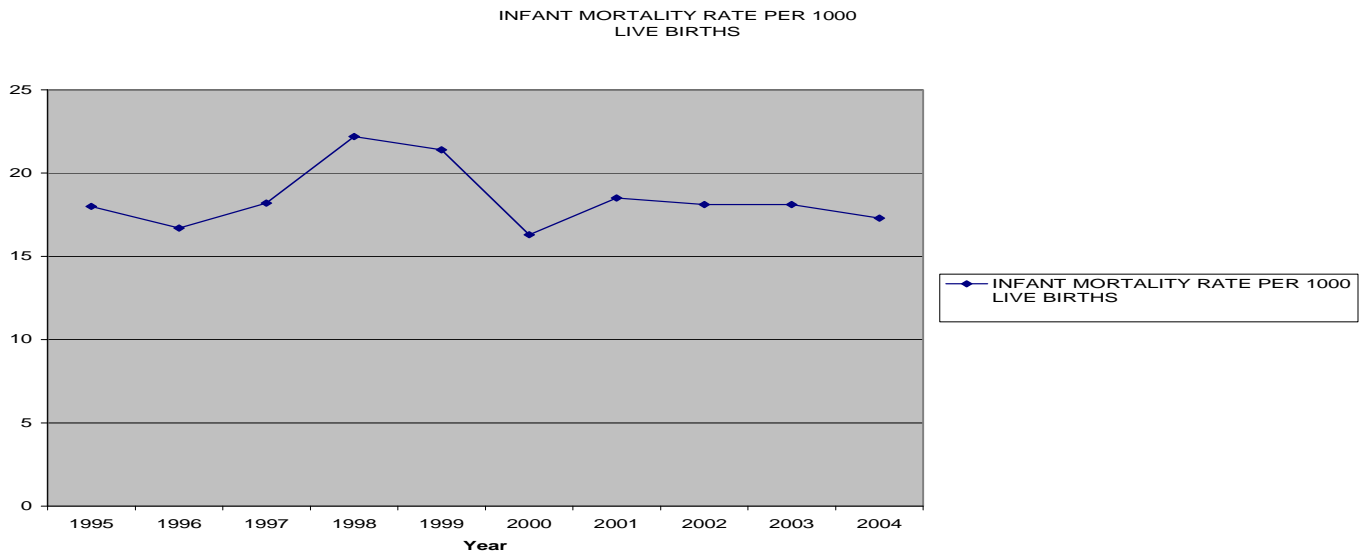
During the period 1995 to 2004 little change occurred in the infant mortality rate as it moved from 18.0 per 1000 live births in 1995 to 17.3 per 1000 in 2004.

Table 2: Infants Deaths and IMR 1995-2004

| YEAR | TOTAL INFANT DEATHS | INFANT MORTALITY RATE PER 1000 LIVE BIRTHS |
|------|---------------------|--|
| 1995 | 47 | 18.0 |
| 1996 | 39 | 16.7 |
| 1997 | 41 | 18.2 |
| 1998 | 47 | 22.2 |
| 1999 | 47 | 21.4 |
| 2000 | 35 | 16.3 |
| 2001 | 39 | 18.5 |
| 2002 | 36 | 18.1 |
| 2003 | 35 | 18.1 |
| 2004 | 32 | 17.3 |

Source: Health Planning & Information Unit

Figure 5: Infant Mortality Rate Per 1000 Live Births 1995-



Morbidity Profile

Non-Communicable Disease

Lifestyle-related diseases; primarily Chronic Non-Communicable Disorders are the leading causes of morbidity.

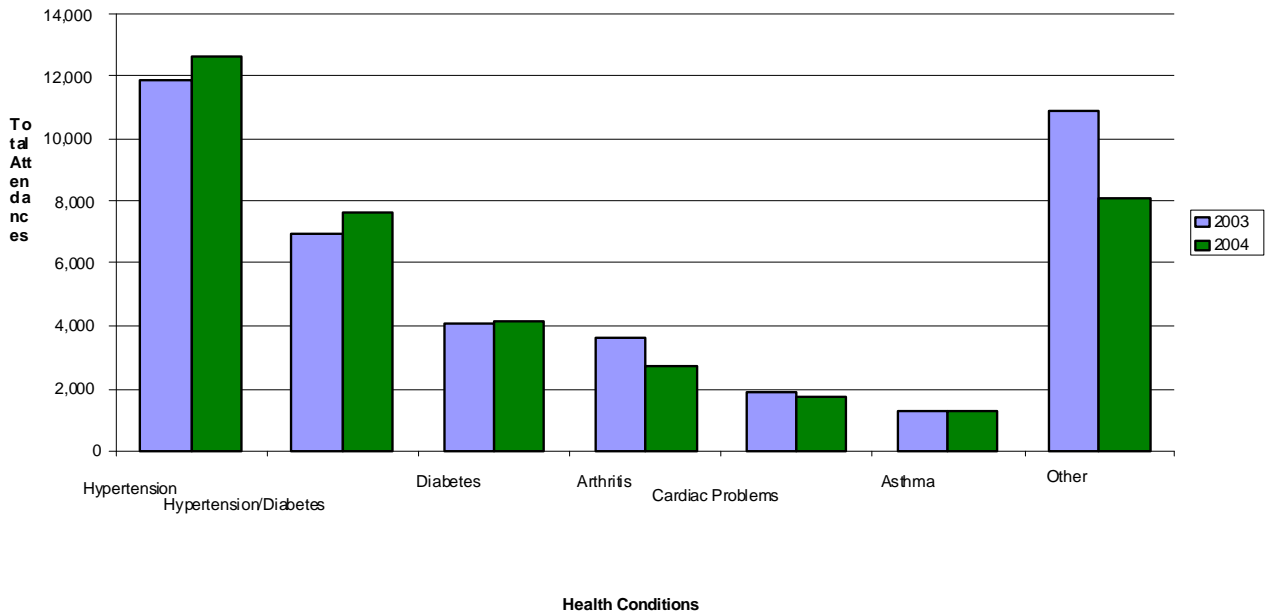
Hypertension, Diabetes, the combination of diabetes and hypertension, arthritis, cardiac problems and asthma were the most common diseases responsible for clinic visits in 2003 and 2004. Similar occurrences were documented in the past five (5) years.

**Table 3: 10 LEADING HEALTH CONDITIONS 2003 – 2004
PRIMARY HEALTH CARE SYSTEM**

| RANK ORDER | CONDITIONS | NO. OF VISITS ACCORDING TO DISEASE CONDITIONS | | % VISITS ACCORDING TO DISEASE CONDITIONS | |
|---|-----------------------|---|---------------|--|--------------|
| | | 2003 | 2004 | 2003 | 2004 |
| 1 | Hypertension | 11,869 | 12,662 | 29.2% | 38.1% |
| 2 | Hypertension/Diabetes | 6,982 | 7,628 | 17.1 | 22.9% |
| 3 | Diabetes | 4,037 | 4,130 | 9.9 | 12.4% |
| 4 | Arthritis | 3,632 | 2,720 | 8.9 | 8.1% |
| 5 | Cardiac Problems | 1,869 | 1,730 | 4.6% | 5.3% |
| 6 | Asthma | 1,326 | 1,329 | 3.3% | 4.0% |
| 7 | Gastritis | 1,155 | 967 | 2.8% | 2.9% |
| 8 | Injuries | 910 | 780 | 2.2% | 2.4% |
| 9 | Myalgia | 706 | 701 | 1.7% | 2.1% |
| 10 | Lumbago | 620 | 572 | 1.5% | 1.7% |
| Total | | 33,105 | 33,219 | 81.2% | 99.9% |
| TOTAL ATTENDANCE ACCORDING TO CONDITIONS | | 40,614 | 38,314 | | |

Source: Public Health Care System

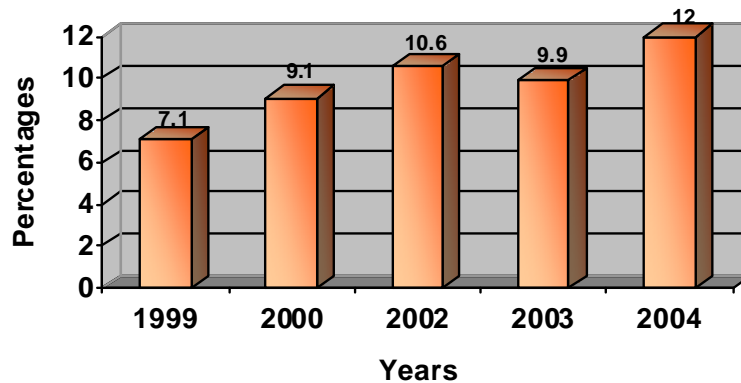
Figure 6: Leading Health Conditions Reported in 2003 & 2004



****Source:** Health Planning and Information Unit

Hypertension is the leading cause of clinic visits in all health districts and accounts for almost one third (1/3) of total clinic visits. Male to female clinic attendance for hypertension has consistently showed a two thirds (2/3) majority in favor of females over the past five (5) years. Diabetes is also a common disease in St Vincent and the Grenadines accounting for a significant percentage of clinic visits in any one year.

Figure 7: Diabetic Visits as a % of Total Visits to PHCS 1999 - 2004



Source: Health Planning and Information Unit

Cancer

According to the data extracted from the histology register of the Milton Cato Memorial Hospital (MCMH) over a nine (9) year period 1992 – 2000, cancer recorded 37 cases in 1994 compared with 87 cases in 1995 and 1999. Cancer of the cervix was the most common site identified followed by cancer of the breast, skin, Lymph nodes and the prostate gland. Data were not available by sex or age.

Prior to 2001, specimens for histology were transferred to other CARICOM countries for analysis. From 2001 a resident pathologist was added to the health staff and specimens are now being analysed locally. The Cancer Society has as one of its objectives the development of a cancer registry.

Injuries and Violence

Intentional and non-intentional injuries continue to increase at alarming rates. In 2005, homicide ranked 7th, while in 1998, it was the 10th leading cause of death. The continued poor socialization of the male youth in particular, the easy access to drugs and other mind-altering substances, an entertainment diet rich in violence and the ease with which weapons are acquired are but a few of the factors driving this continued alarming rise in violence. There is need to recognize violence as a public health problem and with multi-sectoral collaboration, develop appropriate interventions.

The clinic visits for injuries continue to reflect annual increases. Records of 832 visits were made in 2002, of which 54(7%) were related to violence. While the health district of Chateaubelair recorded the most visits for injuries 184(24%), the health district of Georgetown had the most visits for violence-related injuries, 23(42%).

Communicable Diseases

HIV/AIDS

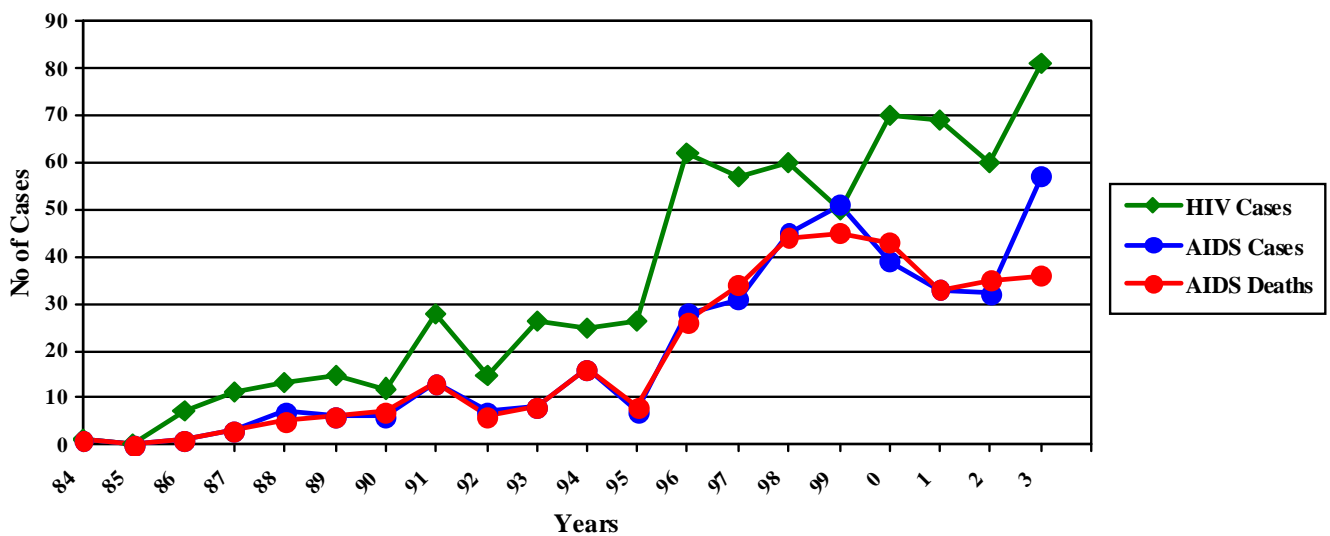
The first reported case of HIV infection in St. Vincent and the Grenadines was in 1984. The total documented cases of HIV at the end of year 2004 were 796; total AIDS cases 431 (54 % of HIV cases); total deaths 405 (94 % of AIDS cases). The documented number of persons living with HIV/AIDS (PLWHA) as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

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

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

AIDS-related deaths account for about 5% of total deaths annually, with male deaths responsible for about 66 % and female deaths about 34 %. Approximately 60 % of AIDS-related deaths occur among the age-group 25-44 years.

**Figure 8: HIV, AIDS Cases and Deaths in SVG
1984-2004**



According to the HIV data stratified by age group and sex, it has been observed that females outnumbered males in the paediatric age groups, the age groups 15-19 and 65-69. Males have dominated all other age groups. One explanation why females outnumber males in the younger age group could be that young females test earlier than males as testing can be offered while seeking antenatal care. There is also the phenomenon of one male having sexual relations with several females.

Individuals within the age group 20-44 years have accounted for 70 % of total cases while teenagers represented 6 % and Paediatric cases 4 %. A similar sex distribution presented itself in the AIDS category with the same age group accounting for the majority of cases (67%).

Figure 9: HIV Cases by Age Group and Sex 1984 -2004

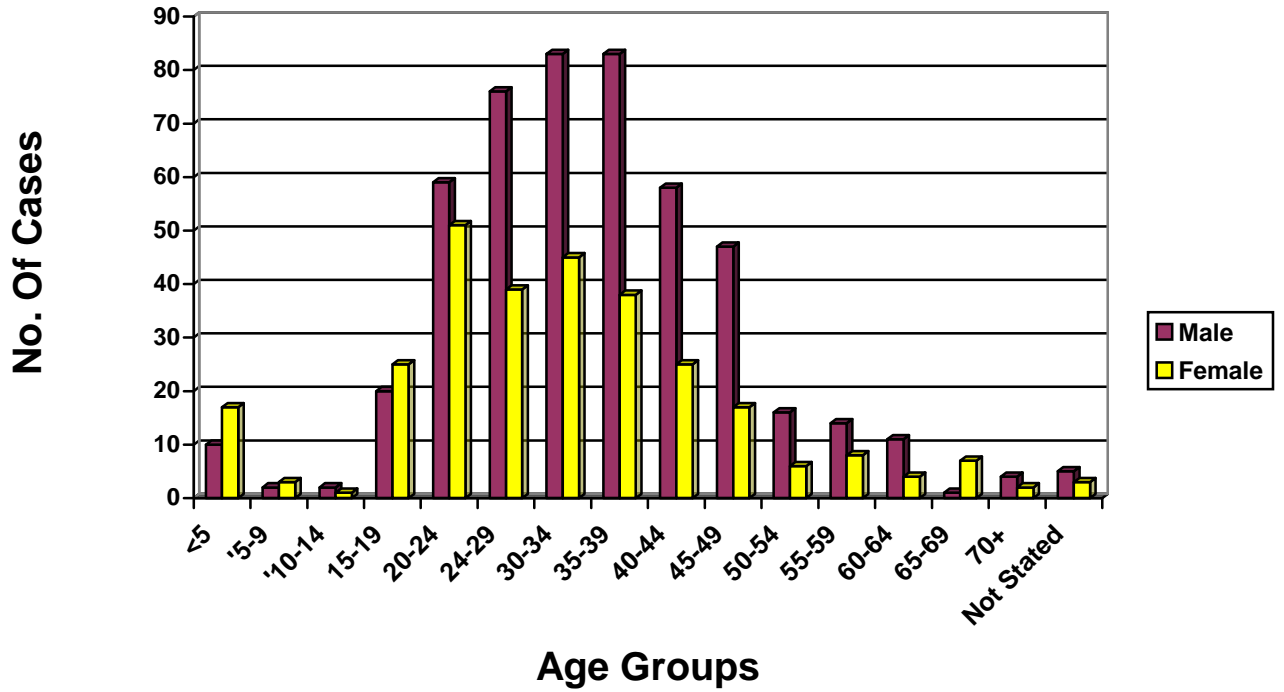
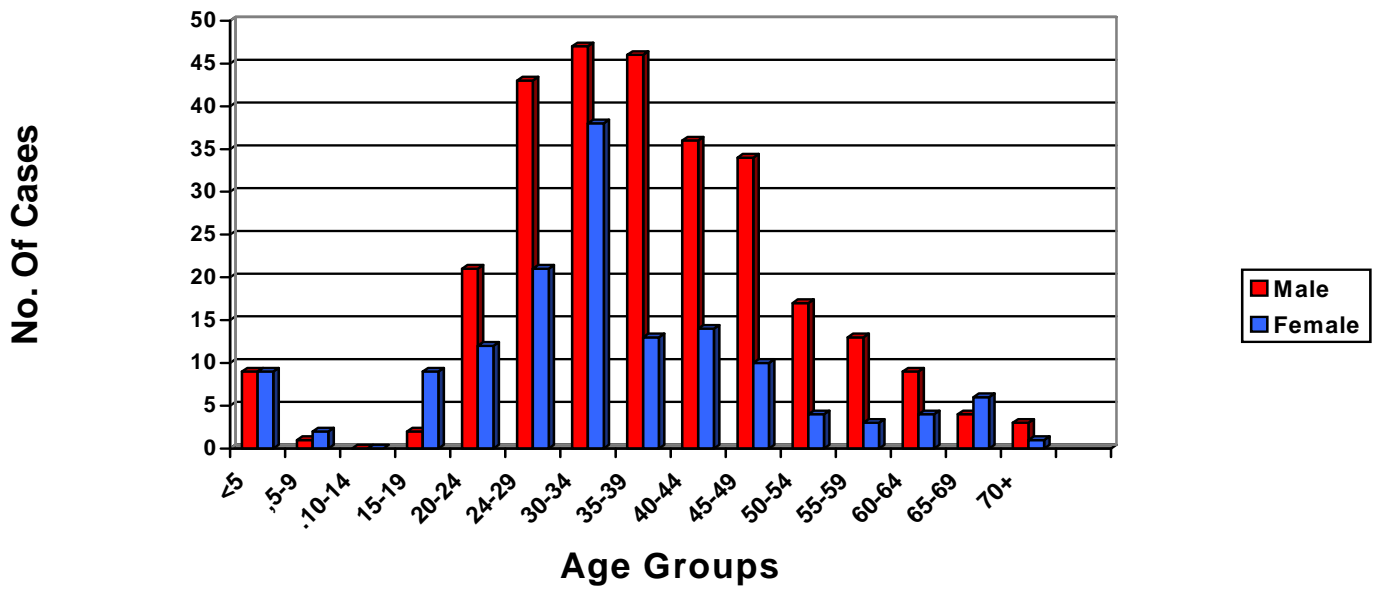


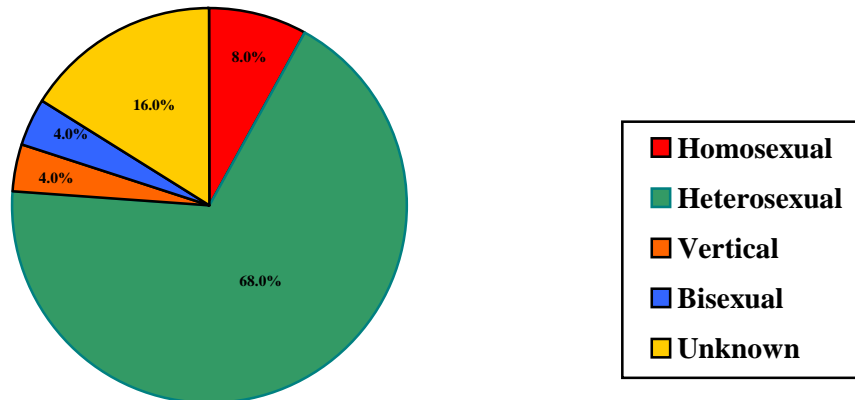
Figure 10: AIDS Cases by Age Group and Sex 1984-2004



Transmission Categories

The cumulative data from 1984- 2004 identified heterosexuals as the main category of transmission. Sixty-eight (68) percent of persons acquired the infection through that route.

Figure 11: HIV Numbers by Various Transmission Categories 1984 - 2004



Mother to Child Transmissions

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

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

The pandemic, now in its 20th year in SVG, continues to pose a real threat to the substantial gains made to improve the health status of the country. Efforts are being made to scale up the country's response to the pandemic. The government of SVG has embarked on a national project, at a cost of US\$8.75 million, to be implemented over a five -year period (2005 – 2009). This project is financed primarily by a combination of loan, grant and credit from the World Bank, and complemented by a contribution from the government and other funding agencies including the Global Fund and The Pan Caribbean Programme (PANCAP) through CARICOM.

The objective of the project is to reduce the spread of HIV/AIDS through:

- The up-scaling of programs for the prevention of HIV/AIDS

- The up-scaling of programs for the treatment and care of people living with HIV/AIDS
- The reduction of the degree of stigma and discrimination associated with HIV/AIDS
- The strengthening of the institutional capacity of the Ministry of Health and the Environment.

Other Communicable Diseases of Local, Regional and International Interest

The total number of cases of Communicable Diseases reported to the Health Planning and Information Unit within the Ministry of Health and the Environment in 2003 was 33,428. The data continues to reflect a steady increase in the total number of reported cases of Communicable Diseases over the last four years.

Table 4: Number of Communicable Diseases 2000 – 2003

| Year | Reported Cases of Communicable Diseases |
|------|---|
| 2000 | 21,143 |
| 2001 | 24,959 |
| 2002 | 29,017 |
| 2003 | 33,428 |

Source: Health Information Unit

Acute respiratory infection, has for many years been the leading communicable disease and again, remained in the top position accounting for 49% of the overall total, 6% more than 2002 with 43%.

**Table 5: Reported Cases of Acute Respiratory Infection
1999-2003**

| Year | Number of Cases |
|------|-----------------|
| 1999 | 9,662 |
| 2000 | 9,331 |
| 2001 | 12,379 |
| 2002 | 12,963 |
| 2003 | 16,374 |

Source: Health Information Unit

The number of confirmed cases of Dengue Fever ranged from one (1) in 1999 to an epidemic of 100 confirmed cases in 2002. Type 3 viruses were identified in St. Vincent and the Grenadines for the first time in 2002. The risk of the most serious Dengue Hemorrhagic fever increases

whenever there is a transmission of multiple types of the Dengue virus. In 2003 there were four confirmed cases from a total number of 34 samples tested.

The period 1999-2003 recorded figures for Gastro-enteritis ranging from 1,744 in 2002 to 4,124 in 2003.

Table 6: Reported Cases of Gastro-enteritis 1999 – 2003

| Year | Number of Cases |
|------|-----------------|
| 1999 | 3,631 |
| 2000 | 2,751 |
| 2001 | 2,426 |
| 2002 | 1,744 |
| 2003 | 4,124 |

Source: Health Information Unit

Immunization Status

The diseases for which immunization are offered under the Expanded Program of Immunization (EPI) are Tuberculosis, Poliomyelitis, Diphtheria, Pertussis, Tetanus, Measles, Mumps and Rubella.

In July 2003, the Pentavalent Vaccine, which is a combination vaccine for Diphtheria, Pertussis, Tetanus, Haemophilus Influenza B and Hepatitis B, was introduced.

The immunization coverage for these vaccines from 2000-2004 has been above 90%.

Table 7: Immunization Status of Children 0 – 5 years 2000-2004

| VACCINES | 2000 | 2001 | 2002 | 2003 | 2004 |
|-----------------|-------|-------|-------|-------|-------|
| BCG | 100.0 | 100.0 | 90.0 | 100.0 | 100.0 |
| Polio | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| DPT, Hep B, HIB | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| MMR | 96.0 | 98.0 | 99.2 | 90.7 | 100.0 |

Source: Community Nursing Service Reports

Of these diseases, Tuberculosis is the only prevalent one seen within the last five years and this was among adults. Thirteen (13) cases were diagnosed in 2000, ten (10) cases each in 2001 and 2002 and fourteen (14) in 2003.

Four (4) or 29% of these cases were also diagnosed with HIV. The reported cases of Tuberculosis each year have been predominantly males.

The communicable diseases, subject to International Health Regulations are Cholera, Plague and Yellow Fever. It has been more than fifty years that Yellow fever and Cholera have not been identified in St. Vincent and the Grenadines. Plague is not known to have been identified.

Endemic diseases

We continue to see the following diseases, Hepatitis B, Ring Worm and Scabies.

Zoonoses

There were 15 cases of Leptospirosis reported in 2003, five (5) cases less than in 2002, in which 15 cases were recorded. The disease continues to affect predominantly the male population most of whose occupation is farming.

FAMILY HEALTH

Child Health

A total of 20,324 visits were made to child health clinics in the year 2002. The reasons for visits included growth monitoring, immunization, referrals and other health problems.

Birth weight is an indicator of low maternal nutritional status and a predictor of the nutritional status of the infant. The prevalence of low birth weight in infants as a percentage of total live births, fluctuated from 6.1% in 2000 to 6.3% in 2001 and 5.1% in 2002.

Visits for child health complications were relatively few in number, they accounted for 214 visits or 1% of total child health visits made. The problems include malnutrition, respiratory infections, Diarrhoeal diseases and injuries.

Gastroenteritis was recorded as the second leading communicable disease reported, in the under-five age group behind Acute Respiratory Infections. Over the last three years there has been an excess of 1000 cases of gastro reported annually in this age group.

The nutritional status of children 0-59 months old indicate that for the period 2001 to 2002 the prevalence of energy protein malnutrition (EPM), both moderate and severe, remained negligible while the prevalence of overweight/obesity was significant. Trend data from 1998 show a steady rise in overweight in this population particularly in children over 24 months of age, which may be attributed to inappropriate breastfeeding, and complementary feeding patterns no longer monitored in the national health statistics.

Table 8: Nutritional Status (Weight for Age) of children 0-59 Months attending Public Health Centres by Age Group in 2001 and 2002

| NUTRITIONAL STATUS | AGE GROUP IN MONTHS | | | | | | | | | |
|----------------------------------|---------------------|-------------|-------------|-------------|-------------|-------------|-------------|------------|--------------|--------------|
| | 0-11 | | 12-23 | | 24-35 | | 36-59 | | TOTALS | |
| | 2001 | 2002 | 2001 | 2002 | 2001 | 2002 | 2001 | 2002 | 2001 | 2002 |
| Normal | 83.9% | 86.5% | 89.9% | 90.7% | 89.7% | 86.8% | 90.6% | 81.8% | 87.5% | 87.8% |
| Moderately Undernourished | 3.6% | 3.7% | 4.3% | 4.1% | 3.3% | 2.4% | 1.1% | 2.2% | 3.6% | 3.6% |
| Severely Undernourished | 0.1% | 0.1% | 0.2% | 0.1% | 0.2% | 0.1% | 0.6% | 0.2% | 0.2% | 0.1% |
| Obese | 12.3% | 9.4% | 5.5% | 5.0% | 6.6% | 10.5% | 7.6% | 15.6% | 8.6% | 8.3% |
| Coverage | 5025 | 5324 | 4520 | 4636 | 1832 | 1893 | 1026 | 742 | 12403 | 12595 |

Source: Nutrition Unit, Ministry of Health & the Environment

Anaemia: Iron deficiency anaemia continues to be the most significant micronutrient deficiency in St. Vincent and the Grenadines and is not routinely monitored in children. Assessment of anaemia status in antenatals indicated that from 1996 to 2000 there was a fluctuating trend in the percentage of antenatals with low haemoglobin levels (<10 g/dl) from 7% at first visit in 1995 to 6% in 1997 and over 10.6% in 1999.

A 1996 CFNI/UNICEF survey of micronutrients status (Vitamin A, Vitamin E and Iron) in a sample of pregnant women and children showed that while Vitamin A and Beta-carotene status in the target population was good, 41.2% of children 1 to 4 years and 18.9% of children 5 to 19 years were iron deficient (serum ferritin) and 20.8% of children 1 to 4 years were deficient in Vitamin E. This study showed that while the status of Vitamins A and E were good in antenatals the overall iron deficit (serum ferritin) was 42.8%

Low Birth Weight: Birth weight is an indicator of low maternal nutritional status and a predictor of the nutritional status of the infant. The prevalence of low birth weight infants as a percentage of total live births fluctuated from 6.1% in 2000 to 6.3% in 2001 and 5.1% in 2002.

Physical examinations are being done for 90% of children entering and leaving primary school. The nutritional data for 2002 have indicated that 87.8% of children met the criteria for normal nutritional status, 8.6% was obese while 3.6% moderately undernourished.

Youths and Adolescents

The following data were extracted from the adolescent survey, which was conducted in the latter half of 2001 in collaboration with PAHO. The survey involved students from schools across St Vincent and the Grenadines.

The most commonly used substance among the respondents was alcohol. Other substances used are inhalants (11%), marijuana (85%), cigarette (7%); each of the other substances recorded 2%

or less use. It was noted that 3% of respondents used alcohol weekly or daily. 86% of adolescents stated they are not sexually active while 73% said they would seek contraceptives from the appropriate sources if and when they need them.

St Vincent and the Grenadines conducted the Global Youth Tobacco, survey in 2001. The sample was among students in grade 7 – 8 and forms 1 – 3 with a total sample of 1511. The survey revealed that 24% of students currently use some form of tobacco: 15% currently smoke cigarette and 15% use other forms of tobacco.

Anthropometrics assessment of primary school children through the school health programme in 2001/2002 show that of three hundred and twenty-seven (327) children aged 10-12 years assessed, 75.2% were normal weight, 16.5% were overweight (BMI>85th percentile) and 8.3% were underweight (BMI<5th percentile).

Over the last 18 years total teenage pregnancies have fallen from around 941 at the inception of the Ministry of Health program in 1975 to 398 in 2003. Presently teenage pregnancies have been accounting for approximately 21% of total pregnancies annually. However, the latest figures (1995-2003) pertaining to teen- age births show minimal decrease over that period.

Women Health

Antenatal Services

In the year 2002, health centres registered a total of 9,237 clinic visits for antenatal services. The clinic visits presented do not include the antenatal visits that would have been made to the private physicians and the obstetrical outpatient department of the Milton Cato Memorial Hospital. The records show that there were 1, 147 antenatal ‘first visits’ made in 2002. This represents approximately 50% of pregnant women. Of this number 297 or 25% made their ‘first visits’ before the 16th week of gestation while 860 or 75% made their ‘first visits’ after the 16th week of gestation.

Postnatal Services

There were 1, 365 postnatal visits documented for 2002. This number was far from being reflective of the estimated total pregnancies (1, 991) or total live births (1, 968) for 2002.

Family Planning Services

In the year 2002, there were 1, 264 new acceptors of the Family Planning Programme. Of this total, 701 or 55% had oral contraceptives while 484 or 38% were given Noristerat Progesterone Injection. Six (6) new acceptors opted for the method of sterilization while two (2) clients were fitted with intra uterine contraceptive devices. Active acceptors continue to increase with corresponding increases in the numbers of condoms distributed annually. The female condom was introduced in 2007.

There has been a decrease in the utilization of the Tubal Ligation contraceptive method. Two hundred and eight (208) clients accepted this method in 2002, a small decrease compared to 2001 when it was 228.

Table 9: Contraceptives Distribution at PHCS by Year and Cost 2000 - 2004

| YEAR | DISTRIBUTION | | | COST \$EC | | |
|------|--------------|--------|-------------|-----------|-----------|-------------|
| | Condoms | Pills | Injectables | Condoms | Pills | Injectables |
| 2000 | 209,606 | 23,313 | 6318 | 20,414 | 3200.00 | 15,539.00 |
| 2001 | 221,945 | 21,018 | 9547 | 40,474 | 9212.50 | 13,832.68 |
| 2002 | 281,613 | 21,935 | 8393 | 60,443 | 70,992.00 | 42,285.28 |
| 2003 | 244,652 | 17,032 | 10,105 | 16,786 | 55,793.00 | 22,040.00 |
| 2004 | 218,900 | 16,177 | 8146 | 10,528 | 218,900 | 12,062.00 |

Source: NFPP Unit

*Injectables – Noristerat & Medroxy Progestérone

*Pills – Logynon & Microgynon

Contraceptives are also sold over the counter (Pharmacies) and through the private health care system (Planned Parenthood).

Men's Health

Little attention was paid to Men's Health in the past. Routine PSA are carried out at all health centres but programmes targeting males have not been implemented with any degree of consistency. The main health condition affecting males is prostate cancer.

Table 10: Deaths from Prostate Cancer 1996 – 2004

| Year | Total Deaths | Total Deaths from Neoplasm | Deaths from Prostate Cancer | Prostate Cancer as a % of Neoplasm Deaths | Prostate Cancer Deaths as a % of Total Deaths |
|------|--------------|----------------------------|-----------------------------|---|---|
| 1996 | 777 | 124 | 28 | 22.6 | 3.6 |
| 1997 | 743 | 102 | 18 | 17.6 | 2.4 |
| 1998 | 830 | 116 | 18 | 15.5 | 2.2 |
| 1999 | 833 | 154 | 30 | 19.5 | 3.6 |
| 2000 | 700 | 127 | 26 | 20.5 | 3.7 |
| 2001 | 750 | 133 | 34 | 25.6 | 4.5 |
| 2002 | 770 | 122 | 24 | 19.7 | 3.1 |
| 2003 | 790 | 117 | 34 | 29.0 | 4.3 |
| 2004 | 798 | 116 | 16 | 13.7 | 2.0 |

The Elderly

St. Vincent and the Grenadines has joined the ranks of countries with an ageing population. The 2001 Census indicated a population of 106,253 of which 10,474 are 60 years of age and over representing 9.8% of the total population. For those ages 55 years and over the figure increases to 13,257 persons or 12.5% of the total population and for those age 50 years and over, it increases to 16,990 persons or 16% of the total population.

Table 11: Population 50 Years and Over by Sex & Percentage- 2001 Census

| Age | Total Population | % Total Population | Male | Female |
|--------------|-------------------------|---------------------------|---------------|---------------|
| 50-54 | 3, 733 | 3.5 | 1, 938 | 1, 795 |
| 55-59 | 2, 783 | 2.6 | 1, 393 | 1, 390 |
| 60-64 | 2, 734 | 2.6 | 1, 310 | 1, 424 |
| 65-69 | 2, 551 | 2.4 | 1, 226 | 1, 325 |
| 70-74 | 1, 951 | 1.8 | 891 | 1, 060 |
| 75-79 | 1, 514 | 1.4 | 634 | 880 |
| 80-84 | 943 | 0.9 | 385 | 558 |
| 85+ | 781 | 0.7 | 257 | 528 |
| TOTAL | 16, 900 | 16 % | 8, 034 | 8, 960 |

Source: Statistical Department

This demographic change has implications for health care delivery with regard to the elderly in the State. In 2004 a National Policy on Ageing and a five-year Plan of Action was developed. This plan will be revisited in 2007 with a view to having it adopted by Cabinet.



Golden Years Centre, Cane Grove

In 2006 the National Insurance built and commissioned two day care centres for the elderly, one at Cane Grove on the Leeward side of the island and the other at Black Point on the Windward.



Persons attending the opening of the Golden Years Centre, Cane Grove

Mental Health

There is no doubt that Mental Health disorders are on the increase as there are many stressors that precipitate mental disorders in the society today. In St. Vincent and the Grenadines mental health services are provided through the Mental Health Centre, which is a 160-bed capacity hospital. The center caters for acute and chronic patients of both sexes with an average census of 165 to 179.

Table 12: Admissions to the Mental Health Centre 2002 - 2004

| Year | Admissions | | | New Cases | | | Readmissions | | |
|-------------|-------------------|---------------|--------------|------------------|---------------|--------------|---------------------|---------------|--------------|
| | <i>Male</i> | <i>Female</i> | <i>Total</i> | <i>Male</i> | <i>Female</i> | <i>Total</i> | <i>Male</i> | <i>Female</i> | <i>Total</i> |
| 2002 | 513 | 100 | 613 | 107 | 20 | 127 | 406 | 80 | 486 |
| 2003 | 308 | 89 | 397 | 59 | 22 | 81 | 226 | 50 | 316 |
| 2004 | 357 | 70 | 427 | 55 | 19 | 74 | 387 | 66 | 383 |

Source: Mental Health Centre

Table 13: Common Mental Health Disorders 2002 - 2004

| DISORDERS | 2002 | 2003 | 2004 |
|------------------------|-------------|-------------|-------------|
| Schizophrenia | 123 | 106 | 111 |
| Manic Depressive | | 10 | 12 |
| Drug Induced Psychoses | 299 | 35 | 45 |
| Senile Dementia | | 10 | 11 |
| Acute Psychoses | 123 | 20 | 26 |
| Mental Retardation | | 13 | 12 |

Source: Mental Health Centre

Each year there is a ten percent new admission rate. Eighty five percent of all admissions since 2001 have been males with forty percent of these being drug abusers. The other major diagnosis is Schizophrenia.

Integration of mental health services into primary care is very limited due to inadequate psychiatric surveillance and support services such as social workers, counselors and occupational therapists. Indeed, there is no structured rehabilitation programme offered at any government health institution although plans are well advanced to construct a resident rehabilitation centre. The Marion House offers programmes aimed at both counseling and rehabilitation and some faith-based organizations engage in services to meet the psycho- social needs of persons, but these programmes are insufficient to offset the many social problems challenging the society.

Oral Health

The Government's Oral Services are offered at ten health centres. The services offered include preventive and restorative dentistry and minor oral surgery. These services target mainly the school age population whose main problem was identified as dental caries.

The Dental department has increased the number of community talks, primary school programmes and one-on-one talks with patients. This has proved to be successful as more patients are seen for preventative treatment and restorative care than in the past. Extractions are still however the highest reasons for visits and are direct results of clients being scared of the dentist and thus delay seeking treatment, the lack of dental education and the low cost of this treatment.

Data on indices to quantify Decayed, Missing and Filled teeth (DMFT) in St. Vincent and the Grenadines had not been collected. It is the intention to commence this process in 2007. These Governmental Oral Health Services are complemented by a number of private services.

Eye Care

Eye care has for sometime been offered as part of the specialist services delivered at the Milton Cato Memorial Hospital. To access this care patients are referred from within the public health system. Eye care is also offered as a private health service. A national eye- screening programme “Vision Now” was introduced in July 2005 through the collaborative effort of the government of Cuba. This programme continued into 2006 and saw over 16,000 persons screened with 1,625 of them travelling to Cuba for corrective surgery and over 1000 receiving glasses.

Rehabilitation Services

The main rehabilitation service offered is physiotherapy. The hospital physiotherapy department continues to have a steady increase in patient load. In 2002 the department saw 2374 patients and provided 4115 treatment sessions. Occupational therapy is offered on a limited scale at the Mental Health Centre. Efforts are being made to upscale rehabilitation services offered to psychiatric, drug abuse and other patients.

Environmental Health

The problem of air pollution is becoming a major concern for St. Vincent and the Grenadines. Air pollution is highest at peak hours in Kingstown, due to vehicular exhaust and construction work. As a response to the environmental concerns for air quality, leaded fuel was phased out in 1999.

Crude burning of rubbish and plastics is widespread within the state. Rubbish, in this context, means vegetative waste, which arises from the clearing of lands for agricultural purposes, the trimming of weeds from yards and cutting hedges. There is no organized system for the collection of green and/or brown waste, and plastics used in the banana industry. Pollution from smoke during charcoal production is still a factor in some residential areas. Used tires are destroyed, mainly by burning in a remote area of the country.

The Central Water and Sewerage Authority (CWSA) is the statutory body responsible for water resources including the production of potable water and the provision of sewage services. The main source of water is through surface sources (river and streams). Water from underground sources (wells and springs) as well as rain harvesting is utilized on the Grenadines Islands. The Public Health Department is responsible by law for regulating and monitoring the activities of the Central Water and Sewerage Authority. However, this is not done because of a lack of human, financial and physical resources within the Public Health Department. Most recent data indicate that over 95% of all households are connected to the communal water system and therefore receive safe disinfected water. All other persons live within one mile of standpipes and thus receive potable water.

St. Vincent and the Grenadines is a party to the Basel Convention. While there is no legislation to be used in the implementation of the Basel Convention, the Solid Waste Management Unit works in conjunction with the Environmental Services Unit to address issues related to Hazardous Waste Management.

The number of houses now equipped with septic tanks has increased to over 60% since the last census. The Government has embarked on a programme to convert the 39% outdoor facilities presently existing to the sewage system. Plans are also being advanced to construct a septic disposal system.

Almost the entire country now benefits from a level of regular weekly refuse collection. For the residents of Kingstown proper, refuse is collected daily. The residents in the Grenadines have twice per week collection and the remainder of the country receives collection once per week. The commercial and industrial sectors are responsible for their own collection and disposal. There are no tipping fees in St Vincent and the Grenadines. Under the OECS/World Bank Solid Waste Management Project, two major sanitary landfills have been completed on the mainland St. Vincent.

Food safety continues to be a major focus in St. Vincent and the Grenadines. The number of food establishments has increased but there is no system for registering and licensing these establishments. Food handlers' clinics are conducted twice per year at District Health Centers. These clinics provide education and information on food safety but attendance is voluntary. All persons involved in food vending must attend these clinics in order to be certified. Due primarily to the socio-economic condition, it has been noted that the number of itinerant vendors, although seasonal, has increased.

INSTITUTIONAL CAPACITY

Steering Role and Sector Leadership:

The Ministry of Health and the Environment is the executive arm of government with responsibility for Health and Environmental policies and service delivery. The organizational chart at appendix 1 represents the organizational framework by which the Ministry operates. The Minister of Health and the Environment is the political directorate, while the administrative leader is the Permanent Secretary and the Chief Medical Officer (CMO), the technical head. The administrative and technical leaders are guided by the rules and regulations of the Public Service.

In support of this structure there has been the establishment of a Senior Management Committee, which involves senior administrative and technical personnel at the Ministry. The primary responsibility of this committee is policy development and implementation. Specific terms of reference for the Senior Management Committee guide its operations. The Health Planner, although administratively under the Ministry of Finance and Planning, is based at the MOHE and is responsible for strategic planning and implementation of the Public Sector Investment Programme.

At the programme level, heads of department meet to discuss their programme plans and are accountable for the implementation, monitoring and evaluation of annually prepared operational plans. Additionally, departments conduct staff meetings aimed at discussing departmental programmes and personnel issues, problem resolution and staff development. Formal and Ad hoc

committees are formed consisting of persons with technical expertise required for the specific initiatives to assist the Planning Unit in performing its functions.

The Ministry of Health and the Environment has been engaged in an extensive process, which should lead to changes in the governance of the health system. There has been wide consultation on the proposed change of the main hospital to a statutory body. The legislation has been drafted and the Cabinet's decision on the matter is imminent. In November 2006, an evaluation of the Primary Health Care System was undertaken with the support of the Pan American Health Organisation. The findings of these studies will be consolidated and used to re-fashion and re-orient the health care delivery services in the state. The intention, in the future, is to improve the quality of care while devolving health care delivery services, with the Ministry of Health and the Environment responsible for policy setting, regulation of practice, harmonization of services offered and monitoring and evaluation.

Partnerships

The public health agenda has benefited from many partnerships over the years. The Planned Parenthood Association has contributed to population control, the Red Cross and the Disaster Preparedness Office now NEMO have contributed to management of crisis situation. The Rotary and the LIONS Clubs, the Cancer Society and the National Diabetic and Hypertensive Association have all contributed to health care delivery. Increased collaboration with all partners has been strengthened in the implementation of the HIV/AIDS programme and will be followed as a "best practice" in the other health programmes.

Technical Assistance

Support in the form of technical and financial assistance is also obtained from regional and international agencies such as the World Health Organization (WHO), the World Bank, Pan American Health Organization (PAHO), the European Union (EU), Centre for Epidemiological Surveillance (CAREC), the Organization of Eastern Caribbean States (OECS), the French, Japanese and Taiwanese Missions, St Georges University and other benefactors especially Vincentians in the regional and international Diaspora. These partnerships are valuable to the development of the health sector and ultimately the nation

Regulatory Framework

The delivery of health care services is governed by several different pieces of legislation. Most of these legislations are outdated and do not provide for governance and regulation of a present day health care system. Even when legislation has been enacted the system does not always make adequate provision for enforcement. While there is provision for the regulation of professionals and their practice there is none for the business and or facilities providing health care.

The health professionals, medical, nursing and pharmacists, are organized and regulated by their respective Councils. Other health professionals will be organized under one umbrella, the

Council of Health Professionals. Given that over 90% of the health workforce is employed with the Ministry of Health and the Environment, the government’s role in defining policies to train, retain and manage the human resource is very critical to the improvement and maintenance of efficiency and effectiveness in health care delivery.

Financing, Universal Coverage and Social Protection in Health

World Health Organisation (WHO) advocates that ‘the purpose of health financing is to make funding available as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective public and personal health care.’”

Health financing systems and mechanisms are expected to field adequate resources, foster efficiency and equity and be sustainable. At present health care is financed through the consolidated fund and from individual and household contributors mainly utilizing a fee for service system. During the period 1996-1999 discussions ensued and preparations were made for the implementation of a national health insurance programme. The process was reactivated in 2006 and a committee was appointed to advise the government on the introduction of this programme.

Essential Public Health Functions

Table 14: Essential Public Health Functions, St Vincent & the Grenadines 2002

| | FUNCTIONS | RATINGS |
|----|--|----------------|
| 1 | Monitoring, Evaluation and Analysis | .46 |
| 2 | Health Promotion Activities | .59 |
| 3 | National Approach IEC | .79 |
| 4 | Empowering Civil Society | .67 |
| 5 | Policies, Institutional Capacity for Planning and Strategic Implementation | .68 |
| 6 | Institutional Capacity for Regulation and Enforcement in Public Health | .52 |
| 7 | Promoting Equitable Access to Care | .96 |
| 8 | Human Resource Development and Training in Public Health | .77 |
| 9 | Ensuring Quality of Personnel and Population Based Health Sources | .43 |
| 10 | Research in Public Health | .33 |
| 11 | Emergencies and Disasters in Health | .94 |

An evaluation of the Essential Public Health Functions (EPHF) was conducted in 2002. The results showed that monitoring and evaluation, ensuring quality and population based sources and research were the three weakest areas of the system. Two of the stronger areas were the handling of emergencies and disasters and promoting equitable access to care.

Chapter 3:

OVERVIEW OF THE HEALTH SERVICE

ORGANIZATION OF SERVICES

Health services in St. Vincent and the Grenadines are significantly state-owned and centralized with little separation by population groups. There has however been an increase of private sector involvement in health care delivery over the past twenty years.

The Ministry of Health and the Environment provides, Primary, Secondary and Tertiary services through the following administrative structure and programmes;

- ◆ Milton Cato Memorial Hospital (MCMH)
- ◆ Environmental Health Department
- ◆ Environmental Services Unit
- ◆ Lewis Punnett Home/geriatric
- ◆ Mental Health Centre
- ◆ Community Health Services
- ◆ 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

The Ministry of Health and the Environment intends to, over a period of time, divest several of its programmes and restructure others so that it can focus more on policy formulation, monitoring and evaluation.

Primary Health Care Services

At the primary care level, thirty-nine (39) Health Centres, spreading over nine (9) health districts, provide services to the users of these facilities. On an average, each Health Centre is equipped to cater to a population of 2,900 with no one required to travel more than three (3) miles to access care.



Biabou Health Centre

Table 15: Health Districts by Health Centres and Population 2004

| Health Districts | Health Centres | Population |
|-------------------------|----------------------------|-------------------|
| District 1 | Kingstown | 18, 042 |
| District 2 | Calliaqua | 26, 190 |
| District 3 | Marriaqua | 17, 107 |
| District 4 | Cedars | 10, 334 |
| District 5 | Georgetown | 12, 157 |
| District 6 | Pembroke | 18, 232 |
| District 7 | Chateaubelair | 6, 907 |
| District 8 | Northern Grenadines | 4, 881 |
| District 9 | Southern Grenadines | 1, 377 |

- * Source: clinic records (Institution and Year)

The primary care services available include emergency care, medical care, prenatal and postnatal care, midwifery services and child health services including immunization school health, family planning services, communicable and non-communicable diseases control. Oral health services are delivered at selected health centres throughout the state while mental health services are offered on a visiting basis at all health centres.

The rural-urban transformation shift in the population has impacted the population distribution within districts, resulting in the need to re-define district boundaries. Most health centres are staffed with a full-time District Nurse, a Nursing Assistant and a Community Health Aide. Other district health team members such as District Medical Officer, Pharmacist, Nursing Supervisor, Family Nurse Practitioner, Environmental Health Officer, Family Life Educator, Social worker, Nutrition Officer and other visiting staff provide support. Given the new challenges in health care there is need for a paradigm shift in the delivery of primary health care to a more

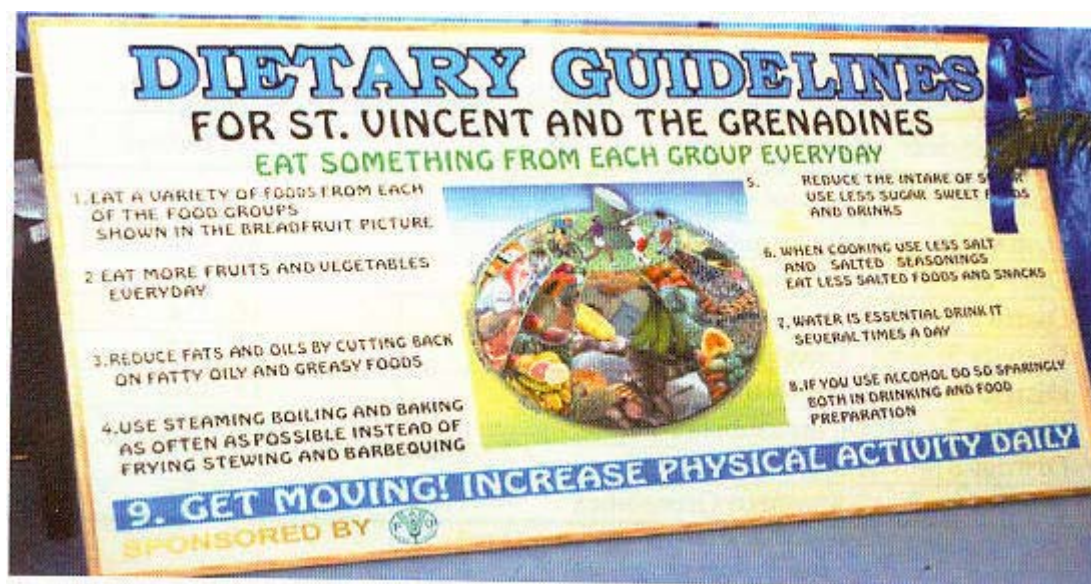
comprehensive integrated family centered care delivered by a team of generalists and specialists health care providers.

The Environmental Health Department presently takes responsibility for Public Health related matters while the Environmental Health Services Unit focuses on global environmental issues and is also responsible for the co-ordination of several environmental programmes and projects at the local level. There is a policy initiative to amalgamate these two departments with a heightened public focus.

Two departments coordinate nutrition programming in the Ministry of Health and the Environment; the Nutrition Unit and the Nutrition Support Programme.

The Nutrition Unit was established in 1989 from the Joint WHO/UNICEF Nutrition Support Programme (JNSP) as a support to the Maternal and Child Health Programme. The primary purpose of the Nutrition Unit was reduction of malnutrition in young children. The Unit's mandate has broadened over the past years to cover service provided in two major functional areas; Public Health Nutrition and Dietetics. This includes the prevention and control of nutrition-related health conditions and the promotion of improved food and nutrition security and optimal nutrition status. These are achieved through nutrition monitoring and surveillance; information, education, promotion, training and intervention programmes; the supervision of Foodservice Operations and the delivery of nutrition care service in public hospitals and health centres. There is need for sufficient Nutritionists at the primary care level and Dietitians at the secondary care level for the desired level of service provision.

The Nutrition Support Programme has two components: a.) A school-feeding programme which provides approximately 2,531 pre-schoolers in seventy three (73) pre- schools with hot milk and biscuit on a daily basis; 7,449 primary school students and 253 multipurpose center students in sixty one (61) primary schools and four (4) multi-purpose centers with four hot meals and one snack-type meal on a weekly basis; and b.) A supplemental feeding programme which provides 1885 mothers, infants and children registered in antenatal, postnatal and child health clinics in thirty-seven (37) public health centres with monthly food packages.



Secondary 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. Plans are underway to upscale the Georgetown Hospital to include a state of the art Diagnostic and Renal Dialysis Unit.

Milton Cato Memorial Hospital



The delivery of care is organized into seven departments; these are Accident and Emergency, Out-patient Department, Surgery, Medicine, Operating Theatre, Pediatric and Obstetrics/Gynecology.

The Accident and Emergency Unit manages patients based on a triage system, i.e. those requiring care most receive it first. Apart from the Maternity Unit, the Accident & Emergency is the main area of admission to the institution. Of the total number of patients seen between 2000 and 2004, only five hundred and seventy-three (573) or 0.38% were classified as red tag or critical. This is an indication of the utilization of the department by non-emergency cases. It is important to note the significant increase in the number of cardiac-related conditions seen. There has been a steady increase from 362 in 2000 to 1,205 in 2004.

Table 16: Priority Conditions seen at Accident & Emergency MCMH 2000 – 2004

| PRIORITY CONDITIONS | 2000 | 2001 | 2002 | 2003 | 2004 |
|-----------------------------|---------------|---------------|---------------|---------------|---------------|
| Road Traffic Accident | 273 | 365 | 326 | 297 | 345 |
| Police Cases | 474 | 579 | 379 | 422 | 373 |
| Fresh Wounds | 4,449 | 4,078 | 3,597 | 3,579 | 3,678 |
| Asthma | 2,482 | 2,852 | 2,386 | 2,770 | 2,181 |
| Cardiac | 362 | 258 | 446 | 761 | 1,205 |
| Ingestion of Poison | 23 | 16 | 51 | 29 | 18 |
| Gastroenteritis | 1,560 | 993 | 846 | 1,244 | 1,025 |
| Critical – Red Tag Patients | 166 | 85 | 52 | 130 | 140 |
| Diabetes | 476 | 463 | 602 | 864 | 759 |
| Casualties | 26,655 | 25,068 | 26,142 | 29,001 | 25,046 |
| Admissions | 5,153 | 5,243 | 5,131 | 5,895 | 5,318 |
| Total Cases | 31,104 | 29,146 | 29,739 | 32,580 | 28,724 |

** Source: Accident & Emergency Records

Although the number of asthma cases remains relatively constant, the number of admissions to the ward areas has declined, especially on the paediatric ward. This is due to an organized asthma programme and the introduction of an asthma bay and vigorous intervention at the Accident and Emergency Unit and Community Health Services.

Twelve specialist clinics are conducted in the Out Patient Department. These are Ears Nose and Throat, Dermatology, Ophthalmology, Psychiatric, Paediatric, Orthopaedic, Obstetric or Gynaecology, Urology, Surgical, Medical, Family Planning and Asthma. This service is complemented by overseas consultants who provide services such as Cardiology, Reconstructive Surgery (Plastic Surgery) and Ophthalmology. Record keeping is problematic at times but steps have been taken to improve the quality of this service. This department, although recently renovated, is cramped and requires additional space.

There are three (3) operating theatres that are not optimized. There are six (6) surgical firms. Most firms operate on an 8 am – 4 pm time schedule. Only emergency surgery should be done between 4 pm – 8 am and on weekends.

A two (2) bed Intensive Care Unit is attached to the Operating Room. For the past five (5) years (2000-2004), five hundred and one (501) patients were admitted to the unit. Fourteen (14) of these were transferred overseas by air ambulance and other means of transport for further management. This is an important unit, where all critical cases requiring intensive care are managed. Admissions are mainly for head injuries and cardiac-related complications such as Myocardial Infarction. An additional two to four beds in this unit would satisfy short-term requirements.

There is a male and a female surgical ward where surgical conditions are managed. These wards receive patients for general surgery, orthopedic and ophthalmology and on the female ward patients with gynecological conditions.

There is a male and female medical ward on which all patients with medical conditions are managed. Detoxification of patients is to be included in the medical care being offered.

The paediatric ward consists of fifty-five (55) beds with an average census of thirty. This is a mixed ward with mainly medical surgical conditions.

Table 17: Vital Indicators Milton Cato Memorial Hospital

| Indicators | 2000 | 2001 | 2002 | 2003 | 2004 |
|----------------------|---------|---------|---------|---------|---------|
| Admissions | 8, 853 | 9, 277 | 9, 446 | 9, 693 | 9, 205 |
| Discharges | 8, 847 | 9, 255 | 9, 205 | 9, 454 | 8, 951 |
| Deaths | - | 250 | 253 | 236 | 259 |
| In-Patient days | - | 47, 613 | 46, 204 | 44, 346 | 48, 792 |
| Bed complement | - | 186 | 186 | 190 | 211 |
| Turnover Rate | 38.7 | 49.5 | 50.7 | 46.4 | 48 |
| % Bed occupy | 60 | 70 | 70 | 64 | 70.2 |
| Deliveries | 1, 892 | 1, 961 | 1, 751 | 1,742 | 1, 666 |
| Live Births | 1, 895 | 1, 955 | 1,753 | 1,738 | 1, 650 |
| Still Births | 20 | 30 | 23 | 20 | 26 |
| Neonatal Deaths | 21 | 24 | 13 | 22 | 23 |
| Maternal Deaths | 1 | 0 | 1 | 2 | 0 |
| Anemia in Pregnancy | 154 | 196 | 184 | 93 | 72 |
| HIV Positive Mothers | 5 | 9 | 9 | 11 | 14 |
| Surgeries | 2,717 | 3,048 | 3,300 | 3,526 | 3,543 |
| Casualty Attendance | 31, 104 | 29, 146 | 29, 739 | 32, 580 | 28, 724 |
| Out-patient Visits | 18,957 | 16,547 | 16,300 | 18,651 | |
| Intensive Care Unit | 94 | 96 | 113 | 115 | 83 |

** Source: MCMH Statistics 2004

Ambulance services were introduced in the 1960s and are offered to the general public free of cost. The services are maintained mainly by donations from benefactors in the International Community. Recently, however, purchases of ambulances have been made from the Consolidated Fund.



At present there are nine (9) ambulances located at specific areas throughout the state. These are considered inadequate to meet the needs over the next five years. There is need also, to implement ongoing training programmes for Emergency Medical Technicians, Ambulance Drivers, and other first responders, and to ensure that ambulances are well maintained and functional.

Over the years the scope and quality of laboratory services have continued to improve. The acquisition of modern equipment has led to significant improvement in the quality of the service. The *Coulter Haematology Analyzer* introduced in 2002 has resulted in a marked reduction in the turn-around time for some tests e.g. PSAs, TFTs, HIVs and HepBs. This equipment also allowed for expanded capability and capacity of the practice of medicine locally. Tests like therapeutic drugs, drugs of abuse, troponin and myoglobin among others have been included for the first time. The *BD Facscount*, introduced in March 2003 has allowed the laboratory to effectively handle the increased demand for CD4 counts resulting in the introduction of antiretroviral therapy for HIV/AIDS programme as well as the increasing demand for routine haematology. The laboratory has benefited from two information programmes, RABIS and PHILIS. Discussions are ongoing regarding the need for a Public Health laboratory and strengthening of the laboratory information system, since the quality of the health care provided will depend primarily on the strength of the information generated from the laboratory.

Notwithstanding, the shortage of Cyto-technologists in the region which had a negative impact on the national service, resulting in increasing waiting times for Pap smear reports, the addition of an anatomical pathologist in 2002, has greatly enhanced the scope of the services and significantly reduced the turn-around time for histopathology reports. A major regional effort to improve this situation is currently underway.

Participation in the EU-sponsored “Strengthening of Medical Laboratories in the Caribbean” project has contributed significantly to a clearer understanding of the quality of laboratory services in the state and the way forward in achieving standardization and accreditation.

The Central Pharmacy and Pharmaceutical Services are charged with the procurement, preparation, dispensation and distribution of all drugs within the national health system. The division is also responsible for procuring and distributing medical and other supplies that facilitate the proper functioning of the health system, and performs these functions through the Medical Stores. The bulk of Pharmaceuticals are purchased through the OECS Pharmaceutical Procurement Services (PPS) formerly the Eastern Caribbean Drugs Service. According to the Regional Formulary and Therapeutic Manual, there are seventy-six (76) categories of drugs from which the Ministry of Health and the Environment can purchase. There are presently 39 district pharmacies supplying drugs to the Public Health system. There are thirteen (13) registered private pharmacies and thirty-one (31) registered pharmacists. Of these, the Ministry of Health and the Environment employ nineteen (19).

Over the past fifteen (15) years, the Department of Radiology and the services of radiology have developed significantly. The services were expanded to include a full range of fluoroscopy examinations, conducted to modern standards, and introduction of Interventional Ultrasound guided procedures. Six years ago, 1998, the State of St. Vincent and the Grenadines gained

headway beyond other OECS countries by the introduction of Computerize Axial Tomography scanning in the private sector, which has been working in tandem with the hospital services, saving patients from having to travel abroad to access this facility. Four years ago, an additional service plain film unit was installed in the Department of Accident and Emergency, improving access for emergency radiography. During this period, several persons were trained as Radiographers but the department still experiences shortages in staffing as persons have migrated.

Rural Hospitals

Five rural hospitals, with a combined bed capacity of fifty-eight (58), provide a minimum level of secondary care, for which specialist intervention is not indicated. In addition there is one other privately owned and operated acute care hospital, the Maryfield with a bed capacity of twelve (12). Government also operates a 186-bed Mental Health Centre (MHC) that provides care to acute and chronic Psychiatric patients and a 106-bed Lewis Punnett Home, which caters to an indigent elderly population and a small number of physically and mentally, challenged adults. Five private institutions with a combined bed capacity of 55 offer resident care to the elderly.

Health Information and Planning

The Health Planning and Information Unit was established within the Ministry of Health and the Environment in 1984. The unit is seriously understaffed but reasonable success has been achieved. There are seven information systems currently in use. They are Mort-base (mortality data), Non-Com (Non-Communicable Diseases), Com-Dis (Communicable Diseases), and Maternal and Child Health/Family Planning (MCH/FP) and the Perinatal Database. The ORIAN is the system used in Pharmaceuticals and PHILIS and LABIS at the Laboratory. Data captured from other sources form part of quarterly reports and ultimately the Ministry records. Resources are required to allow for focus on emerging and re-emerging infections. Surveillance is being strengthened and a framework for monitoring and evaluation of programmes is being implemented.

Health Expenditure

Financial support from Government comes through the submission of annual budgetary proposals put forward to the Ministry of Finance and Planning, and based on plans and programmes derived from the strategic and Operational planning processes. Governments' contribution to health care has been considerable.

**Table 18: Budgetary Allocation for the Ministry of Health and the Environment
2000-2004 (EC\$M)**

| | 2000 | 2001 | 2002 | 2003 | 2004 |
|-----------------------------------|-------------|-------------|-------------|-------------|-------------|
| Recurrent Budget | 37.4 | 39.8 | 43.0 | 42.1 | 42.8 |
| Capital Budget | 17.1 | 15.8 | 8.4 | 16.6 | 7.5 |
| Total Health Budget | 54.5 | 55.6 | 51.4 | 58.7 | 50.3 |
| National Budget | 424 | 438 | 420 | 487 | 483 |
| Health as% National Budget | 12.8 | 12.7 | 12.2 | 12.0 | 10.4 |
| Health as % of GDP | 4.6 | 4.7 | 4.9 | 4.6 | 4.3 |

**** Source: Government Estimates**

It must be noted that other departments, private sector, individuals and households make significant direct and indirect contributions to health. There is need to quantify these contributions through the introduction of a National Health Accounts System.

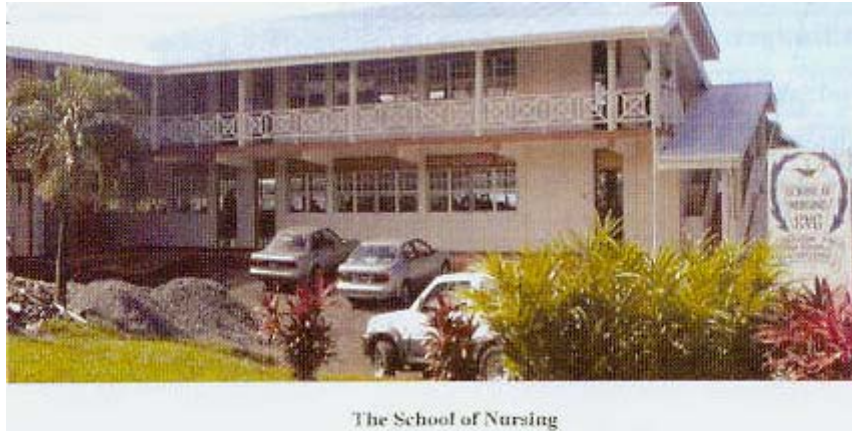
Human resources

There is need to assess and implement strategies aimed at strengthening health human resource capacity of the country. The data on health human resources are not very organized. The 2005 figures show the following ratios:

Table 19: Health Professions by Disciplines, Numbers and % Population 2004

| Health Professionals | Number | Per 10,000 Population |
|-----------------------------|---------------|------------------------------|
| Physicians | 101 | 9.51 |
| Registered Nurses | 243 | 21.49 |
| Nursing Assistants | 146 | 11.67 |
| Nursing Auxiliaries | 115 | 10.82 |
| Laboratory Technicians | 13 | 1.22 |
| Pharmacists | 36 | 3.39 |
| Environmental Officers | 14 | 1.32 |
| Psychiatrist | 2 | 0.19 |
| Psychologist | 1 | 0.09 |
| Dentists | 13 | 1.22 |
| Counselors | 5 | 0.47 |
| Nutrition Officers | 12 | 1.13 |
| Health Educators | 7 | 0.66 |

The General Nursing Council's register of trained nurses shows 398 nurses of varying categories (362 per 100,000 populations) are registered. St. Vincent is home to the Government School of Nursing, as well as the Grenada based off shore Kingstown Medical College. The School of Nursing has recently strengthened the Registered Nursing Programme to accommodate an increase in its enrollment. There is shortage of staff in disciplines such as Radiography, physiotherapy, social work and pharmacy.



The School of Nursing

CONCLUSION

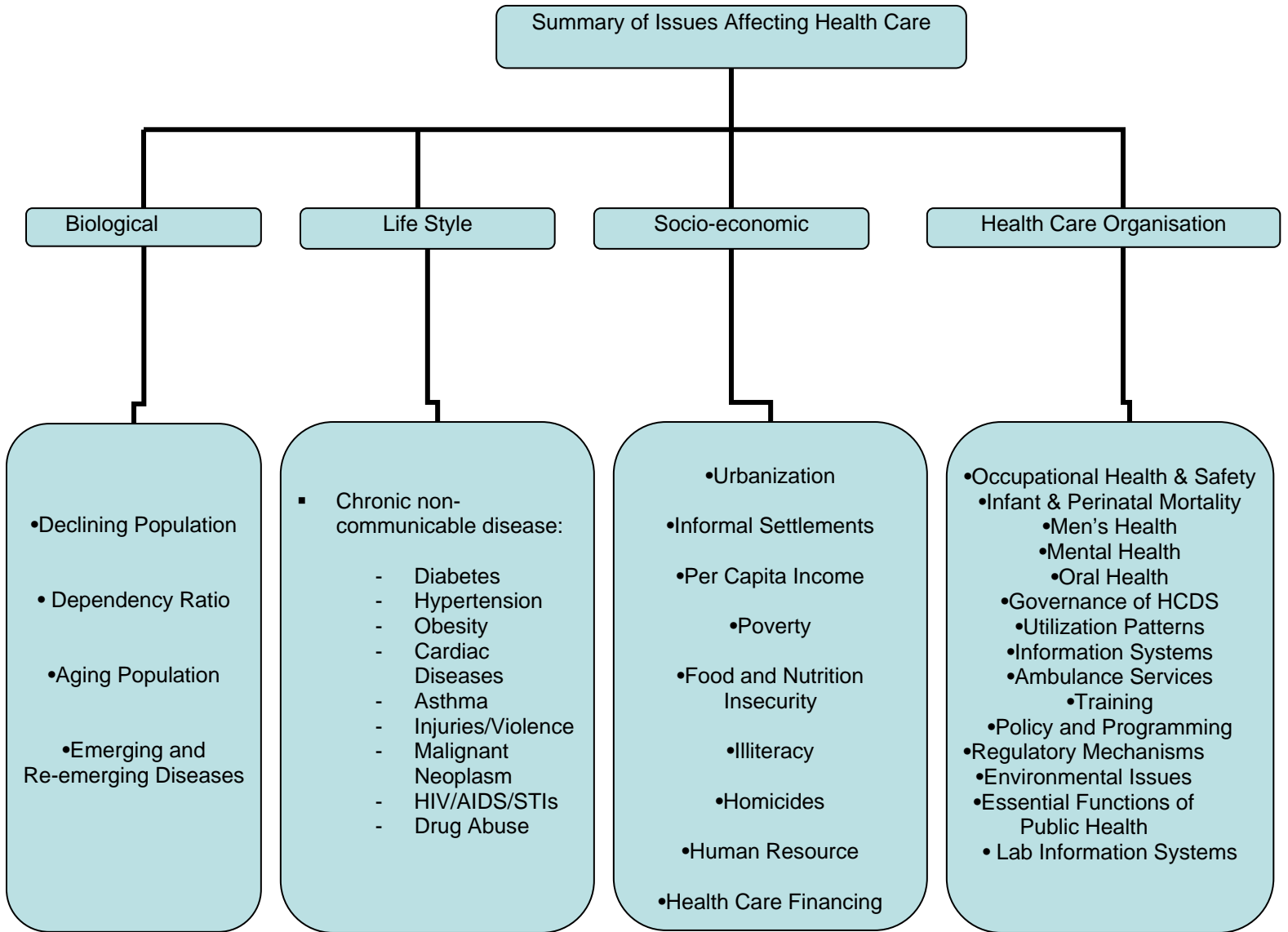
In conclusion, there has been tremendous improvement in the health of the people of this nation over the past years and all must be commended, the government, the health sector and the people of this state. Every effort must be made to ensure that the gains made over the past years are not eroded but sustained and improved.

The reformation of the health system is integral to achieving the Millennium Development Goals that were established by the United Nations in 2000, particularly to eradicate extreme poverty and hunger; combat HIV/AIDS, Malaria and other diseases; and ensure environmental sustainability.

The main challenges to the performance of the health care system include bringing about fundamental behavior change in the population in order to tackle the growing prevalence of lifestyle related illnesses. The absence of an adequate information system and lack of appropriate research agenda to facilitate evidence-based decision making are also hindrances to the effective performance of the health system. Importantly, health-financing mechanisms need to be re-organized and human resource capabilities maximized.

The strategic directions outlined in the Log Frame on the next few pages offer a strategic orientation focusing on the identified health problems arising from the situational analysis. The collective effort of every citizen is therefore vital to the achievement of realizing individual, community and population health. Remember, **THE HEALTH OF THE NATION IS THE WEALTH OF THE NATION.**

Figure 12: Summary of Issues Arising from Situational Analysis



**ST VINCENT AND THE GRENADINES
NATIONAL STRATEGIC HEALTH PLAN LOG FRAME 2007 - 2012**

| SUMMARY OF OBJECTIVE | INDICATORS | ASSUMPTIONS | MEANS OF VERIFICATION |
|---|---|---|---|
| GOAL: To improve the health status of the people of St Vincent and the Grenadines | | | |
| PURPOSE: To develop an efficient, effective, equitable, sustainable and quality oriented health system that will enable the people of SVG to live healthier and more productive lives. | | | |
| STRATEGIC DIRECTIONS: | | | |
| 1. Strengthening of the Health Information Systems and the Organization and management of resources for health | 1.1 Planning processes in all sectors, utilize updated information (not later than 2 years old) to inform decision making by end 2012 1.2 Human resource available in numbers and skills mixed to adequately meet the needs of health care system by 2012 | <ul style="list-style-type: none"> ▪ Plans are utilized and resources are available ▪ Budgetary allocation are available ▪ Estimated staff positions remain filled | <ul style="list-style-type: none"> ▪ Programme Plans ▪ MTESP ▪ Corporate Plan ▪ Training reports ▪ Budgetary estimates ▪ Cabinet memos ▪ HHR Sector Plan |
| EXPECTED OUTCOMES: | | | |
| 1.1 Adequate, accurate, timely Information available to Direct national health Planning | 1.1.1 Strengthen information systems to include: <ul style="list-style-type: none"> • Patient registration system • Lab information system • National health accounts • HIV/AIDS/STI database • Clinical Health Information System by 2012. 1.1.2 Provide feedback on the national indicators to program heads annually by 2008 1.1.3 Train health care staff and managers at national and district levels in basic epidemiology and use of information to direct planning and decision-making processes by year 2008 1.1.4 Produce health reports (Core Data Set, Digest of Health Statistic) annually/biannually | <ul style="list-style-type: none"> ▪ Systems remain functional ▪ Information is utilized ▪ Systems remain functional ▪ Knowledge is applied | <ul style="list-style-type: none"> ▪ Output Forms ▪ Reports ▪ CMO Report ▪ Output Forms ▪ Inventories ▪ Reports ▪ Directories |

| SUMMARY OF OBJECTIVE | INDICATORS | ASSUMPTIONS | MEANS OF VERIFICATION |
|--|---|--|---|
| EXPECTED OUTCOMES: | | | |
| 1.2 National human resource for health database established and linked to the regional network. | 1.2.1 Establish a database of Health Human Resource utilizing GNC and other health disciplines by year 2008 1.2.2 Establish a repository Human Resource database for Health within the HPIU by 2010. 1.2.3 Establish a website linked To a regional database by 2010. | <ul style="list-style-type: none"> ▪ Resources available ▪ Staff committed ▪ Systems remain functional | <ul style="list-style-type: none"> ▪ Output forms ▪ Database Output reports ▪ Website |
| 1.3 Plan for the management and development of human resources for health completed and in implementation by 2007 | 1.3.1 Strategic Plan for HRH development available by year end 2008 | <ul style="list-style-type: none"> ▪ Resources available ▪ Staff committed | <ul style="list-style-type: none"> ▪ Human Resource health Sector plan |
| 1.4 National human resources Capacity strengthened in The private and public Sectors | 1.4.1 Selected professionals or managers trained for priority areas by the year 2007 -2012 1.4.2 Staff will be deployed as per needs of institution allowing for utilization patterns between 85 – 100% year 2007 – 2012 | <ul style="list-style-type: none"> ▪ Resources available ▪ Staff committed | <ul style="list-style-type: none"> ▪ Training Reports ▪ Staff Deployment List |
| STRATEGIC DIRECTIONS: | | | |
| 2. Promote and improve the Prevention and management Of chronic diseases and other Priority health needs by Developing, restructuring and Implementing appropriate Health programmes | 2.1 Mortality for the following conditions reduced over the period 2007 – 2012 <ul style="list-style-type: none"> ▪ Hypertension by 10% over 2004 ▪ Diabetes Mellitus by 10% over 2004 ▪ Motor Vehicle accidents by 50% over 2004 ▪ Injuries and Violence by 25% over 2004 figures ▪ AIDS related by 20% over 2004 figures ▪ Acute Respiratory Infections in children 0 – 5 Years reduced by 50% over 2004 figures 2.2 Baseline data on prevalence of Obesity establish by year end 2008 2.3 Baseline on prevalence of Depression establish by year end 2009 | <ul style="list-style-type: none"> ▪ There are no disasters or serious emerging infections. ▪ Health continues to receive adequate resources. ▪ Appropriate programmes are planned and implemented ▪ Appropriate programmes are planned and implemented ▪ Public compliance is high | <ul style="list-style-type: none"> ▪ CMO Report ▪ Digest of statistics ▪ Core data sets ▪ Programme reports |

| SUMMARY OF OBJECTIVE | INDICATORS | ASSUMPTIONS | MEANS OF VERIFICATION |
|--|--|--|---|
| STRATEGIC DIRECTIONS | | | |
| | <p>2.4 Readmissions to MHC and MCMH Due to drug dependency reduced by 25% by year 2010.</p> <p>2.5 100% of health care workers oriented to CCHII and other health promoting strategies by 2008.</p> | <ul style="list-style-type: none"> ▪ Knowledge is applied in programming and planning for health care delivery | <ul style="list-style-type: none"> ▪ Survey reports ▪ Training reports |
| EXPECTED OUTCOMES: | | | |
| <p>2.1 Positive health outcomes achieved through a re-oriented PHC Service</p> | <p>2.1.1 Redefinition of the boundaries of health districts and implementation of recommendations of the evaluation of PHC Services initiated by 2007</p> <p>2.1.2 Increase utilization patterns for males at District Health Centres by 20% by 2010</p> <p>2.1.3 Improve consumers satisfaction with PHCS to above 80% by year end 2010</p> <p>2.1.4 Reduction in Infant/Perinatal Mortality by 25% by year end 2008</p> <p>2.1.5 Implementation of an organized waste disposal system to include bio-hazardous and septic waste by year end 2008</p> | <ul style="list-style-type: none"> ▪ Management modalities are effective ▪ Public is compliant ▪ Resources are constantly available ▪ Change process is properly managed | <ul style="list-style-type: none"> ▪ Organizational chart ▪ Reports ▪ Survey reports ▪ Evaluate reports |
| <p>2.2 Reduction in morbidity and mortality due to NCDs and HIV/AIDS</p> | <p>2.2.1 Implementation of a structured PHC programme for non - communicable diseases by year end 2008</p> <p>2.2.2 Upscale marketing strategies aimed at behavior modification by end 2007</p> <p>2.2.3 Strengthen surveillance systems to high alert levels by year end 2008</p> | <ul style="list-style-type: none"> ▪ Public is compliant ▪ Public is compliant | <ul style="list-style-type: none"> ▪ CMO report ▪ Surveillance report ▪ Media spots ▪ Output forms |

| SUMMARY OF OBJECTIVE | INDICATORS | ASSUMPTIONS | MEANS OF VERIFICATION |
|---|---|---|---|
| EXPECTED OUTCOMES: | | | |
| 2.3 Public exhibit behaviors congruent with healthy lifestyle practices | 2.3.1 Legislation enacted to mandate the utilization of safety devices during driving and hazardous occupations by year end 2007 2.3.2 Smoking prohibited in government buildings and facilities by year end 2008 2.3.3 Drug prevention rehabilitation programme implemented fully by year end 2008 | <ul style="list-style-type: none"> ▪ Legislation is enforced ▪ Public is compliant ▪ Programme is utilized and is effective | <ul style="list-style-type: none"> ▪ Legal documents ▪ Warning signs ▪ Programme reports |
| 2.4 Secondary health care services improved through the implementation of hospital governance at MCMH | 2.4.1 Milton Cato Memorial Hospital, a statutory body with re-oriented management systems by 2008 2.4.2 Secondary health care up-scaled through expansion of services at GHC by year end 2012 2.4.3 Patient satisfaction in services at MCMH above 80% by year 2009 | <ul style="list-style-type: none"> ▪ Systems are efficient and effective ▪ Facility becomes operational ▪ Ratings remain consistent ▪ Prudent fiscal measures are applied | <ul style="list-style-type: none"> ▪ Legal documents ▪ Site visits ▪ Operational guidelines document ▪ Survey report |
| STRATEGIC DIRECTIONS: | | | |
| 3. Articulate policies to promote universal coverage, equity and sustainability of the health system | 3.1 Increased utilization of health services by nationals and visitors by year end 2012 3.2 Articulation of Policy Statement to guide the delivery of services by end 2012 3.3 Mobilization of resources (financial and otherwise) to deliver an upgraded health care service by year end 2012 | <ul style="list-style-type: none"> ▪ Public compliance with expectations ▪ Maintenance of these services ▪ Application of sound financial and management principles | <ul style="list-style-type: none"> ▪ Chief Medical Officer report ▪ Annual reports ▪ Site visits ▪ Audit reports ▪ Programme reports |
| EXPECTED OUTCOMES: | | | |
| 3.1 Ensure adequate, equitable and sustainable resources for health | 3.1.1 Financial management and information system revised to facilitate unit costing of a range of primary and secondary services by 2008 | <ul style="list-style-type: none"> ▪ Political commitment and cabinet approval | <ul style="list-style-type: none"> ▪ National Health Accounts report |

| SUMMARY OF OBJECTIVE | INDICATORS | ASSUMPTIONS | MEANS OF VERIFICATION |
|---|--|---|--|
| STRATEGIC DIRECTIONS: | | | |
| EXPECTED OUTCOMES: | | | |
| | 3.1.2 Evidence of mobilization of additional financial resources for health services by 2008-2012 3.1.3 Autonomous system for the management of health finances instituted by year end 2010 | <ul style="list-style-type: none"> ▪ 6% of GDP allocated to health in national accounts ▪ Political commitment and cabinet approval | <ul style="list-style-type: none"> ▪ Financial statements ▪ NHIP Board establish |
| 3.2 Equitable allocation of financing in the health sector | 3.2.1 National Health Accounts implemented by 2008 3.2.2 Evidence of improved allocation and utilization of funds to reflect policy priorities of health and disease prevention by 2010 | <ul style="list-style-type: none"> ▪ Allocations are reflected in Government estimates and available disbursements to the priority programmes ▪ Relevant data is available, analyzed and utilized in equitable allocation | <ul style="list-style-type: none"> ▪ National Health account report ▪ Submission in annual advance proposals for priority programmes |
| 3.3 Every resident has equal access to basic package of health services irrespective of capacity to pay | 3.3.1 Basic package of health services defined and sustained by end 2008 - 2012 | <ul style="list-style-type: none"> ▪ Cabinet approves basic package and resources are available | <ul style="list-style-type: none"> ▪ Basic package document is available for dissemination to the public |
| STRATEGIC DIRECTIONS: | | | |
| 4. Strengthening the steering role of the Ministry of Health and the Environment | 4.1 Mechanisms to reorient the MOHE's role in governance instituted by year end 2008 4.2 Functional capacity of the health sector strengthened by year 2010 | <ul style="list-style-type: none"> ▪ Leadership is committed and effective ▪ Human resource remains stable and committed | <ul style="list-style-type: none"> ▪ Policy documents ▪ Staff list ▪ Performance reports |
| EXPECTED OUTCOMES: | | | |
| 4.1 National Health Policy formulated and directed by MOHE | 4.1.1 National Health Policy that defines the roles and functions of stakeholders in the Health Sector, and the national health priorities, developed and disseminated and utilized by end 2009 | <ul style="list-style-type: none"> ▪ The National Health Policy will reflect a re-orientation of the overall health sector and the direction of programmes of the Ministry of Health and the Environment and other stakeholders | <ul style="list-style-type: none"> ▪ National Health Policy ▪ Ministry of Health and the Environment Organization Chart |

| SUMMARY OF OBJECTIVE | INDICATORS | ASSUMPTIONS | MEANS OF VERIFICATION |
|--|---|---|---|
| STRATEGIC DIRECTIONS: | | | |
| EXPECTED OUTCOMES: | | | |
| 4.2 Improved performance of the EPHFs | 4.2.1 Increase the capacity for performance of the EPHFs by year 2010 | <ul style="list-style-type: none"> ▪ Requisite structural conditions and institutional development for improved EPHF performance | <ul style="list-style-type: none"> ▪ EPHF profile |
| 4.3 Harmonization of health services offered by different providers (public, private and NGOs) | 4.3.1 Mechanisms for the harmonization of services offered by the different providers defined and established by year 2011 | <ul style="list-style-type: none"> ▪ Parties will collaborate on issues related to the delivery of health services | <ul style="list-style-type: none"> ▪ Memorandum of understanding of service level agreement between Ministry of Health and the Environment, Private Service Providers and NGOs |
| 4.4 Participatory mechanisms for consensus building in health established | 4.4.1 Formal mechanisms established for involving participation including the private sector, NGOs and civil society by end 2008 | <ul style="list-style-type: none"> ▪ Health is accepted as a multi-sectoral issue | <ul style="list-style-type: none"> ▪ Committee minutes reports and plans of action |
| 4.5 Health legislation and regulations reviewed and updated | 4.5.1 Legislative and administrative arrangements revised and updated for the standardization of the delivery of services by end 2012 | <ul style="list-style-type: none"> ▪ Legal Affairs will treat the revised legislation with some measure of urgency | <ul style="list-style-type: none"> ▪ Public Health Laws |

PROGRAMME INDICATORS AND STRATEGIES

FAMILY HEALTH

Child Health

GOAL

A population of 0-8 years who are healthy and well adjusted to their environment equipped to embark on a happy life.

INDICATORS

- Breast-feeding initiated in 99% of newborns by 2006 and through to 2009.
- Immunization coverage of 100% in the under five population for diseases covered by EPI program 2007 – 2012.
- 98% of children attain positive growth monitoring milestones annually through to 2012
- Reduction in Infant Mortality and Perinatal Mortality ongoing to 2012.
- Reduction by 50% in childhood diseases by 2012 over 2004 figures.
- 100% of Clinic Staff trained in the identification and early treatment of Child Abuse ARI/Asthma and Gastro Enteritis by 2012.
- 100% schools have staff trained in the identification and early management of Child abuse, Acute Respiratory infections asthma, Gastro Enteritis by year- end 2012.

STRATEGIES

- ◆ Continue child health clinics sessions at all health centres 2007-2012.
- ◆ Simplified Peri-natal records developed and utilized at all public health institutions (clinics and hospital) by 2012.
- ◆ Collaborate with Ministry of Education to support activities in preschools and primary schools.
- ◆ Establish standards to protect the mentally challenged children by 2010
- ◆ Include parenting skills in all community health training programmes.
- ◆ Maintain policy and standards with respect to baby Friendliness at Milton Cato Memorial Hospital and throughout the day care centres.
- ◆ Establish database to make informed decision re diarrhoeal diseases by year- end 2012.
- ◆ Collaborate with Ministry of Social Development to establish database on child abuse by 2012.
- ◆ Maintain the functioning of the Maternal and Child Health Committee and the Breast Feeding and young child feeding Committee.
- ◆ Collaborate with private enterprise to facilitate Child Health Development activities 2007-2012.

YOUTH AND ADOLESCENTS

GOAL:

To create a supportive environment which will empower youths and adolescents to make meaningful decisions for their well being.

Indicators

- Reduction in teenage pregnancy by 25% over 2004 figures by year 2012.
- Reduction in drug related admissions to Mental Health Centre by 50% by year 2012 over 2005 figures.
- Prevalence of over and under nutrition decreased by 20% in 2012 over that of 2004.
- Incidence of HIV/AIDS/STI'S among adolescents decrease by 40% by 2012
- 100% secondary schools have teachers trained in the management of asthma by 2010.

Strategies

- ◆ Strengthen counseling programmes in all primary, secondary and tertiary educational institutions during 2007-2012.
- ◆ Expand the DARE programme to all primary and secondary schools by 2012.
- ◆ Utilize culture and drama to spread the message about drugs and their effects beginning in the 2007 drama festival.
- ◆ Implement a rehabilitative programme, which incorporates detoxification, short term resident and long term follow up and skills training aspects of beginning 2007 – 2012.
- ◆ Launch an intensive programme against teenage pregnancy on a National level by 2007 – 2012.
- ◆ Strengthen parenting programmes to include teenage mothers and fathers in all Health districts by year 2012.
- ◆ Extend programme for adolescents to all district health centers by 2012.
- ◆ Lobby for legislation to protect youth and adolescents by year-end 2012 to include the following areas.
 - Age of consent, sex and alcohol
 - Compulsory secondary education
 - Stiffer penalties for Rape and Child molestation.
 - Media censorship for television/movies
 - Protective gear while driving
 - Access to health care for adolescents/youths
- ◆ Strengthen the Health and Family Life Education programme within the Ministry of Education by year- end 2012.
- ◆ Collaborate with Ministry of Social Development in the “Students at-Risk programme”.
- ◆ Develop educational packages geared to the teaching of the following areas in all tertiary educational institutions by 2012:
 - Safe Sexual practices
 - Good nutritional/habits and physical activity

- Conflict and conflict management.
- ◆ Expand the Health and Family Life Education programme to all secondary schools by 2012.
- ◆ Review food basket for the benefit of adolescents by 2008.
- ◆ Collaborate with other stakeholders to deliver skills training programmes to target five hundred youths by 2010.
- ◆ Evaluate and expand the School Health programme by year- end 2008.

REPRODUCTIVE HEALTH

GOAL

To ensure and improve quality, accessibility and appropriate utilization of Reproductive Health Services.

INDICATORS

- Increase the active acceptors rate by 50% over 2004 by year- end 2009.
- Protocols for the Management of high risk pregnancies re-established and utilized at 100% of clinics and other health care institutions by year 2010.
- 100% of births attended by relevant health care professionals by year end 2007-2012
- Incidence of Infant and Peri-natal Mortality decreased by 20% by the end of 2010
- Decrease of 5% in Morbidity and Mortality from specific Reproductive disorders by year end 2010.
- Increase in antenatal visits in the first trimester of pregnancy from 25% to 50% of pregnant women by 2010.
- Increase in post- natal visits by 50 percent over the 2004 figures by year end 2012.

STRATEGIES

- ◆ Preparation of sufficient numbers and mix of human resource to continue the reproductive health programmes 2007-2012.
- ◆ Collaborate with other agencies working in Reproductive Health 2007-2012
- ◆ Strengthen the Maternal and Child Health Programme in the Primary Health Care system by year-end 2010.
- ◆ Continue the functioning of the Maternal and Child Health committee 2012
- ◆ Strengthen the Peri-natal Information System (SIP) within the maternal and health programme by year- end 2008
- ◆ Renew and improve systems of auditing used in Maternal and Child Health programmes by year -end 2008.
- ◆ Strengthening of the Family Planning programme 2007-2012.
- ◆ Reactivation of Baby Friendly Initiative at Milton Cato Memorial Hospital and all other baby care institutions by year- end 2008.

- ◆ Introduction of laws and adoption of policies re: The International Code on Marketing Breast-Milk Substitutes by year end 2008.

MALE HEALTH

GOAL

To improve the health status and quality of life for males by reducing morbidities and mortalities.

INDICATORS

- Increase utilization by 30% of males at health centres by the end of 2012 over the 2004 figures.
- Increase life expectancy of males by 2 years by year 2012 over that of 2004 rate.
- Cancer of the prostate reduced by 10% in 2012 over figures of 2004

STRATEGIES

- ◆ Implement an integrated programme geared specifically to males in all health centres by 2010.
- ◆ Expand the screening program on prostate cancer beyond 2008.
- ◆ Target the male population specifically in health promotion programmes 2007-2012
 - Parenting programmes
 - Nutritional programmes
 - Community outreach
 - Health Education
 - Occupational health
 - Sports and recreational programmes
 - Skills training
 - Immunization of farmers

WOMENS HEALTH

GOAL: To improve the health status and the quality of life for women.

Indicators

- Incidence of cancer of the Cervix reduced by 30% in 2012 over figures of 2004.
- Incidence of cancer of the breast reduced by 30% in 2012 over figures of 2004.
- Incidence of obesity in women reduced by 2% in 2012 over 2005 figures.

Strategies

- ◆ Extend cancer-screening programmes to all health centres by 2009.
- ◆ Launch a national breast examination programme by 2009.
- ◆ Subsidize diagnostic tests for mammograms and Pap smear for indigents and at-risk individuals 2007-2012.
- ◆ Collaborate with other agencies during the planning period to execute programmes aimed at benefiting women
 - Domestic Violence
 - Obesity and overweight
 - Menopause

ORAL HEALTH

GOAL

Improve oral health of the population, specifically, children 5-7 years and persons with systemic diseases.

Indicators

- The DMFT index in children ages 5-7 years reduced by 30% by year 2012.
- The CPI reduced to 14-19% in about 50% of Diabetics by year 2012.

Strategies

- ◆ Articulate a policy for the improvement of Oral Health by year-end 2008.
- ◆ Strengthen the fluoride system programme for all children ages 5-7 (group) attending primary school by year 2008.
- ◆ Establish continuous quality improvement, monitoring and evaluation systems, in schools oral health preventative programme by year 2009.
- ◆ Introduce Oral Prophylactic care for diabetics in all dental clinics by year 2009.
- ◆ Improve information systems network for the national surveillance of oral health by year 2009.
- ◆ Deliver preventative, restorative dental health seminars at all dental clinics throughout the state 2007-2012.
- ◆ Provide emergency dental services for needy persons 2007-2012.
- ◆ Provide dental services to persons resident in Government institutions 2010-2012.

HIV/AIDS/STIs

GOAL

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

Indicators

- Reduction in the incidence of HIV/AIDS/ STI by year 2012.
- 25% of reproductive population participated in VCT programme by year 2010.
- 50% reduction in the mortality rate from HIV/AIDS within the five- year interval.

Strategies

- ◆ Strengthen intersectoral management, organisational structures and institutional capacity by:
 - Implementation of sector plans for all Sectors by 2008
 - Introduction of hotline by 2008
 - Strengthening of management capacity by 2008
 - Strengthening of surveillance and database systems by 2008.
- Strengthen HIV/AIDS prevention and control programmes by:
 - Conducting training programmes for all categories of caregivers by 2012.
 - Conducting needs assessment and studies of behavioral patterns of vulnerable groups by 2008.
 - Implementation of communication programmes by 2007-2012.
 - Development of teaching manual on HIV/AIDS by 2008.
 - Strengthening of VCT programmes by 2007-2009
- Strengthen care, support and treatment programme for people living with HIV/AIDS and their families by:
 - Utilization of treatment manual to guide the management of HIV/AIDS programmes 2007-2012.
 - Maintaining of the Mother to Child Transmission Programme MTCTP by 2007-2012.
 - Strengthening of Social Welfare programme for people living with HIV/AIDS as indicated by 2007-2012
 - Extension of Antiretroviral (ARV) therapy to all people living with HIV/AIDS as indicated by 2007-2012.
 - Enactment of relevant legislation to protect people living with HIV/AIDS and other community members.
 - Strengthening of Primary Health Care services to increase the response capacity by 2010.

- Strengthening of diagnostic capabilities to respond to HIV/AIDS by 2012
- Development of effective plans to decrease Stigma and Discrimination against People Living with AIDS.

NON- COMMUNICABLE DISEASES

GOAL

To reduce the effects of Non-Communicable diseases on the population at risk and the associated cost burden on the state.

Indicators

- Incidence of Non- communicable diseases reduced by 20% in 2009 over the 2004 figures.
- Mortality rates for Non-Communicable disorders decrease by 5% by 2009.
- Cost burden of Non-Communicable diseases reduced by 10%.
- Injuries from motor vehicle accidents reduced by 5% throughout the planning period.
- No. of persons reached in education programmes increased by 50% annually 2007-2009.
- Amputations for diabetes reduced by 25% in 2009 over 2004 figures.

Strategies

- ◆ Conduct a symposium for decision makers on issues relating to the impact of non-communicable diseases on the Vincentian society.
- ◆ Formulate a policy statement to guide the management of non-communicable diseases by 2009.
- ◆ Implement a structured primary health care non-communicable disease programme by year end 2008.
- ◆ Train health care providers, educators and significant others to provide preventive, curative and rehabilitative care to patients and clients 2008-2009.
- ◆ Implement a national strategic plan for non communicable Diseases by 2008
- ◆ Establish a coordinating mechanism for the management of non -communicable diseases by year -end 2008.
- ◆ Utilize behaviour modification techniques and marketing strategies to encourage lifestyle and behavioural changes among school children and adolescents by year 2008.
- ◆ Formulate an operational guideline document complete with protocols and standards to guide the management of non-communicable diseases by 2007.
- ◆ Strengthen the database on non- communicable diseases to include a directory comprising all relevant sections by 2007.
- ◆ Conduct research into the behavioural practices of school children and adolescents with a view to effecting changes in their dietary patterns by the year 2012.
- ◆ Introduce an active surveillance system to include private practitioners by year- end 2009.

- ◆ Support nationals interested in the establishment of services to benefit the non-communicable disease programme, viz, Nutrition, Counseling, Podiatry and alternative medicines.
- ◆ Introduction of Health Promotion activities (exercise programs) especially at the workplace by year-end 2008.

Diabetes / Hypertension

- ◆ Strengthen the programmes at all health centres to facilitate weekly clinic sessions by year-end 2008.
- ◆ Launch an intensive education programme geared toward effecting changes in eating patterns among diabetics and hypertensives by 2008.
- ◆ Establish a directory of Diabetics and Hypertensives by 2008.
- ◆ Launch a national screening programme for first- degree relatives of Diabetics and hypertensives during 2008.
- ◆ Coordinate with PPS and private sector in the procurement of drugs used to treat non-communicable diseases to improve affordability 2008.
- ◆ Support the work of the Diabetic/Hypertensive association 2007-2012.
- ◆ Establish a programme to address foot care by 2008

Cancers

- ◆ Lobby for the enactment of anti-smoking legislation by 2008.
- ◆ Conduct a National Food Composition and Anthropometrics survey by 2009.
- ◆ Extend cancer screening programme to target all high-risk and vulnerable groups by 2008
- ◆ Establish a directory of cancer affected and related personnel by year end 2008.
- ◆ Establish mechanisms to support financing of high cost cancer therapy for needy persons by year 2012.
- ◆ Mount a national education programme on life-style behaviours against cancers in 2009.
- ◆ Conduct formative research to guide behaviour modification programme by 2007-2012.
- ◆ Conduct research to determine carcinogenicity in selected areas by 2007-2012.
- ◆ Support the cancer society in their work to reduce cancers in the society 2007-2012.

Asthma

- ◆ Strengthen the asthma clinics held in all Health districts throughout the state by year-end 2008.
- ◆ Establish a registry of asthmatic clients by year end 2008
- ◆ Equip all district hospitals and health centres with medication, equipment and supplies to manage asthmatic attacks by year-end 2008.

- ◆ Provide health care providers, teachers, parents and person in at-risk occupations with knowledge and skills to prevent and control asthmatic attacks 2007 -2012.
- ◆ Conduct research on asthma by undertaking the ISAAC survey phase 2 -2007-2008
- ◆ Determine the nature and patterns of allergens and spores on asthma during 2009-2010.

Violence

- ◆ Collaborate with Ministries of Social Development, National Security and Education, to reduce injuries and violence 2007 – 2012
- ◆ Establish a database to monitor injuries and violence over the planning period.
- ◆ Enact legislation to enforce road safety mechanisms by year- end 2008.
- ◆ Mount an education programme at national level to reduce the incidence of injuries and violence in 2008-2009.

COMMUNICABLE DISEASES

GOAL:

To reduce the incidence and prevalence of communicable diseases.

Indicators

- Maintain the current zero incidence rate for Diphtheria, measles and yellow fever, Small pox, Malaria, Poliomyelitis.
- Maintain immunization status of 100% for EPI diseases
- Reduce incidence of other Communicable diseases, Dengue, Leptospirosis, tuberculosis, herpes simplex.

Strategies

- ◆ Maintain immunization programme 2007 – 2012.
- ◆ Expand Directly Observed Treatment Short course (DOTS) programme 2007-2009
- ◆ Improve surveillance for all Communicable diseases 2007-2012.
- ◆ Strengthen clinical management of all communicable diseases 2007-2009.
- ◆ Launch awareness programme for communicable diseases 2007/2009.
- ◆ Improved surveillance for the prevention of “exotic” vectors entering into St. Vincent and the Grenadines 2007-2012.

MENTAL HEALTH

GOAL

Improve the quality of Mental Health Care to the population of St. Vincent and the Grenadines and decrease the burden of mental illness on society.

Indicators

- Reduction in the incidence of violent acts in schools by year 2009.
- Vibrant drug rehabilitation programme established by year 2008.
- Reduction in the admissions to Mental Health Centre by 20% of 2004 admission achieved by year 2012.

Strategies

- Strengthen Community Mental Health Outreach Programmes.
 - Expansion of the Psychiatric Health Team by year end 2008
 - Establishing monthly community mental health clinics in all health districts by year-end 2007-2009.
 - Provide family centered psychiatric services in all health districts by year-end 2009.
 - Establish mental health support groups including users of services, family members and other interested parties in all health districts by year-end 2009.
 - Revive Mental Health Association by year-end 2008.
 - Train and support groups in the care of mentally ill persons by year end 2009.
- Information, education and communication strategies for mental health planned and implemented.
 - Implement an Information Education and Communication Strategy on mental health by 2008.
 - Liaise with other departments and agencies to promote positive mental health through 2007 - 2012
 - Conduct biennial refresher programmes for providers of mental health Services by year 2007-2012
 - Implement caregivers programme for Psychiatric Health Aide by 2008.
 - Erect bulletin boards in strategic places to promote positive mental health 2007-2009.
 - Increase public education programmes through the use of multi media resources 2007 through to 2012.

- Provide modern, secure and appropriate facilities for the management of persons with mental disorders.
 - Institute care aimed at detoxification of drugs at Milton Cato Memorial Hospital by year- end 2009.
 - Construct/Refurbish center to deliver rehabilitative care by year end 2008.
 - Expand occupational therapy building to facilitate installation of modern equipment and provision of working space by year-end 2008.
 - Establish eight (8) bedded wards for Acute Psychiatric patients at Milton Cato Memorial Hospital by year-end 2009.
 - Refurbish wards at Mental Health Center to facilitate grouping of related diagnosis (DRGs) by year- end 2012.
 - Provide equipment and supplies to continually operationalize mental health services within the state 2007 - 2012.

- Supportive framework for mental health developed and implemented.
 - Establish a National Drug Council by year 2008
 - Amend existing legislation for mental health by year-end 2008.
 - Reconstitute Mental Health Review Board by year-end 2008.
 - Operationalize guidelines for mental health services formulated and utilized by year-end 2008.
 - Establish criteria for risk and remuneration of staff in mental health services by year-end 2008.
 - Train health care providers in adequate numbers and skill 2007-2012
 - Rationalize staffing needs for psychiatric services 2008-2009
 - Develop programmes to address schizophrenia and depression by year- end 2008-2009.

THE ELDERLY

GOAL

To improve the health status and quality of life for persons 60 years and over.

Indicators

- Register of elderly persons completed by 2008.
- Older persons with support systems increased by 20% in 2012 over 2004 figures.
- Mechanisms for monitoring services for the elderly established by 2007.

Strategies

- ◆ Adopt a policy on services and care for older persons by year 2008.
- ◆ Develop services based on needs and categories of older persons during the period 2007-2012 to include:
 - Home based care
 - Day care centers
 - Residential/Nursing homes
 - Recreational facilities for families including older persons (inter-generational)
 - Transportation- bus passes
 - Soft loans at commercial banks and credit unions.
 - Prosthesis
 - Subsidize electricity and water
 - Toilet facilities where necessary
 - Housing assistance.
 - Wheel chair friendly buildings
 - Programmes for shut-ins.
- ◆ Introduce a subsidized programme in prescription management for older persons- 60 years and over by year 2010
- ◆ Extend the Nutrition Support Programme to older persons who are at risk for nutritional problems by 2008.
- ◆ Provide residential home for the elderly to accommodate both indigent and incapacitated persons by year -end 2010.
- ◆ Facilitate private enterprise in the construction and management of nursing homes and other residential homes for the elderly 2007-2012
- ◆ Review the legislations affecting the care and services to older persons by 2012.
 - Property rights
 - Admission criteria to LPH.
 - Regulatory Body
 - Inspections
 - NIS- other money, pensions
- ◆ Identify standards and specifications necessary to promote safety and security of older persons by 2008.
- ◆ Design and implement specific training programmes geared to the care of the elderly 2007-2012
 - Registered nurses
 - Caregivers
 - Family members
- ◆ Launch a public awareness programme highlighting the characteristics, needs and services of the elderly by 2008.
- ◆ Collaborate with NIS to establish a database and to extend services to the elderly 2007-2009

- ◆ Establish a Network of organizations such as churches, NGOs, public sector and private sector to promote activities on active ageing
 - Employment of older persons
 - Pre-retirement programme
 - Inter-generational recreational programme
 - Involvement in Learning Resource Centers
- ◆ Encourage volunteerism and inter-generational programmes 2007-2012.

FOOD NUTRITION AND PHYSICAL ACTIVITY

GOAL

Improve nutrition and food security status for the population of St. Vincent and the Grenadines and decrease the burden of nutritional disorders and nutrition related CNCDS on society.

Indicators

- Increase in the percentage of population groups with access to and consuming a safe, well-balanced, culturally appropriate diet by end 2008.
- Reduction by 50% incidence/prevalence of overweight in children 1 – 4 years by end 2009 over 2004 figure.
- Determine the prevalence of overweight in school children and obesity in (high risk) adults by end 2008.
- Reduction in prevalence of iron deficiency anemia in children 1 – 4 years and antenatal women by 10% by end 2008.
- Provision of clinical dietetic services to 100% of clients at government hospitals and 80% of clients at health centers by end 2008.

Strategies

- ◆ Establish a food and nutrition council appointed by cabinet with related ministerial mechanisms for intersectional cooperation in Food and Nutrition by end 2008.
 - ◆ Operationize a National Food and Nutrition Surveillance system for the assessment, monitoring, analysis and reporting on nutritional status, household food security and food consumption behaviour of key population groups by end of 2009.
 - ◆ Establish National Nutrition and Dietetic Association by year-end 2008.
1. Strengthened by the Public Health Nutrition programmes.
 - ◆ Establishment of weekly nutrition clinics in all mainland health districts and monthly nutrition clinics in Northern and Southern Grenadines Health Centres by end year 2008.

- ◆ Development and implementation of operational manual for Public Health Nutrition programme by end year 2008.
- ◆ Establishment of annual nutrition outreach programmes and related support groups in all seven (7)-mainland health districts by year-end 2008.
- ◆ Design and implement national nutrition intervention programmes aimed at addressing overweight and IDA in children and IDA in antenatal women by end 2008.
- ◆ Protocols for nutrition management of CNCs developed and implemented by end 2008.
- ◆ Protocols for nutrition screening, assessment, intervention and referral services for MCH and family health be developed and implemented by end 2008.
- ◆ Establish a Dietetics department at Milton Cato Memorial Hospital by end 2008.
- ◆ Develop food based dietary guidelines for St. Vincent and the Grenadines by year-end 2008.
- ◆ Liaise with other stakeholders to promote recreational and sport activities during 2008-2010.

HEALTH SYSTEMS DEVELOPMENT

SECONDARY HEALTH CARE

MILTON CATO MEMORIAL HOSPITAL

GOAL:

To become a state of the art institution in secondary health care delivery.

Indicators

- Milton Cato Memorial Hospital a new entity with reoriented management systems by 2008
- Patient satisfaction in services at Milton Cato Memorial Hospital at above 80% by year 2009.
- Waiting time at Accident and Emergency Department at acceptable standards annually
- Reduction in accounts recoverable by 50% in 2010 over 2004 figures.

Strategies

- ◆ Legislate and ensure that Milton Cato Memorial Hospital becomes a statutory corporation with a board to direct the process of Governance by 2008.
- ◆ Develop a human resource plan to provide professional staff for delivery of services by June 2009.
- ◆ Establish mechanisms for an appraisal system and create an enabling environment to motivate staff to high levels of performance 2008-2009.

- ◆ Establish an integrated information system to support and direct hospital processes and financial systems by year- end 2007 - 2010.
- ◆ Develop financial mechanisms to manage and sustain the organization's goals by 2007-2009.
- ◆ Conduct needs assessment for secondary services within St. Vincent and the Grenadines during 2008-2009.
- ◆ Continue the infra-structural development, in collaboration with stakeholders and other social partners to provide relevant and necessary services 2007-2012.
- ◆ Establish protocols and policies for accreditation of the hospital as a regional center of excellence by December 2008.
- ◆ Collaborate with regional partners to pursue the benefits of shared services viz, Radio therapy, Cardiology, Renal Dialysis, neurosurgery.
- ◆ Facilitate the development of specialist services specifically in peritoneal dialysis, intensive care, urology and Haematology.
- ◆ Implement a programme in Para medicine to equip the ambulance services and specified Non-Governmental Organizations to respond appropriately to emergencies and disasters by 2008.

District Hospitals\ Health Centres

GOAL:

To meet the needs of communities for secondary health care services within a primary care setting.

Indicators

- Increase the occupancy rate of district hospitals
- Increased utilization of figures by district hospitals and Health Centres in their outreach programmes.

Strategies

- ◆ Implement recommendations of the primary Health care evaluation by year end 2007 – 2012
- ◆ Decentralize secondary health care utilizing the team approach in primary health care by year end 2008
- ◆ Review the operations procedure for district hospitals to include community outreach programmes by year- end 2008
- ◆ Train all Primary Health Care workers in Primary Health care approach 2008.
- ◆ Utilize the Health Promotion Charter to design programmes for communities in service delivery by 2008.

- ◆ Provide necessary resources to adequately equip and staff district hospitals and health centres 2007-2012.
- ◆ Equip the district Hospitals to cope with long term rehabilitative care.
- ◆ Train Public Health staff in Essential Public Health Functions by year 2008 - 2009

HEALTH PROMOTION

GOAL

Create a supportive environment to assist citizens in the practice of healthy lifestyles.

Indicators

- Targeted audience for Health Education information increased over the five -year period by 20%.
- Fifteen health-promoting initiatives introduced and sustained within workplace environments during 2007-2012.
- KAPB patterns of population increased by 20% over the baseline data.

Strategies

- ◆ Articulate the Caribbean Charter on Health Promotion for the benefit of stakeholders 2007-2009.
- ◆ Develop the capacity and the expertise of health and education officials to execute health promotion initiatives by 2008 - 2012.
- ◆ Establish partnerships with stakeholders to implement Health promotion initiatives 2007-2012.
- ◆ Liaise with other stakeholders to promote the development of standards for occupational and recreational health safety by 2009.
- ◆ Conduct an evaluation of the benefits of information dissemination in 2007 and 2009.
- ◆ Recognize excellence in health promotion initiatives 2007-2012.
- ◆ Strengthen and expand the public education programmes for health promotion and prevention 2007-2009.
- ◆ Lobby for the enactment of legislation on road safety mechanisms by 2008.
- ◆ Extend Health promotion Programmes to include School for Children with Special Needs, Liberty Lodge Training School, NGOs and Civic Organisations.

HEALTH CARE FINANCING

GOAL:

To generate revenues for the implementation of health care initiatives for the benefit of the population.

Indicators

- Extension of services to allow for universal coverage.
- Introduction of necessary specialist services within the Health care system.
- Available resources to meet the demands of the health care system.

Strategies

- ◆ Generate baseline data to inform decisions on National Health Accounts by year- end 2008.
- ◆ Launch a public awareness programs on the issue of Health Care Financing by year- end 2008.
- ◆ Establish institutional linkages to support health care financing strategies 2007-2012.
- ◆ Collaborate with NIS and Electoral Office to implement a National Registration System to facilitate unique identification by year 2009.
- ◆ Collaborate with other stakeholders to implement mechanisms to ensure collection and pooling of resources and proper purchasing of health services through an NHIP by year end 2008-2012

HEALTH INFRASTRUCTURE

GOAL

To upgrade health facilities and services to ensure accessibility, availability and quality in a variety of settings - Primary and Secondary.

Indicators

- Appropriate facilities available for the elderly and for drug -rehabilitation by year end 2008.
- Safe, secure, appropriate health care facilities in all district areas by year- end 2009.
- Increased utilization of services by 2007-2009.

Strategies

- ◆ Review the boundaries of the primary health care system by year end 2008
- ◆ Strengthen health care delivery services beyond the Rabacca Dry River to improve the emergency response capacity by year-end 2008.
- ◆ Upgrade primary health care services to support interventions in the current health related problems by year- end 2008.
- ◆ Refurbish, renovate, and construct the following by year-end 2012 to include.

1. Clare Valley

2. Lowmans Windward
3. Collins
4. Kingstown
5. South Rivers
6. Sharpes

- ◆ Refurbish selected Health Centres to include room for counseling services by year- end 2009.
- ◆ Liaise with Rotary Club and International Children's Hospital (ICH) to establish a center of excellence for Specialized Pediatric Care by year 2008.
- ◆ Liaise with Casson Trust and the European Union to implement Drug Rehabilitation services by year- end 2008.
- ◆ Construct facilities for the elderly by year end 2010.
- ◆ Refurbish the Union Island Hospital by year end 2008.
- ◆ Construct a Diagnostic Centre and Renal Dialysis Unit by year end 2009

HEALTH PLANNING AND INFORMATION

GOAL

To improve the decision-making capacity of the health sector.

Indicators

- Alertness and response capacity of surveillance system sustained at peak level
- Increase in the number of programmes 2007-2012 under surveillance to include
- Injuries and violence
- Mental Health
- Human Resource
- HIV/AIDS
- Nutritional Disorders

Strategies

- ◆ Establish an IT Platform for the Ministry of Health and the Environment by year end 2008.
- ◆ Continue the collection, analysis and interpretation of data and the dissemination of information locally, regionally and internationally.
- ◆ Strengthen the health information system through networking, improved surveillance and expansion of data collection system.
- ◆ Improve the capacity of Planning unit through the availability of services such as
 - Project Officer
 - Bio-Statistician

-Monitoring and Evaluation Officer.

- ◆ Develop the Library facilities as a source of information for local and regional users.

HEALTH AND THE ENVIRONMENT

GOAL

To improve the level of the environmental services to that necessary for the health and well being of the nation and the maintenance of sustainable development through an expanded and upgraded role.

Indicators

- Functional viable entity for the delivery of environmental services by year -end 2008.
- Breteau indices reduced by 50% of 2004 figures by 2009.
- Levels of contaminants in the environment are at acceptable standards by 2009.
- HACCP awareness increased from 3% - 50% by 2009.
- Reduced population of rodents and household pests by 50% of 2005 figures by 2009.
- Water recreational surveillance extended to include additional parameters by 2009.
- 99% of households have access to water that meets World Health Organisation standards at least within 10 yards of house by 2009.
- Appropriate disposal methods in operation for the following waste by 2009.
 - Biohazard
 - Septage
 - Garbage
 - Sewage
- Comprehensive workers Health Policy and Plan developed and articulated by 2009
- St. Vincent and the Grenadines compliant with the following Regional and International initiatives.
 - Montreal Protocol
 - The Basil Convention
 - UNFCCC
 - UNCBD
 - UNCCD
 - Biosafety Protocol

Strategies

- ◆ Strengthen the institutional capacity of the Environmental Health Division.
- ◆ Implement measures to monitor the level of contaminants in the environment by year-end 2008
- ◆ Upgrade the monitoring mechanisms for water quality by year-end 2009.
- ◆ Implement the HAACP standards by year-end 2008.

- ◆ Mount an intensive initiative to reduce Breteau Index to below hazards levels by 2009.
- ◆ Extend vector control monitoring to include other insects and rodents by 2008.
- ◆ Operationalize a septic plant to treat septage by year 2008.
- ◆ Develop the capacity to monitor liquid and solid waste disposal by year- end 2008.
- ◆ Increase the capacity to monitor Occupational Health and Safety by year-end 2009.
- ◆ Revisit legislation pertaining to environmental issues by year- end 2008.
- ◆ Strengthen public environmental education programmes by 2008.
- ◆ Contribute to the development of Recreational Health 2007-2009.
- ◆ Strengthen the Environmental Services Unit to undertake an expanded role in maintaining regional and international environmental standards and obligations by Year-end 2008.

HUMAN RESOURCE DEVELOPMENT

GOAL

To ensure that cadres of professionals in the various disciplines are available and competent to deliver the Health services.

Indicators

- At least 90% of all budgeted positions filled annually.
- Rationalized health care demands for services are met

Strategies

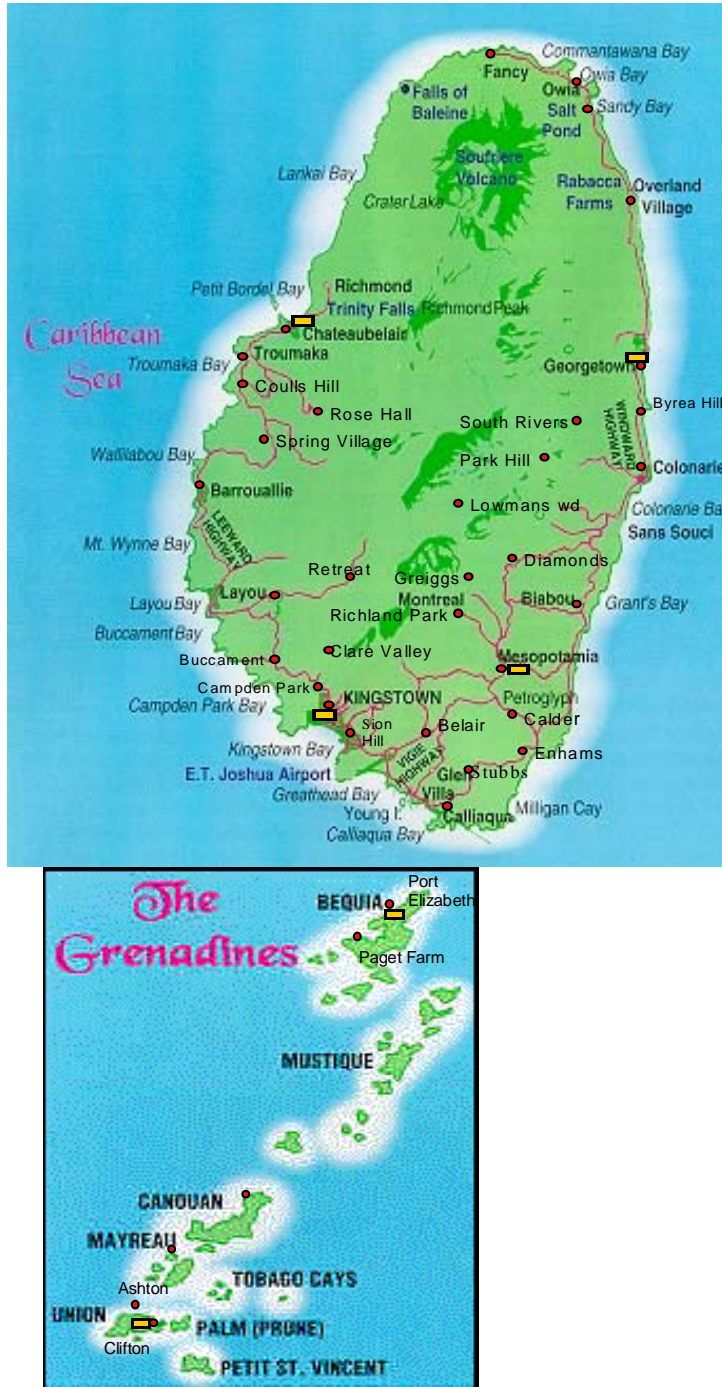
- ◆ Articulate a policy to guide human resource development for Health services by year 2008.
- ◆ Produce a Human Resource Plan for the health Service by year- end 2008.
- ◆ Secure financial assistance to support the human resource development plan for health services 2007-2012.
- ◆ Deploy human resources in appropriate numbers and skill-mix to adequately meet the needs of the health care delivery system.

APPENDIX 1

| Matrix showing collaboration of Partners in planning process | FAMILY HEALTH | HIV/AIDS | NON-COMMUNICABLE DISEASES | COMMUNICABLE DISEASE | MENTAL HEALTH | THE ELDERLY | FOOD NUTRITION, PHYSICAL ACTIVITY | HEALTH SYSTEMS DEVELOPMENT | HEALTH AND THE ENVIRONMENT | HUMAN RESOURCE DEVELOPMENT |
|---|----------------------|-----------------|----------------------------------|-----------------------------|----------------------|--------------------|--|-----------------------------------|-----------------------------------|-----------------------------------|
| Ministry of Health and the Environment | x | x | x | x | x | x | x | x | x | x |
| Ministry of Education | x | x | x | | | | x | | x | x |
| Ministry of Tourism | | x | x | | | | x | | x | |
| Ministry of Social Development | x | x | x | | x | x | | x | | |
| Ministry of Transport, Works | | | | | | | | x | x | |
| Ministry of Agriculture | | x | | | | | x | | x | |
| Ministry of Finance and Development | | x | | | | x | | x | x | x |
| Public Service Division | | | | | | | | | | x |
| Milton Cato Memorial Hospital | | x | | | | | x | x | | |
| School of Nursing SVG | x | x | x | | | x | | x | | x |
| Royal SVG Police Force | x | | | | x | | | x | | |
| Maternal and Child Health | | x | x | | | | | | | |
| Planned Parenthood | | x | | | | | | | | |
| Diabetic Association | | | x | | | | | | | |
| Cancer Society | | | x | | | | | | | |
| National Council of Older Persons | | | | | | x | | | | |
| National Youth Council | x | x | | | | x | | | | |
| Country Coordinating Mechanisms | | x | | | | | | | | |
| Lewis Punnett Trust | | | | | | x | | | | |
| Rotary Club | | | | | | x | | | | |
| Lions Club | | | | | | x | | | | |
| VINLEC | x | | | | | | | | | |
| National Insurance Service | x | | | | | x | | | | |
| Marion House | | | | | x | | | | | |
| NGOs | | x | x | | x | x | | | x | |
| Faith Based organizations | x | x | | | x | x | | | | |
| Private Institutions (Health) | x | | | | | x | | | | |
| Civil Society | x | x | x | x | | x | | | | x |
| PAHO | x | | | | | x | | | | |
| CAREC | x | x | | | | | | | | |
| CFNI | | | | | | | x | | | |
| Sports | x | | x | | | x | x | x | | x |

APPENDIX 2

MAP OF ST. VINCENT AND THE GRENADINES SHOWING THE LOCATIONS OF HOSPITALS AND HEALTH CENTRES



 Hospitals
 Health Centre

REFERENCES

1. Barbados Strategic Plan for Health 2002-2012. Government of Barbados 2003

Central Planning Division – Poverty Reduction Strategy paper NESDEC/PRTF St. Vincent and the Grenadines 2003.

2. First Caribbean Conference on Health Promotion Caribbean Charter for Health Promotion. Trinidad PAHO 1993.
3. Help Age International – the situation of older people in St. Vincent and the Grenadines SVG 2000.
4. Ministry of Health and the Environment, Chief Medical Officer's report 2002. Ministry of Health and the Environment St. Vincent 2002.
5. Ministry of Health and the Environment. Consultants report on operations within the Environmental Health Division, Ministry of Health and the Environment St. Vincent 2004.
6. Pan American Health Organisation Caribbean Cooperation in health phase II. A new vision for Caribbean health PAHO Barbados 1999.
7. Pan American Health Organisation – CPC office Barbados. Performance measurement of essential Public Health functions at the National level in St. Vincent and the Grenadines 2002.
8. Pan American Health Organisation – Health Systems and services profile. Washington DC PAHO 2002.
9. Pan American Health Organisation. Health in the Americas vol. 1 and 2 2002 edition Washington DC 2002.
10. Pan American Health Organization/World Health Organization – Report of the Caribbean Commission on Health and Development – 2006
11. Situation Analysis: The Economic Environment and Financing of Health Services in the Caribbean. Caribbean Commission on Health and Development, October 2004.
12. St. Vincent and the Grenadines Health Sector Development Plan 1999 – 2004
13. SVG 1999 St. Vincent and the Grenadines HIV/AIDS National Strategic Plan 2004-2009 SVG 2004