UNGASS COUNTRY PROGRESS REPORT

Grenada

Reporting period: January 2006–December 2007

Submission date: January 31, 2008

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 HIV/AIDS
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
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Table of Contents

List of Tables

List of Figures

Stakeholders involvement in the preparation of the UNGASS report

The National AIDS Directorate was the lead for the preparation of the UNGASS 2006-2007 report. The process began in October 2007. Information was collected using a combination of review of programme data, collection of surveillance data, reanalysis of research data, desk-top reviews, and interviews with key persons from governmental departments and non-governmental organisations. The initial sensitisation stage and indicator data collection steps were facilitated by a UNAIDS-hired consultant who provided in-country assistance for a period of one week. Thereafter, the data collection and report writing process was conducted by the NAD monitoring and evaluation officer with off-site assistance from the UNAIDS consultant.

The National Composite Policy Index (NCPI) was completed using a consultative process consisting of a meeting for each of parts A and B, followed by individual review of a draft NCPI report. The consensus was compiled to form the final NCPI report. Stakeholders consulted for part A were representatives of the National AIDS Council, National AIDS Directorate, the Ministry of Health, consultants from the Law, Ethics and Human Rights review, and the Ministry of Education. Stakeholders consulted for part B included representatives from the Grenada Red Cross Society, the Grenada Conference of Churches, the Grenada Human Rights Desk, HOPE-PALS Network (PLWHA NGO), the Heritage Theatre Company of Grenada Inc., the Youth Empowerment Foundation of Grenada, the Legal AIDS and Counselling Clinic, GrenCHAP, and consultants from the Law, Ethics and Human Rights review.

Status of the epidemic

Since the first case of HIV in Grenada in 1984, a cumulative total of 348 HIV/AIDS cases had been reported to the surveillance system up to the end of December 2007. More males have been affected with a cumulative male-to-female ratio of 1.8 to 1. Approximatly 70% of reported AIDS cases and AIDS-related deaths were among persons aged 15 to 44 years. The predominant recorded mode of transmission is via sexual intercourse, with heterosexual transmission being the most predominant. Transmission through intravenous drug use is low. No transmissions via blood transfusion have been recorded. It must be noted, however, that risk history is not documented for many cases so there is the potential that the risk profile developed for the country does not accurately reflect reality.

At the end of 2003, the Caribbean Epidemiology Centre (CAREC) and Centers for Disease Control and Prevention (CDC) estimated that 439 persons were living with HIV/AIDS in Grenada[1], resulting in an estimated prevalence rate of 0.42%. In 2007, an estimated 0.65% of pregnant women were infected with HIV, indicating that the epidemic has continued on an upward trend but remains a low level epidemic.

[1] CAREC/PAHO/WHO. Status and Trends – Analysis of the Caribbean HIV/AIDS epidemic 1982-2002. 2004.

Using existing surveillance data and global ranges for prevalence of risk behaviours (e.g. proportion of population who use injection drugs, females sex workers, men who have sex with men), there were an estimated 194 men and 119 women aged 15 to 49 years living with HIV/AIDS at the end of 2007. The national HIV/AIDS care and treatment programme, managed by the National Infectious Diseases Control Unit (NIDCU) of the Ministry of Health, reported a total of 47 persons with advanced HIV disease on antiretroviral therapy at the end of 2007. If a further assumption is made that 20% to 40% of persons with HIV have advanced disease, then there were an estimated 63 to 125 persons in need of treatment. As such, the 2007 treatment coverage in the public sector likely ranged from 38% to 75%. It must be emphasized as this is very approximate as it does not take into account the potential effects of treatment availability, the PMTCT programme, etc on HIV spread in the population. The important point to note here is that there were still unmet needs for antiretroviral therapy in 2007.

In terms of the PMTCT programme, the available data for 2005 indicate that approximately 50% of HIV infected pregnant women received ARV for the prevention of mother-to-child HIV transmission. In 2007, the estimated figure was higher at 70%.

There is a paucity of data on most-at-risk populations due to various contextual and programmatic issues and so it is not possible to state conclusively that Grenada's epidemic is a concentrated one. However, using quantitative data from various sources including national surveillance data, the 2005 Behavioural Surveillance Surveys in six countries of the OECS, the UNICEF baseline survey for the HFLE curriculum study, and information from key informants within MSM and sex worker-specific non-governmental organisations, the Grenada National AIDS Council has identified the following as being high-risk populations: men who have sex with men (MSM), sex workers, prisoners, youths, females, and uniformed personnel (e.g. police and prison officers).

Results from the HFLE baseline survey, the 2005 OECS BSS and the 2007 national household survey provides this risk backdrop for the country:

- A worrisome proportion of young in-school youths are sexually active, and a notable proportion were forced at sexual initiation
- There are knowledge gaps amongst youngsters regarding how HIV can be spread.
- Despite high awareness of HIV in the general population, there are still misconceptions in about how HIV can be spread
- There is a low level of accepting attitudes towards persons with HIV, particularly for activities that indicate potential contact with body fluids, e.g. sharing meals
- Uptake of HIV testing is generally low, with more women tested than men.
- Condom use is generally inconsistent even amongst persons who reported more than one sexual partner in a 12 month period.
- Transactional sex is a concern and is likely fuelled by difficult economic climate and unemployment.

Policy and programmatic response

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 is a multi-sectoral body which is responsible for ensuring the success of the National HIV/AIDS Programme. The National AIDS Directorate operates as the secretariat to the National AIDS Council and has responsibility for the implementation of policy and programmatic decisions. 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 Strategic Plan document in 2008.

In 2006, a total of US$1.05 million was available to Grenada 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.

In terms of the HIV/AIDS response, the National AIDS Council (NAC) believes that 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. The National Infectious Diseases Control Unit (Ministry of Health) has responsibility for the management of 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, Voluntary Counselling and Testing (VCT), and safe blood and transfusion services. The majority of public health care facilities offer pre- and post- test counselling and HIV blood collection services, however HIV/AIDS care, treatment and support are provided from one public facility in the country's capital, St. Georges. This programme provides 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 during pregnancy and delivery, and they are provided with replacement infant feeding for six months to prevent HIV transmission via breastfeeding.

The Grenada national strategic plan explicitly mentions the promotion and protection of human rights. 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. The 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.

Table 1: UNGASS indicator data

<table>
<tr><th rowspan="2">Indicator</th><th colspan="2">Actual data</th><th rowspan="2">Calculated Indicator</th><th rowspan="2">Data source/ comment</th></tr>
<tr><th>Numerator</th><th>Denominator</th></tr>
<tr><td>3 - Percentage of donated blood units screened for HIV in a quality-assured manner</td><td>Number of blood units screened for HIV in laboratories that have both: (1) followed documented standard operating procedures; and (2) participated in an external quality assurance scheme.

2006: 1,004 units screened for HIV

1. Laboratory uses manufacturers' instructions for HIV testing.
2. Laboratory does participate in external quality assurance (UK NEQUA)</td><td>Total number of units donated

2006: 1,100 units donated</td><td>Percentage of donated blood units screened for HIV in a quality-assured manner.

2006: 91.3 %</td><td>National Blood Bank annual reports to PAHO</td></tr>
<tr><td>4 - Percentage of adults and children with advanced HIV infection receiving antiretroviral combination therapy</td><td># of adults and children with advanced HIV infection receiving antiretroviral combination therapy.

2007:<table><tr><td>Age gp</td><td>Males</td><td>Females</td></tr><tr><td><15 yrs</td><td>1</td><td>1</td></tr><tr><td>15 yrs +</td><td>23</td><td>20</td></tr><tr><td>Total</td><td>24</td><td>21</td></tr></table></td><td>Estimated number of adults and children with advanced HIV infection.

2007:<table><tr><td>Age gp</td><td>Males</td><td>Females</td></tr><tr><td><15 yrs</td><td colspan="2">Not available</td></tr><tr><td>15 yrs +</td><td>78</td><td>48</td></tr><tr><td>Total</td><td>---</td><td>---</td></tr></table></td><td>Percentage of adults and children with advanced HIV infection receiving antiretroviral combination therapy.
2007:<table><tr><td>Age gp</td><td>Males</td><td>Females</td></tr><tr><td><15 yrs</td><td colspan="2">Not available</td></tr><tr><td>15 yrs +</td><td>29%</td><td>42%</td></tr><tr><td>Total</td><td></td><td></td></tr></table></td><td>Numerator data: Provisional data from HIV/AIDS programme, National Infectious Diseases Control Unit (NIDCU), Ministry of Health

Denominator data: WorkBook model for 2006. Assumption –</td></tr>
</table>

Indicator	Actual data		Calculated Indicator	Data source/ comment
	Numerator	Denominator		
				40% of the estimated 313 HIV infected adults in Grenada (194 males and 119 females aged 15 to 49 yrs) are in need of treatment.
5 - Percentage of HIV-positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission	*# of HIV-infected pregnant women who received ARVs during the last 12 months to reduce MTCT.* **2006:** 5 Women **2007**: 7 Women	*Estimated # of HIV-infected pregnant women during the same period.* **2006:** 10 Women **2007:** 10 Women	*Percentage of HIV-positive pregnant women who received ARVs to reduce the risk of mother-to-child transmission* **2006:** 50% **2007:** 70%	Numerators: NIDCU, Ministry of Health Denominator: Calculated using HIV seroprevalence among ANC attendees who were tested multiplied by data on total ANC clients.
6 - Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV.	*# of adults with advanced HIV infection who are currently receiving ART … and who were started on TB treatment within the reporting year.* 2006: 0 cases 2007: 0 cases (as of Oct. 11, 2007)	*Estimated number of incident TB cases amongst people living with HIV – To be obtained from WHO.* **2006:** Not available at WHO website.	*Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV.* **2006:** 0 2007: 0	Epidemiology Unit, Ministry of Health

<table>
<tr><th>Indicator</th><th colspan="2">Actual data</th><th>Calculated Indicator</th><th>Data source/ comment</th></tr>
<tr><th></th><th>Numerator</th><th>Denominator</th><th></th><th></th></tr>
<tr><td>7 - Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.</td><td># of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.
2005 BSS:<table><tr><td>Age gp</td><td>Males</td><td>Females</td></tr><tr><td>15-19 yrs</td><td>5</td><td>13</td></tr><tr><td>20-24 yrs</td><td>18</td><td>55</td></tr><tr><td>25-49 yrs</td><td>23</td><td>37</td></tr></table></td><td>All women and men aged 15-49.
2005 BSS:<table><tr><td>Age gp</td><td>Males</td><td>Females</td></tr><tr><td>15-19 yrs</td><td>263</td><td>323</td></tr><tr><td>20-24 yrs</td><td>175</td><td>210</td></tr><tr><td>25-49 yrs</td><td>277</td><td>299</td></tr></table></td><td>Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.
2005 BSS:<table><tr><td>Age gp</td><td>Males</td><td>Females</td></tr><tr><td>15-19 yrs</td><td>2%</td><td>4%</td></tr><tr><td>20-24 yrs</td><td>10%</td><td>26%</td></tr><tr><td>25-49 yrs</td><td>8%</td><td>12%</td></tr></table></td><td>OECS BSS 2005/2006 secondary data analyses.</td></tr>
<tr><td>8 - Percentage of (most-at-risk populations) who received an HIV test in the last 12 months and who know their results</td><td colspan="3">Data not available</td><td></td></tr>
<tr><td>9 - Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes</td><td colspan="3">Data not available</td><td></td></tr>
<tr><td>10 - Percentage of orphaned and vulnerable children aged 0-17 whose households received free</td><td colspan="3">Data not available</td><td></td></tr>
</table>

<table>
<tr><th>Indicator</th><th colspan="2">Actual data</th><th>Calculated Indicator</th><th>Data source/ comment</th></tr>
<tr><th></th><th>Numerator</th><th>Denominator</th><th></th><th></th></tr>
<tr><td>basic external support in caring for the child</td><td colspan="3"></td><td></td></tr>
<tr><td>11 - Percentage of schools that provided life-skills-based HIV/AIDS education within the last academic year</td><td># of schools that provided (at least 30 hours of) life-skills-based HIV/AIDS education (to each grade) within the last academic year.
2006/2007:<table><tr><td>School level</td><td>Public</td><td>Private</td></tr><tr><td>Primary</td><td>0</td><td>Unk</td></tr><tr><td>Secondary</td><td>0</td><td>Unk</td></tr><tr><td>Total</td><td>0</td><td>Unk</td></tr></table></td><td>Total # of schools.
2006/2007:<table><tr><td>School level</td><td>Public</td><td>Private</td></tr><tr><td>Primary</td><td>30</td><td>13</td></tr><tr><td>Secondary</td><td>19</td><td>0</td></tr><tr><td>Total</td><td>49</td><td>13</td></tr></table></td><td>Percentage of schools that provided (at least 30 hours of) life-skills-based HIV/AIDS education in the last academic year.
2006/2007:<table><tr><td>School level</td><td>%</td></tr><tr><td>Primary</td><td>0%</td></tr><tr><td>Secondary</td><td>0%</td></tr><tr><td>Total</td><td>0%</td></tr></table></td><td>Key informant – Curriculum Development Officer at the Ministry of Education (from programme documents).

Three (3) secondary schools participate in the UNICEF pilot study of the HFLE curriculum, however these are offered only to students in forms 1 to 3.</td></tr>
<tr><td>12 - Current school attendance among orphans and non-orphans aged 10–14</td><td colspan="3">Data not available</td><td></td></tr>
</table>

<table>
<tr><th>Indicator</th><th colspan="2">Actual data</th><th>Calculated Indicator</th><th>Data source/ comment</th></tr>
<tr><th></th><th>Numerator</th><th>Denominator</th><th></th><th></th></tr>
<tr>
<td>13 - Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.</td>
<td># of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>99</td><td>112</td></tr>
<tr><td>20-24 yrs</td><td>87</td><td>99</td></tr>
<tr><td>Total</td><td>186</td><td>211</td></tr>
</table></td>
<td>All young people aged 15–24 surveyed.

2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>263</td><td>323</td></tr>
<tr><td>20-24 yrs</td><td>175</td><td>210</td></tr>
<tr><td>Total</td><td>438</td><td>533</td></tr>
</table></td>
<td>Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.
2005 BSS
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>38%</td><td>35%</td></tr>
<tr><td>20-24 yrs</td><td>50%</td><td>47%</td></tr>
<tr><td>Total</td><td>43%</td><td>40%</td></tr>
</table></td>
<td>OECS BSS 2005/2006 secondary data analyses</td>
</tr>
<tr>
<td>14 - Percentage of (most-at-risk populations) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.</td>
<td colspan="3">Data not available</td>
<td></td>
</tr>
</table>

<table>
<tr><th rowspan="2">Indicator</th><th colspan="2">Actual data</th><th rowspan="2">Calculated Indicator</th><th rowspan="2">Data source/ comment</th></tr>
<tr><th>Numerator</th><th>Denominator</th></tr>
<tr>
<td>15 - Percentage of young women and men aged 15-24 who have had sex before the age of 15</td>
<td># of young women and men aged 15-24 who have had sex before the age of 15.

2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>77</td><td>75</td></tr>
<tr><td>20-24 yrs</td><td>64</td><td>30</td></tr>
<tr><td>Total</td><td>141</td><td>105</td></tr>
</table></td>
<td>All young women and men aged 15-24 surveyed.

2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>263</td><td>323</td></tr>
<tr><td>20-24 yrs</td><td>175</td><td>210</td></tr>
<tr><td>Total</td><td>438</td><td>533</td></tr>
</table></td>
<td>Percentage of young women and men aged 15-24 who have had sex before the age of 15

2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>29%</td><td>23%</td></tr>
<tr><td>20-24 yrs</td><td>37%</td><td>14%</td></tr>
<tr><td>Total</td><td>32%</td><td>20%</td></tr>
</table></td>
<td>OECS BSS 2005/2006 secondary data analyses.</td>
</tr>
<tr>
<td>16 - Percentage of women and men aged 15–49 who have had sex with more than one partner in the last 12 months</td>
<td>of women and men aged 15–49 who have had sex with more than one partner in the last 12 months.
2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>62</td><td>49</td></tr>
<tr><td>20-24 yrs</td><td>77</td><td>39</td></tr>
<tr><td>25-49 yrs</td><td>72</td><td>23</td></tr>
</table></td>
<td>All women and men aged 15-49 surveyed.

2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>263</td><td>323</td></tr>
<tr><td>20-24 yrs</td><td>175</td><td>210</td></tr>
<tr><td>25-49 yrs</td><td>277</td><td>299</td></tr>
</table></td>
<td>Percentage of women and men aged 15–49 who have had sex with more than one partner in the last 12 months.
2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>24%</td><td>15%</td></tr>
<tr><td>20-24 yrs</td><td>44%</td><td>19%</td></tr>
<tr><td>25-49 yrs</td><td>26%</td><td>8%</td></tr>
</table></td>
<td>OECS BSS 2005/2006 secondary data analyses</td>
</tr>
</table>

<table>
<tr><th>Indicator</th><th colspan="2">Actual data</th><th>Calculated Indicator</th><th>Data source/ comment</th></tr>
<tr><th></th><th>Numerator</th><th>Denominator</th><th></th><th></th></tr>
<tr>
<td>17 - Percentage of women and men aged 15–49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse</td>
<td># of women and men aged 15–49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse.

2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>43</td><td>25</td></tr>
<tr><td>20-24 yrs</td><td>52</td><td>21</td></tr>
<tr><td>25-49 yrs</td><td colspan="2">Not available[2]</td></tr>
</table>
</td>
<td>Number of respondents (15–49 years) who reported having had more than one sexual partner in the last 12 months.

2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>62</td><td>49</td></tr>
<tr><td>20-24 yrs</td><td>77</td><td>39</td></tr>
<tr><td>25-49 yrs</td><td colspan="2">Not available</td></tr>
</table>
</td>
<td>Percentage of women and men aged 15–49 who have had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse.
2005 BSS:
<table>
<tr><td>Age gp</td><td>Males</td><td>Females</td></tr>
<tr><td>15-19 yrs</td><td>69%</td><td>51%</td></tr>
<tr><td>20-24 yrs</td><td>68%</td><td>54%</td></tr>
<tr><td>25-49 yrs</td><td colspan="2">Not available</td></tr>
</table>
</td>
<td>OECS BSS 2005/2006 secondary data analyses</td>
</tr>
<tr><td>18 - Percentage of female and male sex workers reporting the use of a condom with their most recent client</td><td colspan="3">Data not available</td><td></td></tr>
<tr><td>19 - Percentage of men reporting the use of a condom the last time they had anal sex with a male partner</td><td colspan="3">Data not available</td><td></td></tr>
</table>

[2] Data not available -Due to the type of survey questions asked to this age-group, for which questions were asked relating to three different types of sexual partners, it was not possible to obtain one figure for persons with multiple sex partners.

Indicator	Actual data		Calculated Indicator	Data source/ comment
	Numerator	**Denominator**		
20 - Percentage of injecting drug users who report using a condom the last time they had sex	Not applicable to Grenada			
21 - Percentage of injecting drug users who report using sterile injecting equipment the last time they injected	Not applicable to Grenada			
22 - Percentage of young women and men aged 15–24 who are HIV infected.	*# of HIV-positive ANC attendees (aged 15 to 24 years old)* **2006: 0** **2007:** 2	*# of antenatal clinic attendees (15 to 24 years old) tested for their HIV infection status.* **2006:** (15-19) 356 (20-34) 143 **2007:** (15-19) 260 (20-34) 945	*Percentage of young women and men aged 15 to 24 years who are HIV infected.* **2006:** 0 **2007:** Not available	NIDCU PMTCT patient and programme records
23 - Percentage of most-at-risk populations who are HIV infected.	**2005**: 3 prisoners HIV positive	**2005**: 137 prisoners surveyed	**2005**: 2.2% seroprevalence amongst prisoners tested. MSM: Data not available Sex workers: Data not available	Report on an HIV Seroprevalence Survey among male inmates in Her Majesty's Prison, Grenada conducted on August 2-3, 2005. CAREC, October 2005.

<table>
<tr><th>Indicator</th><th colspan="2">Actual data</th><th>Calculated Indicator</th><th>Data source/ comment</th></tr>
<tr><th></th><th>Numerator</th><th>Denominator</th><th></th><th></th></tr>
<tr>
<td>24 - Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy</td>
<td># of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.
<table>
<tr><th colspan="3">Children (< 15 years old)</th></tr>
<tr><th>Cohort</th><th>Males</th><th>Females</th></tr>
<tr><td>2003</td><td>0</td><td>0</td></tr>
<tr><td>2004</td><td>0</td><td>0</td></tr>
<tr><td>2005</td><td>0</td><td>0</td></tr>
<tr><td>2006</td><td>1</td><td>1</td></tr>
</table>
<table>
<tr><th colspan="3">Adults (15 years and older)</th></tr>
<tr><th>Cohort</th><th>Males</th><th>Females</th></tr>
<tr><td>2003</td><td>2</td><td>7</td></tr>
<tr><td>2004</td><td>5</td><td>2</td></tr>
<tr><td>2005</td><td>4</td><td>1</td></tr>
<tr><td>2006</td><td>4</td><td>1</td></tr>
</table></td>
<td>Total # of adults and children who initiated ART during the 12 months prior to the beginning of the reporting period.
<table>
<tr><th colspan="3">Children (< 15 years old)</th></tr>
<tr><th>Cohort</th><th>Males</th><th>Females</th></tr>
<tr><td>2003</td><td>0</td><td>0</td></tr>
<tr><td>2004</td><td>0</td><td>0</td></tr>
<tr><td>2005</td><td>0</td><td>0</td></tr>
<tr><td>2006</td><td>1</td><td>1</td></tr>
</table>
<table>
<tr><th colspan="3">Adults (15 years and older)</th></tr>
<tr><th>Cohort</th><th>Males</th><th>Females</th></tr>
<tr><td>2003</td><td>4</td><td>7</td></tr>
<tr><td>2004</td><td>5</td><td>2</td></tr>
<tr><td>2005</td><td>4</td><td>1</td></tr>
<tr><td>2006</td><td>5</td><td>1</td></tr>
</table></td>
<td>Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.
<table>
<tr><th colspan="3">Children (< 15 years old)</th></tr>
<tr><th>Cohort</th><th>Males</th><th>Females</th></tr>
<tr><td>2003</td><td>---</td><td>---</td></tr>
<tr><td>2004</td><td>---</td><td>---</td></tr>
<tr><td>2005</td><td>---</td><td>---</td></tr>
<tr><td>2006</td><td>100%</td><td>100%</td></tr>
</table>
<table>
<tr><th colspan="3">Adults (15 years and older)</th></tr>
<tr><th>Cohort</th><th>Males</th><th>Females</th></tr>
<tr><td>2003</td><td>50%</td><td>100%</td></tr>
<tr><td>2004</td><td>100%</td><td>100%</td></tr>
<tr><td>2005</td><td>100%</td><td>100%</td></tr>
<tr><td>2006</td><td>80%</td><td>100%</td></tr>
</table></td>
<td>Source: ART patient monitoring database and patient records, Ministry of Health.</td>
</tr>
<tr>
<td>25 - Percentage of infants born to HIV infected mothers who are infected</td>
<td colspan="3">To be estimated at UNAIDS head quarters</td>
<td></td>
</tr>
</table>

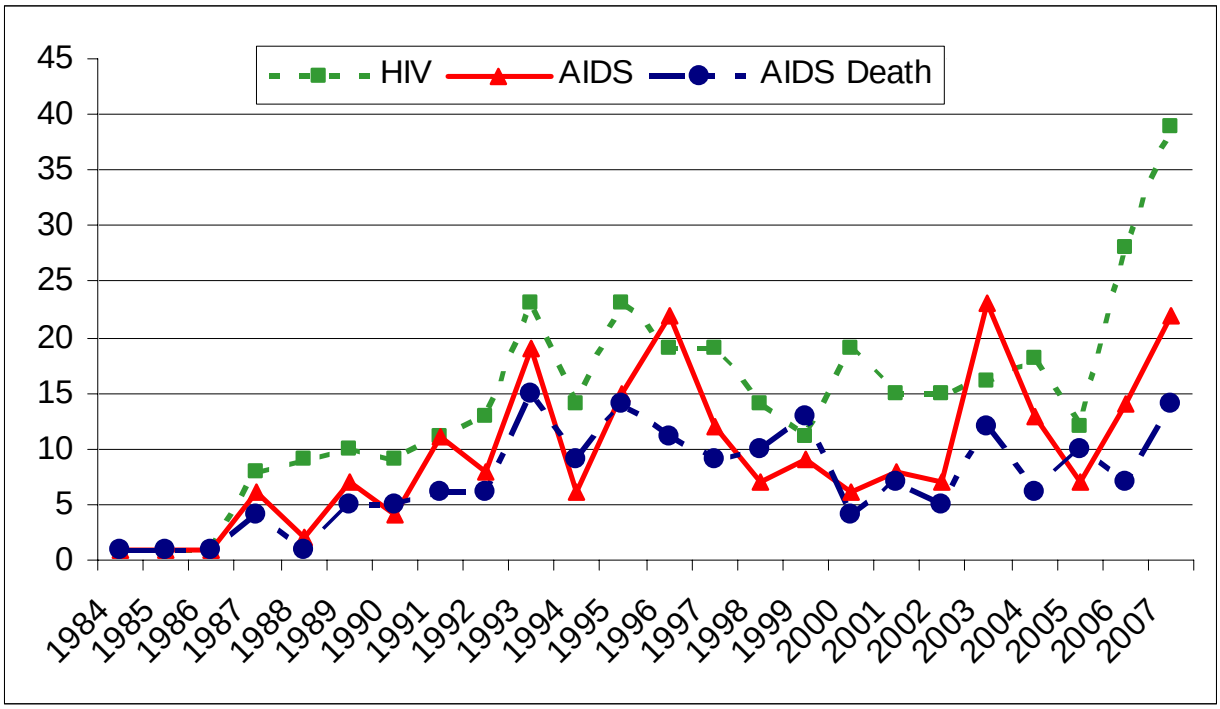
1. Overview of the AIDS epidemic

Since the first case of HIV in Grenada in 1984, a cumulative total of 348 HIV/AIDS cases had been reported to the surveillance system up to the end of December 2007. More males have been affected with a cumulative male-to-female ratio of 1.8 to 1. Approximately 70% of reported AIDS cases and AIDS-related deaths were among persons aged 15 to 44 years. The trend for HIV, AIDS and AIDS deaths reported to the surveillance system is shown in Figure 1. The 39 reported AIDS cases for 2007 represents the highest annual total reported thus far in Grenada.

Figure 2 shows the age and sex distribution of all reported HIV/AIDS cases. It is worthy of note that, in the age-group 15 to 24 years, there are more females than males indicating a feminization of the epidemic.

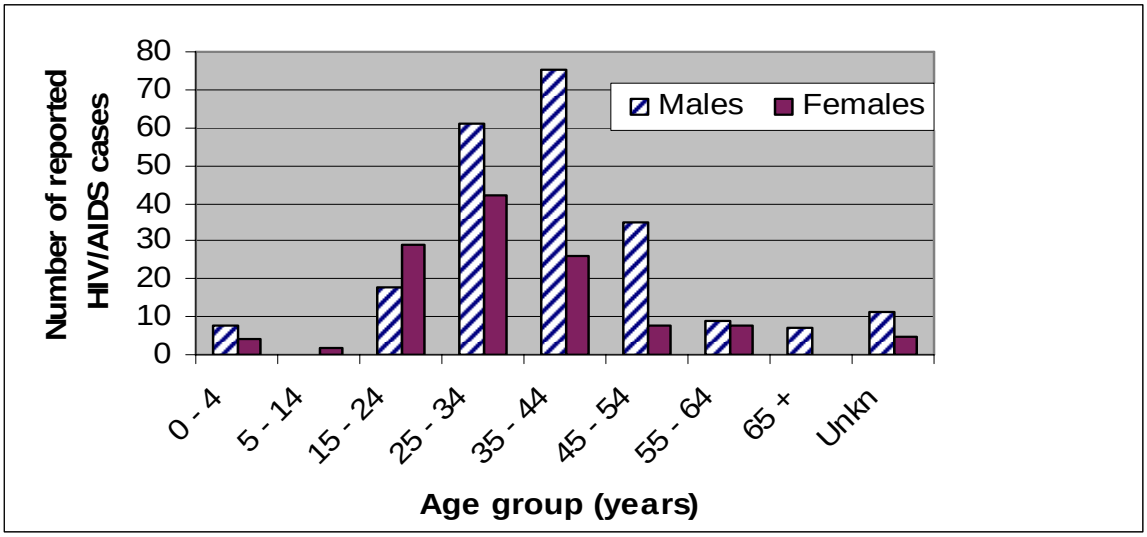
The predominant recorded mode of transmission is via sexual intercourse, with heterosexual transmission being the most predominant. Transmission through intravenous drug use is low. Transmission through blood transfusion is 0% because of the systematic screening of blood for transfusion in Grenada. It must be noted, however, that risk history is not documented for many cases.

Figure 1: Annual reported cases of HIV, AIDS, and AIDS-related Death in Grenada, 1984 to 2007.



Data source: National Infectious Diseases Control Unit, Ministry of Health, January 2008.

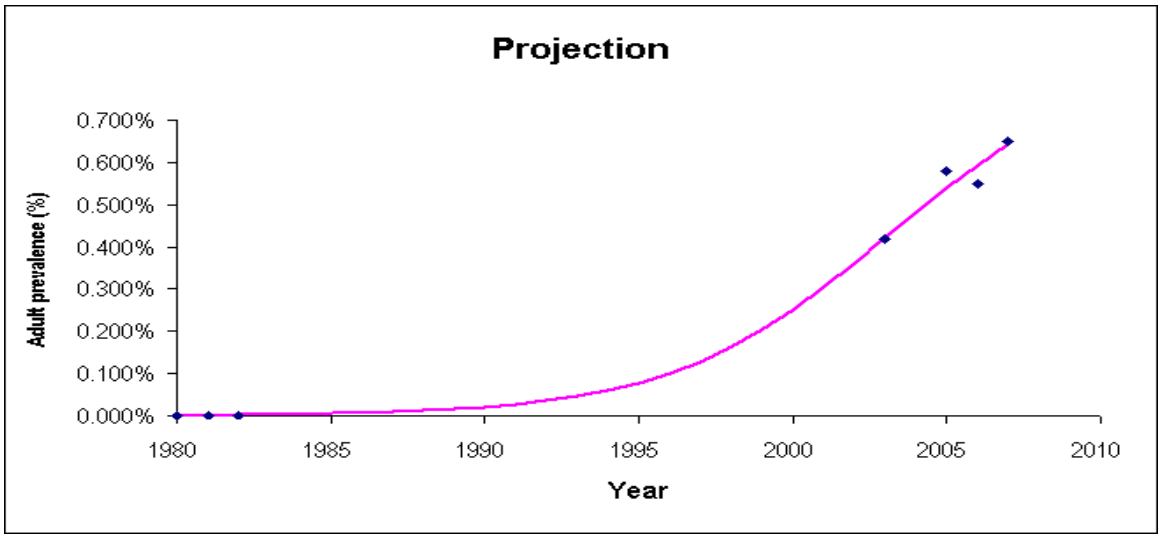
Figure 2: Age- and sex- distribution of HIV/AIDS cases in Grenada, 1984 to 2007.



Data source: National Infectious Diseases Control Unit, Ministry of Health, January 2008.

At the end of 2003, the Caribbean Epidemiology Centre (CAREC) and Centers for Disease Control and Prevention (CDC) estimated that 439 persons were living with HIV/AIDS in Grenada[3], resulting in an estimated prevalence rate of 0.42%. In 2007, an estimated 0.65% of pregnant women were infected with HIV, indicating that the epidemic has continued on an upward trend (Figure 3).

Figure 3: WorkBook model of HIV epidemic based on HIV seroprevalence rates amongst antenatal clinic clients.



[3] CAREC/PAHO/WHO. Status and Trends – Analysis of the Caribbean HIV/AIDS epidemic 1982-2002. 2004.

There is a notable lack of data on most-at-risk populations due to various contextual and programmatic issues. This presents difficulties in modelling the epidemic and generating estimates to aid in programme planning. The available data on HIV seroprevalence amongst pregnant women indicates that Grenada's HIV epidemic is a low-level one, however it is not possible to say with certainty whether or not there are concentrated epidemic in high-risk populations such as men who have sex with men.

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, is responsible for ensuring the success of the National HIV/ AIDS Programme. It is 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 in 2008.

The strategic plan this is currently being developed includes the following sectors: Health, Education, Armed Forces, Women, Youth, Finance, Planning and Tourism. Health, Education, and Finance have earmarked budgets however other sectors can access financial resources from a general HIV/AIDS pool through the National AIDS Directorate and the Ministry of Finance. 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, e.g. the HFLE baseline survey provided information on in-school youths, poor communities were identified using the 2006 Core Welfare Indicator Questionnaire Survey (CWIQ). 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.

The strategic plan will include an operational plan which will delineate programme goals, detailed budget and funding sources. For the 2003 strategic plan, which is currently being revised, civil society organizations were invited to a consultation where the draft document was reviewed and approved by all. It was also approved by the National AIDS Council. The new plan will also undergo a similar process.

There is also a National Health Sector development plan. In the context of HIV/AIDS, this plan addresses the issues of HIV Prevention, Treatment for opportunistic infections, antiretroviral therapy, care and support, impact alleviation. Women's economic empowerment and HIV/AIDS mainstreaming is included in the country's National Strategic Development Plan.

Political Support

The NAC is 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, the Honourable Senator Ann David-Antoine, chairs the National AIDS Council on behalf of the Prime Minister. The Directors of the National AIDS Directorate and the National Infectious Disease Control Unit are ex-officio members of the council. The National AIDS Council (NAC) is accountable to Cabinet through the Office of the Prime Minister for the results of the national HIV/AIDS programme and therefore advises Cabinet on those policies and strategies that require Cabinet approval. NAC works towards setting national priorities, and towards implementing and updating 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 is 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 is also responsible for mobilizing national and international resources for the fight against HIV/ AIDS, for ensuring that HIV/ AIDS activities that are financed by internal and external funds are harmonized and integrated, and for ensuring Grenada's active participation in regional and international consultations.

The National AIDS Directorate, established in 2002, operates as the secretariat to the National AIDS Council and has 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:

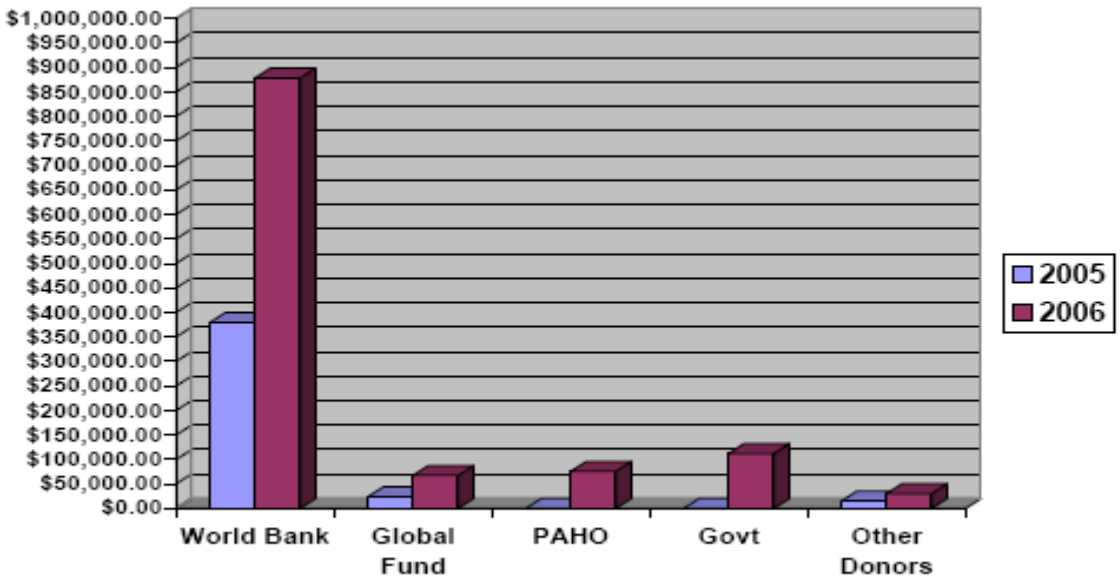
- HIV focal persons appointed in some line ministries
- Six line ministries are engaged in the National AIDS response and re-implementing work plans for HIV/AIDS
- Revision of health and family life education curriculum in schools to focus more on the issue of HIV/AIDS
- Increase in the number of civil society organisations including faith based organizations implementing workplans 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 organisations

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 for the period 2000–2005, representative of between 3.5 and 4.5 percent of the Gross Domestic Product (GDP). Information on private health services is extremely limited. However, the MoH estimated that, for 2002, private health expenditure was 1.7 percent of GDP, with total health expenditure (public and private) at 5.7 percent of GDP.

In 2006, a total of US$1.05 million was available to Grenada 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 (see Figure 4 below). 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.

Figure 4: Donor funds provided to Grenada for the HIV/AIIDS response, 2005 and 2006.



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 National AIDS Council (NAC) believes that 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 2006 and 2007, activities have ranged from production of IEC materials, programmes to promote accurate reporting on HIV by the media, innovative programmed for condom distribution, community sensitization on HIV/AIDS prevention strategies using "edutainment" (combination of education and entertainment) and participatory methodologies and youth-centered programmes (for both in-school and out-of-school youths).

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, Grenada is currently participating in a three-year UNICEF-led study that aims to monitor the impact of the Caribbean Regional Health and Family Life Education (HFLE) curriculum on students' attitudes and behaviour (with a focus on HIV and violence prevention). Three (3) secondary schools in Grenada are participating in the study with the curriculum being offered to students in forms 1 through 3. Based on the results of the study, it is envisioned that such a standardized curriculum will be used in all public schools with

the aim of educating students on the facts about HIV/AIDS while also providing them with life skills that will help them make healthy and safe decisions. In anticipation, 65 teachers from 20 secondary schools have begun training in life-skills and HIV/AIDS education.

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. Table 2 below shows screening results for the periods 2003 to 2006. In 2003 and 2005, all (100%) donated blood units were screened for HIV. In 2006, while the screening coverage was less than 100%, it must be noted that units that are not tested (e.g. due to insufficient quantity or other deficiencies) are not used for donations.

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 are donated by family members of hospitalized patients and are 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.

Table 2: Data on testing of donated blood by the national blood bank, Grenada, 2003-2006.

Variable	2003	2004	2005	2006
# of blood units donated	808	N/A	835	1100
% of blood units screened for HIV	100%	N/A	100%	91.3%
% of blood units positive for HIV	0.1%	N/A	0.1%	0
% of blood units positive for Hepatitis B surface antigen	2.1%	N/A	1.8%	0.5%
% of blood units positive for Hepatitis C virus	0.5%	N/A	0.2%	0.1%
% of blood units positive for syphilis	0.4%	N/A	1.1%	0.3%
% of blood units positive for HTLV 1	1.6%	N/A	1.0%	0.5%

HIV/AIDS Care, treatment and support

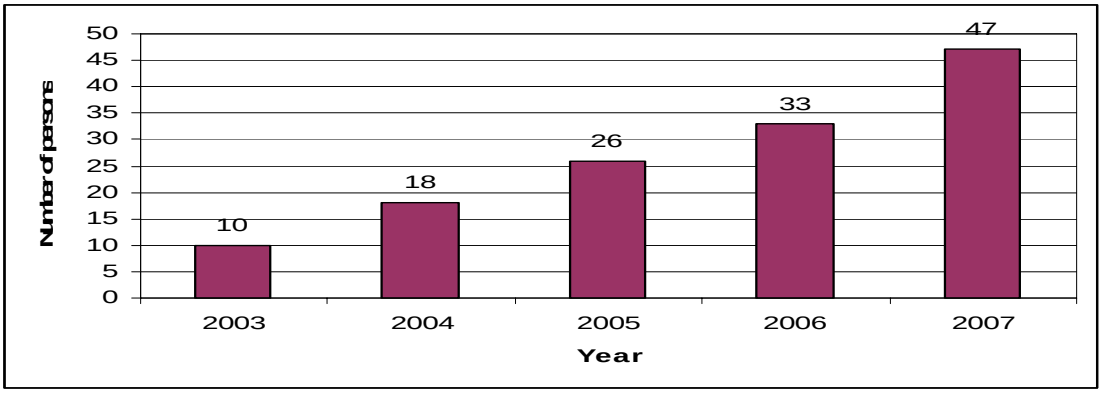
The National AIDS Council (NAC) is committed to improving the quality of life of persons living with and affected by HIV/ AIDS. The NAC is also mindful of the role played by several government agencies, faith-based organizations, other NGOs in the fight against HIV/ AIDS and combined effort is required 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 and HIV blood collection services, however HIV/AIDS care, treatment and support are centralized and operate from one public facility in the country's capital, St. Georges. This 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 by 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 are accessed under the Global Funds project and under the OECS governments' regional system for procurement of medical supplies.

In terms of programme implementation, the NIDCU had recorded a total of 47 persons with advanced HIV disease who were receiving antiretroviral therapy (ART) by the end 2007. This figure represents over 90% of persons with advanced HIV disease who were under care with the programme. Figure 5 shows the increase in treatment provision since the programme started in October of 2003. Table 3 shows provisional[4] data on 12-month survival amongst NIDCU patients who have received ART. Despite the fairly high 12-month survival rates, there are challenges with longer-term adherence that need to be addressed.

Figure 5: Number of persons with advanced HIV disease on antiretroviral therapy at the end of each year, Grenada, 2003 to 2007.



[4] A new patient monitoring database system has recently been adopted for use, and so data reported here may change when data cleaning is completed.

Table 3: Twelve-month patient survival after commencement of antiretroviral therapy (ART) for advanced HIV disease, Grenada, 2003 to 2006

Treatment cohort year	Number who started ART during cohort year				Percent who were still alive after 12 months			
	Males		Females		Males		Females	
	<15 years old	15 years +	<15 years old	15 years +	<15 years old	15 years +	<15 years old	15 years +
2003	0	4	0	7	---	50%	---	100%
2004	0	5	0	2	---	100%	---	100%
2005	0	4	0	1	---	100%	---	100%
2006	1	5	1	1	100%	80%	100%	100%

Using existing surveillance data and global ranges for prevalence of risk behaviours (e.g. proportion of population who use injection drugs, females commercial sex workers, men who have sex with men – see Table 4), there were an estimated 194 men and 119 women aged 15 to 49 years living with HIV/AIDS at the end of 2007 (Appendix 1). If a further assumption is made that 20% to 40%[5] of persons with HIV have advanced disease, then there were between 63 to 125 persons in need of treatment. Using these estimates, the 47 person on treatment in the public sector at the end of 2007 translates to a 2007 treatment coverage rate ranging between 38% and 75%. It must be emphasized as this is very approximate as it does not take into account persons treated in the private sector, nor does the estimation model include the potential effects of treatment availability, the PMTCT programme, etc on HIV spread in the population. The important point to note here is that there were still unmet needs for antiretroviral therapy in 2007.

[5] Assumptions modified from: CAREC (2006). The Caribbean HIV/AIDS Epidemic and the situation in member countries of the Caribbean Epidemiology Centre.

Table 4: Assumptions made for 2006 WorkBook estimates model of persons with HIV/AIDS in Grenada.

High-risk population	Assumptions for proportion of population aged 15 to 49 years		Basis of assumptions	Assumptions HIV Seroprevalence	
	Low	High		Low	High
Injection Drug Users (IDU)	0.1%	0.7%	UNAIDS: Few countries will have more than 0.7% of the adult (15-49) population who inject drugs. In reality the figures might be much lower	1%	15%
Men who have sex with men (MSM)	2%	5%	UNAIDS: Research has found that in most countries between 2% and 5% of men aged 15-49 have sex with other men.	1%	15%
Female sex workers (FSW)	0.4%	0.8%	UNAIDS: Few countries have good estimates of the number of sex workers. In Thailand the estimated number of sex workers is roughly 0.8% of the female population (15-49).	1%	15%
Male customers of FSW	5%	20%	UNAIDS: Few countries have good estimates of the number of clients of sex workers. In Thailand the estimated number of clients is roughly between 5% and 20% of the male population (15-49).	1%	5%
Prisoners	250 persons	350 persons	CAREC: 233 incarcerated males at time of HIV seroprevalence survey, with 17 moved to other facilities due to Hurricane Ivan.	2%	4%

In 2006, a total of 1,825 women received ante-natal clinic services. HIV testing uptake amongst women attending public antenatal clinics was less than optimal resulting in a total of 906 pregnant women (50%) being tested for HIV. The resulting HIV seroprevalence among these women was 0.55%. Using this seroprevalence and the data on live births, it was estimated that there were approximately ten (10) HIV infected pregnant women in Grenada in 2006. As such, the five (5) HIV-infected pregnant women who were provided with ARV in order to prevent mother-to-child transmission of HIV represent a 50% PMTCT coverage. Using similar methods (see Table 5), the seven (7) pregnant women provided with ARVs brought the 2007 PMTCT coverage to 70%, reflecting an increase. It must be noted that women who agree to be tested in ANC clinics may differ from those that refuse testing and as such the seroprevalence data may not be representative of pregnant women. Validation studies are needed in order to obtain more accurate estimates. It is also important to note that most of the HIV positive ANC clients for the period 2005 to 2007 were previously diagnosed women in repeat pregnancies – 4, 2 and 4 women in 2005, 2006 and 2007 respectively. A success of the programme is the fact that all babies provided with anti-HIV prophylaxis have thus far tested HIV negative at 18 months of age.

Table 5: Antenatal clinic attendance, HIV testing, HIV seroprevalence and PMTCT coverage estimates, Grenada, 2005 to 2007.

Year	A: # of ANC clients	B: # of ANC clients tested for HIV	C: % of ANC tested (i.e. testing coverage)	D: # of HIV positives amongst ANC clients tested	E: % HIV positive amongst ANC clients tested (= D/B)	F: Estimated # of ANC clients HIV+ (=%E x A)	G: # who received prophylaxis	H: % PMTCT coverage (= G/F)
2005	1472	860	58.42%	5	0.58%	9	4	44%
2006	1825	906	49.64%	5	0.55%	10	5	50%
2007	1554	1237	79.60%	8	0.65%	10	7	70%

The Epidemiology Unit of the Ministry of Health has not observed notable increases in tuberculosis cases over the past ten years (see Table 6). Based on reported cases, the annual incidence of tuberculosis between 1997 and 2007 ranged from 1 per 100,000 population to 5 per 100,000 population (2005). The trend has been generally stable of this ten year period indicating that the low-level HIV epidemic has not caused an increase in Tb incidence.

Table 6: Statistics on tuberculosis cases reported to the National Epidemiology Unit, Ministry of Health, Grenada, 1997 to 2007 (Oct 11).

Year	**Total reported confirmed TB cases**	**# diagnosed with HIV**	**# who died**
1997	2	1	1
1998	2	1	1
1999	5	1	1
2000	0	0	---
2001	1	0	---
2002	2	1	1
2003	2	0	---
2004	2	0	---
2005	6	1	---
2006	2	0	---
2007 (up to Oct 11)	2	0	---

Knowledge and behaviour change

School Youths

The baseline survey[6] 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 think that a teacher of 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, the first round of the Behavioural Surveillance Surveys[7] 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

[6] Data source: "Student Baseline Survey Highlights – Grenada", provided for UNGASS reporting to the NAD focal point for education by the curriculum development officer, Ministry of Education.

[7] Behavioural Surveillance Surveys conducted in six countries of the Organisation of Eastern Caribbean States. CAREC, June 2007.

- 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 (Table 7).
- There was low willingness to buy food from an HIV infected food sellers. This may indicate persistent fear of HIV transmission through food.

The national household survey conducted in Grenada in 2007 used a similar methodology as the BSS and showed generally similar findings.[9]

Men who have sex with men

The baseline BSS conducted in 2005 did not have an HIV seroprevalence component. 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 has 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) [10]. 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.

[8] Amongst the general population aged 25 to 49 years old, data was collected on condom use however these data were specific to the type of sex partner (i.e. regular (marital) partners, non-regular (non-commercial) partners, and commercial partners). As such, it was not possible to calculate the indicator on condom use at last sex for respondents who had more than one sex partner in the past 12 months.

[9] The consultation report (Soomer, J,. 2007) was submitted to the NAD in December 2007. As such, there was insufficient time to conduct an assessment and required secondary analyses to generate UNGASS indicators.

[10] TRaC-M: Sex Workers in Dominica and Grenada & Men Who Have Sex With Men in St Lucia, St Vincent & The Grenadines and Trinidad & Tobago," PSI Social Marketing Research Series, 2006 <http://www.psi.org/research/cat_socialresearch_smr.asp>

Table 7: Findings from the 2005 OECS Behavioural Surveillance Survey of the general population aged 15 to 24 years for selected knowledge and stigma/discrimination indicators.

Indicator	Age-group 15 to 19 years		Age group 20-24 years		Total (i.e. Age 15 to 24 years)	
	Males (n=263)	Females (n=323)	Males (n=175)	Females (n=210)	Males (n=438)	Females (n=533)
Knowledge about HIV transmission						
Percentage who both correctly identify ways of preventing the sexual transmission of HIV AND who reject major misconceptions about HIV transmission. (Composite of the five questions below)	37.6%	34.7%	49.7%	47.1%	42.5%	39.6%
Percent who knew that the risk of HIV transmission can be reduced by having sex with only one uninfected partner	87.8%	90.1%	89.1%	94.8%	88.4%	91.9%
Percent who knew that a person can reduce the risk of getting HIV by using a condom every time they have sex.	67.3%	75.5%	78.3%	81.9%	71.7%	78.0%
Percent who knew that a health looking person **can** be infected with HIV	97.7%	92.6%	97.7%	97.1%	97.7%	94.4%
Percent who knew that HIV **cannot** be transmitted from mosquito bites	65.3%	68.7%	70.9%	71.9%	67.8%	70.0%
Percent who knew a person **cannot** get HIV by sharing food with someone who is infected.	74.9%	70.6%	76.6%	78.6%	75.6%	73.7%
Stigma and Discrimination						
Percentage who would be willing to allow an HIV infected student to continue going to school	57.0%	70.3%	68.0%	75.7%	61.4%	72.4%
Percentage who would be willing to allow an HIV infected teacher to teach	52.9%	65.3%	65.7%	74.8%	58.0%	69.0%
Percentage who would be willing to buy food from an HIV infected food seller.	18.6%	13.6%	18.9%	14.3%	18.7%	13.9%

Prison inmates

In August 2005, 137 male inmates (59% of inmates on the survey days) of Her Majesty's Prison in Grenada were surveyed[11] for their HIV serological status. Eight-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 that 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.[12]

Impact alleviation

Grenada has laws that protect PLWHA from discrimination however these are general non-discrimination 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 sub-populations. 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 national strategic plan explicitly mentions the promotion and protection of human rights. The National AIDS Council established a human rights desk which received, records, documents and seeks to address human rights violations through such mechanisms as referrals, partnering and sensitization. This desk is specific to HIV and is funded and operated by the Caribbean Regional Network of People Living with HIV/AIDS through the Global Funds project. One noted area for action is the issue for new legislation to deal with the rights of PLWHA, especially with regard to stigma and discrimination in the work place. With the exception of one private sector organisation which has articulated a policy on HIV, no other organisation has a written policy that guides the management of HIV in the workplace. Currently, the Senior Management Board of the public service is working with the NAD on the articulation of such a policy.

[11] Report on an HIV seroprevalence survey among male inmates in Her Majesty's Prison in St. Vincent and the Grenadines conducted on April 12-13, 2005. CAREC, July 2005.

[12] CAREC/PAHO/WHO. Status and Trends – Analysis of the Caribbean HIV/AIDS epidemic 1982-2002. 2004.

Technical and Financial support has been provided to support a project of the network of PLWHA which is geared towards improving the housing and nutrition of PLWHA and their dependents. Examples of project outcomes include the remodelling of seven (7) homes (funded by World Bank), hiring of a Care Attendant who conducts home-visits to give support/ advice with regards to medication adherence (funded by Global Funds) and support from a community outreach program.

In terms of orphans and vulnerable children, the NAD has commenced efforts to track orphans and vulnerable children (OVC) by pursuing the process of establishing contact with those in the foster care of children's homes.

4. Best practices

Grenada enjoys a high level of political support for its fight against HIV/AIDS. The project is placed under the responsibility of the Prime Minister and the Chair of the National AIDS Council is the Minister of Health. Together, the Prime Minister and the Minister for Health take 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. In Grenada the Ministry of Health also includes the Environment, Social Security and Ecclesiastical Relations and in this way HIV/AIDS is integrated into broader developmental issues. Grenada's HIV/AIDS response program is comparatively new, program managers actively encourage research and evidence driven activities even with the limited resources available to them.

The program has taken a deliberately liberal stance by actively and openly engaging members of the high-risk communities of Men who have Sex with Men and Sex Workers in program and policy design and implementation activities. This has enabled to the project to make inroads into these communities. 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 have also been involved 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 has recently 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 policy of the National AIDS Council is to enable but not to implement programmes. For this reason the focus has been to provide local NGOs, private sector agencies, and government departments with the technical and financial support to enable them to undertake key activities. This facilitates capacity building across these sectors.

The private sector has now taken a keen interest in HIV/AIDS and has formed a committee and is in the process of developing a policy. This contributes to the advancement of work in this area as a national HIV/AIDS policy for the workplace is earmarked for development.

5. Major challenges that hindered the national response and remedial actions

During the period 2006/2007, one major challenge in the national response has been one of human resources within the National AIDS Directorate (NAD). A director was recruited in July 2006, and technical staff was recruited in May 2007. This has contributed to enhancing project implementation in the last 3 quarters of 2007.

6. Support from the country's development partners

Grenada has received considerable support from its development partners. At present the National AIDS Program received financial and technical assistance from developmental partners who, working together, have enabled the country to develop a multi-sectored response. Key regional and international development partners, not listed in any order, include:

- The World Bank
- 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 HIV/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.

7. 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. A major task of the recently hired M&E officer was to compile a list of all indicators required for these purposes and ratify them against the data currently collected by different implementing agencies/departments. With assistance from the Caribbean Health Research Council, a process of indicator harmonization was completed in 2007.

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 plan. This process has begun with support from the CHRC however the process has faced some challenges. In addition challenges with implementation are foreseen because of the way that program data is currently collected, stored, analysed and disseminated. The challenges, however, are not insurmountable. There is a local commitment to reform the process if the relevant technical and financial support can be provided from developmental partners to enable the Monitoring and Evaluation officer to implement the monitoring and evaluation plan once it is completed.

8. Bibliography

1. CAREC/PAHO/WHO. Status and Trends – Analysis of the Caribbean HIV/AIDS epidemic 1982-2002. 2004.

2. CAREC (2006). The Caribbean HIV/AIDS Epidemic and the situation in member countries of the Caribbean Epidemiology Centre.

3. CAREC/PAHO/WHO. Behavioural Surveillance Surveys conducted in six countries of the Organisation of Eastern Caribbean States. CAREC, June 2007.

4. Measure Evaluation. Grenada - Caribbean Region HIV and AIDS Service Provision Assessment Survey (HSPA) 2005. August, 2007

5. Report on an HIV seroprevalence survey among male inmates in Her Majesty's Prison in St. Vincent and the Grenadines conducted on April 12-13, 2005. CAREC, July 2005.

6. TRaC-M: Sex Workers in Dominica and Grenada & Men Who Have Sex With Men in St Lucia, St Vincent & The Grenadines and Trinidad & Tobago," PSI Social Marketing Research Series, 2006 http://www.psi.org/research/cat_socialresearch_smr.asp

7. Soomer, June. Review of the Grenada National HIV/AIDS Strategic Plan 2003 and the Results of the Situational Assessment. Dec. 2007

APPENDICES

Appendix 1: Excerpt from Workbook model created for Grenada using available data and assumptions.

Grenada	Grenada
Region adult (15-49) population:	52,134
% Urban population:	43%
Urban adult population:	22,157
Year	2006

Method used to calculate number of low risk infections	
Select one:	(○) Method A: Partners of high risk (●) Method B: ANC data applied to low risk women

1. Populations at higher risk (PHR)

Names of higher risk population groups	Population Size Estimate		HIV prevalence Estimate (%)		Estimates of adults living with HIV/AIDS				Average number of adults living with HIV	Female statistics		
	Low estimate	High estimate	Low	High	(Low Population x Low Prevalence)	(Low Population x High Prevalence)	(High Population x Low Prevalence)	(High Population x High Prevalence)		Percent (%) female in risk group	Number of women living with HIV	Percent (%) who are women
IDU	52	364	1.00%	15.00%	1	8	4	55	**17**	5.0%	1	
MSM	521	1,303	1.00%	15.00%	5	78	13	195	**73**	0.0%	-	
Female sex workers	105	209	1.00%	15.00%	1	16	2	31	**13**	100.0%	13	
Male clients of female sex workers	1,303	5,213	1.00%	5.00%	13	65	52	261	**98**	0.0%	-	
Prison Inmates	250	350	2.00%	4.00%	5	10	7	14	**9**	10.0%	1	
Optional HR2					-	-	-	-	**-**		-	
Optional HR3					-	-	-	-	**-**		-	
Optional HR4					-	-	-	-	**-**		-	
Sub-total PHR	**1,449**	**4,833**			**17**	**127**	**52**	**374**	**142**		**14**	**10.0%**

2. Populations at lower risk (PLR) that are not already included in PHR

Method B: ANC data applied to low risk women	Population Size Estimate		HIV prevalence Estimate (%)		Estimates of adults living with HIV/AIDS				Average number of adults living with HIV	Female statistics		
	Low	*High*	Low	High	(Low Population x Low Prevalence)	(Low Population x High Prevalence)	(High Population x Low Prevalence)	(High Population x High Prevalence)		Percent (%) female in risk group	Number of women living with HIV	Percent (%) who are women
Urban female low risk pop	10,967	11,022	0.30%	0.65%	33	71	33	72	**52**			
Rural female low risk pop	14,838	14,912	0.20%	0.50%	30	74	30	75	**52**			
Sub-total	**25,805**	**25,934**			**63**	**145**	**63**	**146**	**104**		**104**	**100.0%**
No Risk Population	**21,367**	**24,880**										
Sub-total PLR	**25,805**	**25,934**							**104**		**104**	**0.0%**

3. Total number of adults living with HIV

	Average number of adults living with HIV	Female statistics		
		Percent (%) female in risk group	Number of women living with HIV	Percent (%) who are women
REGIONAL TOTAL	**247**		**119**	**48.1%**

REGIONAL OUTPUTS:

Region:	**Grenada**
Year:	**2006**
Number of adults (15-49) LWH:	**313**
Number of women (15-49) LWH:	**119**
Percent adult (15-49) prevalence (%):	**0.6007%**
Percent of LWH who are female (%):	**37.9%**
Percent of total LWH that are IDU (%):	**5.3131%**

Notes/Comments: