

UNGASS COUNTRY PROGRESS REPORT

Grenada

Reporting period: January 2008–December 2009

Submission date: March 31, 2010

Abbreviations and Acronyms

AIDS:	Acquired Immunodeficiency Syndrome
ANC:	Antenatal Clinic
ART :	Antiretroviral Therapy
ARV:	Antiretroviral Medicines
CAREC:	Caribbean Epidemiology Centre
CARICOM:	The Caribbean Community and Common Market
CHRC:	Caribbean Health Research Council
CRN+:	The Caribbean Regional Network of People Living with
CSW:	Commercial Sex Workers
GFATM:	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
HAART:	Highly Active Antiretroviral Therapy
HIV:	Human Immunodeficiency Virus
MSM:	Men who have Sex with Men
NAD:	National AIDS Directorate
NAP:	National AIDS Program
NGO:	Non-Governmental Organization
NIDCU:	National Infectious Disease Control Unit
NAC:	National AIDS Council
OECS:	Organization of Eastern Caribbean States
PANCAP:	Pan Caribbean Partnership against HIV/AIDS
PLWH:	People Living with HIV
PLWHA:	People Living with HIV and AIDS
PMTCT:	Prevention of Mother- To- Child Transmission
STIs:	Sexually Transmitted Infections
Tb:	Tuberculosis
UNAIDS:	Joint United Nations Program on HIV/AIDS
UNDP:	United Nations Development Program
UNICEF:	United Nations Children's Fund
UNFPA:	United National Family Planning Association
UNIFEM:	United Nations Development Fund for Women
USAID:	United States Agency for International Development

Overview of the AIDS epidemic

Stakeholders' involvement in the preparation of the UNGASS report

The National Infectious Disease Control Unit (NIDCU) was given the responsibility for the preparation of the UNGASS 2008-2009 and off site support was provided by the UNAIDS M&E Adviser. The process began in earnest towards the end of 2009 following a Regional UNAIDS Workshop in Trinidad in October.

The completion of the National Composite Policy Index (NCPI) was done in a consultative manner. Stakeholders consulted for Part A were NIDCU staff and other representatives from the Ministry of Health, as well as the Ministry of Education and Ministry of Finance. Pertinent information for the NCPI came from a document produced following the Law, Ethics and Human Rights Review. Stakeholders consulted for Part B included representatives from Grenada Conference of Churches, Hope-Pals Network, GrenCHAP, Agency for Rural Transformation, and Grenada Broadcasting Network. No representatives came from Grenada Red Cross Society and the Grenada National Organisation of Women.

Status of the epidemic

At the end of 2009 a cumulative total of 403 HIV/AIDS cases have been confirmed in Grenada from its inception in 1984. More males remain affected with a cumulative male to female ratio of 1.8: 1. Among AIDS cases, 85 with 70 % of reported cases and 76 or 82.6% of AIDS-related deaths were among persons aged 15-44 years. The mode of transmission is predominantly via heterosexual intercourse. There is no known case of transmission through intravenous drug use and certainly no record of transmission via blood transfusion.

In 2009 the estimated prevalence rate of persons living with HIV/AIDS in Grenada is 0.57%; it was about the same, 0.56% in 2008.

Statistics provided by the NIDCU reveal a total of 54 persons with advanced HIV disease on antiretroviral therapy, males: 29; females: 25. Approximately 52.9 % of all clients in care received coverage in 2008 and 2009. Six (6) HIV infected pregnant women received ARV over the past two years. HAART was introduced in Grenada in October, 2003. There followed years of fluctuating mortality figures (6 in 2004, 10 in 2005, 7 in 2006, 14 in 2007, 8 in 2008, 7 in 2009) with no clear reduction.

Only 13 persons out of a total of 5,963 tested in 2008 and 2009 were HIV positive. For the same period there were 56 newly diagnosed HIV positive cases.

There is still little or no data on the most-at-risk population. When this is taken into account as well as the small size of the general population, Grenada's epidemic can be best described as a generalized one. The identity of high risk populations was given in the last UNGASS report and has not changed. It includes: men who have sex with men,

sex workers, prisoners, and youth (especially females). It can be argued that stigma (real or imagined) is still present in Grenadian society though perhaps to a lesser degree. This means that the epidemic in these groups is not well captured by data and analyzed. No new behaviour survey was conducted in the last two years.

Policy and programmatic response

As was reported in the last UNGASS Report, Grenada commenced activities towards the revision of its National Strategic Plan for HIV/AIDS in 2007. Much work was done which resulted in the production of a Strategic Plan document in 2008. Unfortunately, however, the National Strategic Plan is still in its draft form due – among other things – to a restructuring of the Programme. From July 1st, 2009 coordination of the National HIV/AIDS Response has moved from the Office of the Prime Minister back to the Ministry of Health. The National AIDS Council and National AIDS Directorate are dissolved, with no formal replacement as yet for the former. The lack of a finalized National Strategic Plan (NSP) has been a major constraint in the preparation of this Report. It is however anticipated that the NSP will definitely be completed very soon. In 2008 and 2009, over EC \$1.5 million was spent on the HIV/AIDS Programme in Grenada. This money came from various donor organizations, such as the World Bank, Global Fund, and Pan American Health Organization, with support at the local level by funds from the Government. Grenada has surely benefitted from significant financial and technical assistance for its HIV/AIDS response over this reporting period. However, this assistance has been limited with the closure of the World Bank funded project and the global economic downturn in 2009.

The National Infectious Disease Control Unit has long been the Unit in the Ministry of Health responsible for providing treatment, care and support to infected persons. Much of its work is done in collaboration with other Ministry of Health departments such as the Pharmacy, Pathology Laboratory, and the community health facilities. Antiretroviral therapy is given to all HIV positive clients who need it at no cost to them. Notwithstanding staff limitations, the NIDCU provides a wide range of clinical care, psychosocial counselling, ancillary support to clients and their relatives, condom education and distribution, as well as pre and post test counselling to the general public. Through the Unit, all new HIV+ mothers are provided with replacement infant feeding. Babies are also given antiretroviral therapy within 72 hours of birth.

It is also questionable whether the introduction of HAART has had any effect on the numbers of persons getting testing. This is partially due to stigma (which remains deeply rooted in the society) as well as to the perception that HIV/AIDS is still seen by many as a death sentence. The majority of persons who tested positive for HIV did not come from VCT either. Only 13 persons out of a total of 5,963 tested in 2008 and 2009 were HIV positive. For the same period there were 56 newly diagnosed HIV positive cases.

There is still little or no data on the most-at-risk population. The identity of high risk populations was given in the last UNGASS report and had not changed. It includes: men

who have sex with men, sex workers, prisoners, and youth. Stigma is prevalent in Grenadian society which has the effect of the epidemic in the most-at-risk groups not being well captured by data and analyzed. No new behaviour survey was conducted in the last two years.

The Government of Grenada, through the Ministry of Health, has reiterated its pledge to continue working closely with all stakeholders, both in the public sector and civil society, in the fight against HIV/AIDS.

Table 1: Overview of UNGASS Indicator Data

<p><i>National Commitment & Action</i></p> <p>1) Amount of national funds disbursed by governments in low and middle income countries: EC\$1,300,000.00 for 2008 EC\$ 522,835.25 for 2009</p> <p>2) National Composite Policy Index</p> <p>Indicates steady progress between 2008 and 2009, however during the period civil society engagement has a shown significant increase.</p>
<p><i>National Programmes:</i></p> <p>3) Percentage of donated blood units screened for HIV in a quality-assured manner 100% (2009)</p> <p>4) Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy</p> <p>100% children receiving ART in 2008 91.67% adults receiving ART in 2008</p> <p>100% children receiving ART in 2009 91.07% adults receiving ART in 2009</p> <p>5) Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to- child transmission</p> <p>2008: 50% 2009:100%</p> <p>6) Percentage estimated HIV-positive incident TB cases that received treatment for TB and HIV</p> <p>100% (In 2008, there were 2 TB cases with HIV-Co-infections, and 1 in 2009 (Ministry of Health, 2009)</p> <p>7) Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results 88.45 % (Ministry of Health, 2009)</p>

- 8) Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results
No data is available for this indicator; no special studies conducted.
- 9) Percentage of most-at-risk populations reached with HIV prevention programmes
N/A (Data not available)
- 10) Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child
N/A (Indicator not reported on; Data not available)
- 11) Percentage of schools that provided life-skills based HIV education within the last academic year – 100% for Primary Schools; 75% for Secondary Schools.
(Ministry of Education; 2008-9 academic year)

Knowledge, Sexual Behaviour and Orphans' school attendance

- 12) Current school attendance among orphans and among non-orphans aged 10-14
(No data available)
- 13) % of young women and men aged 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission - **No data available; no survey done in the reporting period**
- 14) % of MARPS who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission - **No data available; no survey done in the reporting period**
- 15) % of young women and men aged 15-24 who have had sexual intercourse before the age of 15 - **No data available; no survey done in the reporting period**
- 16) % of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months - **No data available; no survey done in the reporting period**
- 17) % of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse - **No data available; no survey done in the reporting period**
- 18) % of female and male sex workers reporting the use of a condom with their most recent client - **No data available; no survey done in the reporting period**
- 19) % of men reporting the use of a condom the last time they had anal sex with a male partner - **No data available; no survey done in the reporting period**
- 20) % of injecting drug users reporting the use of a condom the last time they had sexual intercourse
N/A (Data not available, not a major pop)
- 21) % of injecting drug users reporting the use of sterile injecting equipment the last time they injected

N/A (Data not available; not a major pop)

Impact

22) % of young people aged 15 – 24 who are HIV infected

23) % of MARPS who are HIV infected - **No data available;**

24) % of adults and children with HIV known to be on treatment still alive 12 months after initiation of ART

60 % (Ministry of Health, 2008-9)

Impact

25) % of infants born to HIV-infected mothers who are infected

0% (Ministry of Health, 2008-9)

National response to the AIDS epidemic

National HIV/AIDS Strategic Plan

In 2001, Grenada began the process of Developing a National Strategic Plan and a plan was created and revised in 2003. During this period the National AIDS Council was created as well as most of the program and health management components of the program. The National AIDS Council (NAC) of Grenada, a multi-sectoral body, was responsible for ensuring the success of the National HIV/ AIDS Programme. It was the coordinating body responsible for the oversight, advisory, policy-making, guidance and accountability for the National HIV/ AIDS Programme.

In 2007, Grenada commenced activities towards the revision of its National Strategic Plan for HIV/AIDS. Towards this end a situational analysis was conducted which included interviews with key stakeholders, a desk-top review and a national house-hold survey. The results of these analyses are currently being used to continue work towards developing a finalized Strategic Plan document.

A draft National Strategic Plan was developed for 2008 – 2012 with the goal of reducing the incidence of persons infected with HIV, and reducing its impact on individuals, families and communities. The draft NSP underscores the importance of the Three Ones, Universal Access, Prevention, Treatment, Care & Support, an enabling environment, human rights and a multi-sectoral approach. Recognizing resource constraints and building on the accomplishments so far, the NSP for 2008 to 2012 focuses on the following areas:

- Primary and Secondary prevention through behavior change interventions.
- Stigma & discrimination reduction using a human rights based approach.
- Scaling up of access to treatment, care and support especially in underserved and vulnerable communities with a multi-sectoral approach.
- Strengthening governance systems & Institutional capacity for a sustainable response.
- Improved effectiveness and efficiency through the generation and use of strategic information.
- Creating and strengthening of the support mechanisms to facilitate behavior change in an enabling environment.
- Addressing gender issues.

The strategy addresses the following risk groups: women and girls, youths (persons less than 24 years old), orphans and vulnerable children, men who have sex with men (MSM), sex workers, prisoners, uniformed personnel (police officers, prison officers), the poor, and persons living with HIV/AIDS (PLWHA). These target populations were identified through a consultative process which involved key informants as well as data from selected sources, Cross cutting issues addressed by the strategy include HIV/AIDS and poverty, human rights, involvement of PLWHA, reducing stigma and discrimination, and gender empowerment/equality.

Political Support

From the second half of 2009, the National HIV/AIDS programme has been in transition. The administrative structure is in the process of being revised. Previously, the structure involved the National AIDS Council (NAC) structure which was comprised of a 16-member board with representation from government agencies, private sector, academia, faith-based organizations, youth, persons living or affected by HIV/AIDS, trade unions, and the media. The Minister of Health chaired the NAC. The Directors of the National AIDS Directorate and the National Infectious Disease Control Unit were ex-officio members of the council. The National AIDS Council (NAC) was accountable to Cabinet through the Office of the Prime Minister for the results of the national HIV/AIDS programme. The work of the NAC was to set national priorities, implement and update the National Strategic Plan as needed in line with the “Three Ones Principles” - one national authority, one national HIV/ AIDS programme, and one monitoring and evaluation framework. The NAC was responsible for ensuring universal access to prevention, treatment, care and support and for producing an annual report on the national response on HIV/ AIDS to the Office of the Prime Minister. The NAC was also responsible for mobilizing national and international resources for the fight against HIV/ AIDS, for ensuring that HIV/ AIDS activities that was financed by internal and external funds were harmonized and integrated, and for ensuring Grenada’s active participation in regional and international consultations.

The National AIDS Directorate, which was established in 2002, operated as the secretariat to the National AIDS Council and had responsibility for the implementation of policy and programmatic decisions. The National Infectious Diseases Control Unit (Ministry of Health) has responsibility for the health sector response which encompasses treatment, care and support of PLWHA as well as portions of the prevention programme, notably, prevention of mother-to-child HIV transmission, VCT and safe blood and transfusion services.

Since 2005, there have been some notable achievements such as:

- HIV focal persons appointed in some line ministries
- Revision of health and family life education curriculum in schools to focus more on the issue of HIV/AIDS.

- Increase in the number of civil society organisations including faith based organizations implementing work plans and submitting reports
- Increased numbers of PLWHA advocates
- Establishment of a human rights desk to address human rights concerns of PLWHA
- Increased civil society involvement in decision making and planning
- Increased capacity of civil society organizations

National spending on the health sector and on HIV/AIDS

The Ministries of Health and Education are the largest consumers of government financial resources. Government spending on health averaged 12 percent of the annual recurring budget representative of between 3.5 and 4.5 percent of the Gross Domestic Product (GDP). Information on private health services is extremely limited.

In 2008, Grenada received financial support from various donor organisations, including World Bank, Global Funds, and the Pan American Health Organisation. This was also complemented by some funds from local government revenue. Calculating local government contribution to HIV/AIDS has been particularly challenging because government spending is invariably recorded under the general budget lines of health, wages or social support as there are no HIV/AIDS specific lines in some sections of the national budget from where contributions to HIV/AIDS are made.

Programme implementation

Overview of the health care system

Health services in Grenada are provided primarily through public facilities, although there is an increase in the use of private facilities due to the perception of better quality of care. Primary health care services are decentralized and delivered from a network of 33 medical stations, 6 health centers, and 2 maternity units. Most Secondary care services are centralized at the General Hospital in the Capital, St. Georges, there are two District hospitals: Princess Alice in the rural district of St. Andrew and Princess Royal on the island of Carriacou. One public and two private laboratories, and a diagnostic facility provide support services for Grenada. There are no NGOs currently providing inpatient care in Grenada.

HIV Prevention

The Government of Grenada through the Ministry of Health believes prevention is the key to achieving control of the HIV/ AIDS epidemic. The main focus of prevention efforts is in the areas of communication to ensure proper and adequate knowledge on HIV/AIDS transmission and prevention in the general population, and in particular, in high-risk populations.

During the period 2008 and 2009, activities have ranged from production of IEC materials, programmes to promote accurate reporting on HIV by the media, continuous condom distribution, community sensitization on HIV/AIDS and routine HIV testing.

Key messages of the IEC strategies contain the following key messages:

- abstinence

- delayed sexual debut

- faithfulness

- partner reduction

- consistent condom use

- safe(r) sex

- reducing violence against women, greater acceptance and involvement of PLWHA

Elements of HIV prevention targeted to high-risk sub-populations include information on risk reduction and HIV education, condom promotion, HIV testing and counselling, reproductive health, and vulnerability reduction.

In the area of formal education systems, The Government has continued the teaching of Caribbean Regional Health and Family Life Education (HFLE) curriculum to students with a focus on HIV and violence prevention. It also aim to educate students on the facts about HIV/AIDS while also providing them with life skills that will help them make healthy and safe decisions, with 100% of primary and 75% of secondary schools providing this education in this reporting period.

Another critical area of HIV prevention is in the delivery of safe blood and blood products for transfusions. The national blood bank of Grenada performs screening tests for HIV on-site. All donated blood that tests positive in the screening step is discarded, regardless of the results of confirmatory tests. The laboratory uses manufacturer's instruction in order to ensure standardisation of specimen processing. The laboratory also participates in external quality assurance (UK NEQUA) and submits annual reports to PAHO. When reviewing the HIV seroprevalence of donated blood, it is important to note that only approximately one-quarter of donated bloods come from voluntary donors. The

majority is donated by family members of hospitalized patients and is likely not representative of the general population. Thus the HIV seroprevalence rates amongst these persons are most likely an under-representation of the situation in the general population.

HIV/AIDS Care, treatment and support

The Government of Grenada is committed to improving the quality of life of persons living with and affected by HIV/ AIDS. The Government is also mindful of the role played by several government agencies, faith-based organizations, other NGOs in the fight against HIV/ AIDS and combined effort is required to achieve a multi-sectoral response to HIV/AIDS. The government's HIV/AIDS care, treatment and support programme is managed by the National Infectious Disease Control Unit (NIDCU).

The national strategy includes a policy for comprehensive HIV treatment, care and support. The majority of public health care facilities offer pre- and post- test counselling which will be enhanced in 2010 with the introduction of rapid testing among public and private facilities as well as HIV blood collection services. HIV/AIDS care, treatment and support remains centralized. It is hoped that this service will be decentralized in the near future, making use of newly built facilities in the rural areas. The programme provides all services, including triple ARV therapy to patients with advanced HIV disease, at no cost. HIV positive pregnant women are provided with ARV to prevent transmission to their infants, according to the national PMTCT protocol. Infants receive ART/prophylaxis within 72 hours of birth and are tested for anti-HIV antibodies at the age of 18 months. Mothers cared for in the PMTCT programme are provided with replacement infant feeding for 6 months to reduce the risk of HIV transmission via breast-milk. ARVs, condoms, medicines for opportunistic infections and sexually transmitted infections have been accessed under a project of the Global Fund to fight, AIDS, Tuberculosis and Malaria and under the OECS governments' regional system for procurement of medical supplies.

In terms of programme implementation, the NIDCU had recorded a total of 54 persons with advanced HIV disease who were receiving antiretroviral therapy (ART) by the end 2009. There has been an increase in treatment provision since the programme started in October of 2003. Despite the fairly high 12-month survival rates, there are challenges with longer-term adherence that need to be addressed.

The Epidemiology Unit of the Ministry of Health has not observed notable increases in tuberculosis cases over the past ten years. Based on reported cases, the trend has been generally stable of the last ten years indicating that the low-level HIV epidemic has not caused an increase in Tb incidence.

Knowledge and behaviour change

School Youths

A baseline survey for the HFLE pilot study was conducted in the fall of 2005 and included 525 secondary school students in schools. The median age of respondents was 12 years, with approximately equal numbers of males and females. The highlights of the survey show the following areas of concern amongst this young age group:

- Approximately one in ten (12%) students reported being drunk at least once. Boys were approximately twice as likely as girls to report having been drunk.
- About a third of boys and 8% of girls reported that they had had sex
- Amongst those who reported having had sex, two-thirds did not use a condom all the time
- Forced sex was reported by almost 1 in 5 of all sexually initiated students (16%)
- Less than half (42%) of the students knew that people can have the HIV virus but not show signs of being sick right away
- Approximately one-third of students did not know that a person can be infected with HIV by having sex just once without a condom.
- Only 23% of students thought that a teacher or student who has HIV should be allowed to teach or attend school. Less than half (45%) say they would be willing to remain friends with someone with HIV. Approximately three-quarters would not buy food from a shopkeeper or food seller with HIV.

Older Youths and Adults

In 2005 a Behavioral Surveillance Surveys was conducted in six countries of the OECS. These surveys collected data on knowledge, attitudes, beliefs and practices related to HIV/AIDS and other sexually transmitted infections. Some key findings from the 2005 baseline surveys were:

- Approximately one-quarter (26%) of females aged 20 to 24 years old had been tested for HIV in the 12 months preceding and knew their results compared to 10% of males in the same age-group. The figure was approximately one in ten males (8%) and females (12%) in the age-group 25 to 49 years, and less than one in twenty males (2%) and females (4%) in the age-group 15 to 19 years.
- Less than half of the young people surveyed correctly identified the ways of preventing sexual transmission of HIV and rejected common HIV/AIDS-related myths
- Approximately one in three males (32%) and one in five females (20%) reported having initiated sexual intercourse before the age of 15 years

- Almost half (44%) of males aged 20 to 24 years reported having more than one sexual partner in the 12 months preceding their interview compared one-quarter of male respondents 15 to 19 years old (24%) and 25 to 49 years old (26%).
- More males than females in all age-groups reported more than one sexual partner in the 12 months preceding their interview
- Approximately six out of ten young people aged 15 to 24 years old who reported more than one sexual partner in the 12 months preceding their interview had used a condom at last sex.⁸ Condom use was higher amongst males than females.
- Almost 1 in five males (19%) in the age group 15 to 24 years reported receiving drugs in exchange for sex in the 12 months preceding the interview. The figure was lower (4%) amongst females.
- Less than half of the young people aged 15 to 24 correctly identified ways of preventing sexual transmission of HIV AND rejected major myths
- There was low willingness to buy food from an HIV infected food sellers. This may indicate persistent fear of HIV transmission through food.

A national household survey conducted in Grenada in 2007 used a similar methodology as the BSS and showed generally similar findings. The baseline BSS conducted in 2005 did not have an HIV seroprevalence component.

Men Who have sex with Men

Although questions regarding male-to-male sex were included in the survey questionnaire for the general population sample, the findings did not yield statistically useful information. Under-reporting is assumed and was most likely due to the face-to-face interview methodology used where persons are less likely to report highly sensitive and stigmatizing information. In an effort to obtain information on these hard-to-reach populations, the NAD worked with local NGOs with issues such as referral to the care and treatment programmes, funding and implementation of community-based projects, and development of data collection instruments for programme monitoring and planned surveys. Challenges faced in reaching MSM and sex workers include issues mistrust, fear of disclosure, uncertainty about the legal status of their activities, and uncertainty regarding confidentiality in the health system.

Sex workers

A survey commercial of sex workers was conducted in 2006 by Population Services International (PSI). Results of this “TRaC-M” survey indicated a need to (1) focus on personal risk perception, (2) condom use by CSW with their paying and non-paying partners, and (3) to increase having SW practice putting a condom on a dildo. Although this survey was focused on PSI-related activities, it gives some insight on HIV-prevention education work that is needed for this high-risk group, for example, none of

the interviewed SWs had ever participated in an educational activity to practice proper condom application on a dildo.

Prison inmates

In August 2005, 137 male inmates (59% of inmates on the survey days) of Her Majesty's Prison in Grenada were surveyed for their HIV serological status. Eighty-three percent (83%) of the survey participants were between the ages of 15 to 49 years. The seroprevalence rate for all inmates tested 2.2% - all HIV positive inmates were between the ages of 15 to 49 years. In terms of their HIV testing history, thirty-two inmates (23%), including the three HIV positive inmates, had previously been tested for HIV; seventy-two percent (72%) of the inmates who had never been tested before gave no particular reason for not doing so. It was notable that more than half of the participants (53%) had a sentence of less than 12 months or had been incarcerated for less than 12 months (remanded prisoners). The survey findings of 2.2% HIV seroprevalence was notably higher than the estimated national population prevalence of 0.42% in 2003, but similar to the 2.3% prevalence in a survey of 260 STI patients conducted in 1996. Since 2007, the Ministry of health has collaborated with the prison authorities to conduct routine testing among prison inmates.

- No studies were conducted in this reporting period.

Impact alleviation

Grenada has laws that protect PLWHA from discrimination however these are general nondiscrimination provision that do not specifically mention HIV. In 2007, the National AIDS Council, with support from the Pan Caribbean Partnership against HIV/AIDS (PANCAP), sought to undertake a review of the Legal and Ethical environment surrounding the issue of HIV/AIDS in Grenada. A national assessment was conducted and a report completed. This report cited relevant legislation and legislative gaps that existed. In 2008, consultations with stakeholders will continue in order to develop recommendations for legislative reform. This project seeks to create a legal framework that protects the rights of PLWHA and other groups at risk for or affected by HIV. In this context, it is worth mentioning that there are in existence some laws and policies that present barriers in the provision of services to certain vulnerable subpopulations. For example, it is difficult for youths under the age of 16 years to access condoms, materials, VCT and ART without first obtaining parental consent. In prisons, distribution of condoms is problematic even though there is no written law or policy to this effect.

Additionally, there is no provision in the prison act for protection of medical records for HIV positive prisoners. The draft national strategic plan explicitly mentions the promotion and protection of human rights. The Human rights was established to receive, record, document and seek to address human rights violations through such mechanisms as referrals, partnering and sensitization. This desk was specific to HIV and was funded and operated by the Caribbean Regional Network of People Living with HIV/AIDS

through the Global Funds project. However, arrangements are being made for the desk to be located in the Legal Aid and Counselling Clinic.

Best practices

Grenada has a high level of political commitment for its fight against HIV/AIDS. The National HIV/AIDS Programme is once again spearheaded by the Ministry of Health the Minister for Health takes a keen interest in the evolution of the program with a view to ensuring that the policy framework and resources are existent to support effective program implementation.

The local NGO of MSM and the group for Sex Workers are engaged in HIV/AIDS education, condom and supplies distribution and capacity building programs for their communities with technical and financial support from the National AIDS Council. They also been participated in the processes of the formulation of Grenada's National AIDS Policy, the National Strategic Plan (ongoing process) and periodic review and consultations. Directly and openly engaging these communities in spite of social and religious taboos as well as the uncertainty about the legal status of their activities in Grenada is noteworthy.

Grenada conducted a law, ethics and human rights review which was geared towards assessing the legal, ethical and human rights environment within which the National AIDS Program exists and functions. This review was designed to identify and make recommendations for the removal of legal hindrances to effective program implementation as well as creating enabling structures where needed.

The private sector has shown interest in engaging in HIV prevention. There is a committee in place charged with the responsibility of developing a National HIV/AIDS policy in the workplace.

Major challenges that hindered the national response and remedial actions

During the period 2008/2009, some major challenges in the national response has been the wrapping up of the World Bank funded Project, new political administration and the transition process into the Ministry of Health with insufficient human resources.

Support from the country's development partners

Grenada has received considerable support from its development partners but this has limitations. Adequate funding for the National Response continues to be a challenge. At present, the National AIDS Program received financial and technical assistance from developmental partners who, working together with the Government, have allowed a continued multi-sectored response.

Key regional and international development partners, not listed in any order, include:

- The Global Funds for AIDS, Tuberculosis and Malaria (GFATM)

- Caribbean Community (CARICOM) Pan Caribbean Partnership against HIV/AIDS (PANCAP)
- Caribbean Health Research Council (CHRC)
- Joint United Nations Programme on AIDS (UNAIDS)
- The United Nations Development Programme (UNDP)
- United States Agency for International Development (USAID)
- Organization of Eastern Caribbean States (OECS) HIV AIDS Programme Unit (HAPU)
- Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC)
- United Nations Children's Fund (UNICEF)
- United National Family Planning Association (UNFPA)

There is a need for continued donor support in addition to capacity building in country. Key areas are surveillance and monitoring and evaluation.

Monitoring and evaluation environment

Overview of the current monitoring and evaluation (M&E) system

There is currently no written monitoring and evaluation plan. The main challenge has been the development of national M&E indicators that can both effectively track progress towards programme goals and objectives while satisfying reporting requirements of donor agencies.

Need for M&E technical assistance and capacity-building

Because monitoring and evaluation is not a well-appreciated concept across all actors in the multi-sectored response, particular challenges are faced with respect to data collection. There is a need for the development of a National Monitoring and Evaluation policy and plan. In addition, challenges with implementation remain because of the way that program data is currently collected, stored, analyzed and disseminated.