Grenada National HIV & AIDS Strategic Plan 2009-2015

Latest draft April 7, 2009

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to review

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Medicines
CAREC	Caribbean Epidemiology Centre
CARICOM	The Caribbean Community and Common Market
CEDAW	Convention for the Elimination of all forms of Discrimination Against Women
CHRC	Caribbean Health Research Council
CRC	Convention on Rights of the Child
CRN+	The Caribbean Regional Network of People Living with HIV & AIDS
ECCU	Eastern Caribbean Currency Union
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
SW	Sex Workers
TB	Tuberculosis
UDHR	United Nation Document on Human Rights
UNAIDS	Joint United Nations Program on HIV & AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
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 Counselling and Testing
WHO	World Health Organization

FOREWORD

It is now 25 years since the first HIV person was diagnosed in Grenada. The Government of Grenada, through the National AIDS Council with the support of regional and international organizations, has managed to sustain efforts to fight and mitigate the impact of HIV and AIDS. The Grenada National HIV/AIDS Strategic Plan 2003 has guided the implementation of HIV and AIDS programmes over the past 5 years. A review of the existing Grenada National HIV/AIDS Strategic Plan has shown that there are new emerging issues, which must be taken on board in the fight against HIV and AIDS.

Our commitment to regional and international goals such as the Millennium Development Goal and the UNGASS Declaration of 2001, calls for the people of Grenada to put in place the measures to ensure that the Grenada attains the Millennium Development Goals in a sustainable manner. As the country moves towards Universal Access to HIV prevention, treatment and care, there must be accessible and affordable HIV and AIDS services to the population of Grenada. The efforts in past to curb the HIV and AIDS epidemic has demonstrated that awareness, by itself would not lead to behaviour change therefore more emphasis on behaviour change will be needed at the individual, family and community levels.

As Grenada enters into a new era of managing HIV and AIDS at the national level guided by the Grenada National HIV/AIDS Strategic Plan 2009-2015, it will be necessary to focus on specific measurable and achievable set targets in line with regional and international HIV/AIDS principles. The new strategic plan calls for commitment both at the policy and at the operational levels to ensure a multi-sectoral approach in the fight against HIV and AIDS.

The Grenada National HIV/AIDS Strategic Plan 2009-2015 is our road map that Grenada has adopted in the fight against AIDS over the next 7 years and will guide the country to meet the set targets.

The contribution of the international partners, NGOs, Faith-based organizations, and the wider community was invaluable over the past 5 years. The spirit of cooperation must be present as we implement this plan so that over the next 7 years we can achieve the success that was envisioned in 2009. Let us commit ourselves over the next 7 years to *'Put D Brakes on AIDS'*.

Senator Ann Peters
Chair
National AIDS Council
Minister of State in Ministry of Health

PREFACE

UNAIDS estimates that there were around 250,000 people living with HIV and AIDS in the Caribbean at the end of 2006, the majority in the Dominican Republic and Haiti. While Grenada's HIV & AIDS cases are not at the level of these countries it is in a vulnerable state. The overall *estimated* prevalence rate for HIV/AIDS is 0.42% and an estimated 0.65% rate for HIV/AIDS among pregnant women in 2007 [UNGASS Report 2008].

Grenada requires a dedicated effort to achieve universal access to prevention treatment, care and support services. This ambitious objective depends on the implementation of an expanded multi-sectoral framework to reduce the incidence of new HIV infections; while mitigating the impact of HIV & AIDS on the citizens; and achieving a sustained and effective multi-sectoral infrastructure. The Grenada National HIV & AIDS Strategic Plan 2009-2015 elucidates the reliance on the commitment of every stakeholder to implement the strategies articulated. The stakeholders must embrace the strategic priority areas of targeted behavior change intervention, stigma reduction; up-scaled access to treatment, care and support, enhancing governance and institutional systems, and building the capacity of Strategic Information.

The Grenada National HIV & AIDS Strategic Plan 2009–2015 was developed using a stakeholder participatory methodology. The underlying philosophy is that enhancement in these strategic areas will strengthen the national response and position the country to achieve its mission. This is a plan that the country will be able to execute if there were no external funds available thus ensuring sustainability and continuity of programmes.

The Plan was also constructed on research-based statistics from the NAD, the NIDCU, the UNGASS Report 2008 and the Situation Analysis Report 2007. Epidemiological data highlights issues related to existing vulnerable groups such as 15 -24 year olds, SW and MSM and emerging vulnerable groups such as those over 55 years of age. Moreover, the epidemic is driven by the fact that risky behaviour has continued notwithstanding constant information sharing and education. This strategic plan stresses the need for behaviour change and for a multi-sectoral decentralised approach that would ensure access to information, services, treatment, care and support for all.

ACKNOWLEDGEMENT

The development of the Grenada National HIV/AIDS Strategic Plan 2009-2015 involved the participation of stakeholders at different stages of the consultative process. The first stage was the review of the Grenada National HIV/AIDS Strategic Plan 2003, current policies and strategies, and behaviour change situation analysis and response analysis and a review of the HIV and AIDS epidemiology in Grenada. The second stage was the Stakeholders' Strategic Planning Consultation conducted in February 2008.

The following stakeholders who all played important roles in the process leading to the realization of the Grenada National HIV/AIDS Strategic Plan are warmly acknowledged:

- The National AIDS Council (NAC) and the Government Ministries for bringing into the process, among other contributions, awareness of strengths, constraints and gaps in the national response.
- Non Governmental Organizations (NGOs), civil society, Faith Based Organizations (FBOs), Community Based Organizations (CBOs), People Living with HIV and AIDS (PLWHA), the private sector, and institutions of higher learning are acknowledged for, among other contributions, ideas, inputs they made from the vantage point of their wide-ranging experiences and practice in the area of HIV and AIDS, and working with communities.
- Development partners for their support, resource provision and participation in the process that led to the production of the Grenada National HIV/AIDS Strategic Plan.
- Consultants who prepared working documents and analyses and the draft Grenada National HIV/AIDS Strategic Plan that helped stakeholders focus on key issues at various stages of the strategic planning process.

EXECUTIVE SUMMARY

The Grenada National HIV & AIDS Strategic Plan 2009-2015 is an initiative to accelerate the national response to the HIV and AIDS epidemic and to enhance collaboration among the many sectors to achieve universal access to HIV prevention, treatment, care and support for the population of the State of Grenada. This Strategic Plan builds on the achievements and lessons learnt from the challenges of the Grenada National HIV & AIDS Strategic Plan 2003. The overall aim over the next 7 years is to strengthen ongoing efforts, mobilize new partners and to ensure all HIV & AIDS related activities are well coordinated and prioritized. The Strategic Plan therefore sets out the fundamental principles, the broad approaches and the strategic activities that should be achieved with the identified time frame.

The priority areas identified for action were derived from the foundation built on the areas of prevention, treatment, care and support. However with the additional information from Behavioural Surveillance Survey (2006), Situational Analysis (2007) and the UNGASS report (2008), there is the need to respond to the changing profile of HIV and AIDS in Grenada. This Strategic Plan places greater emphasis on pursuing a responsive human rights agenda, mainstreaming HIV & AIDS in all sectors especially civil society organizations, capacity building for the delivery of HIV services, institutionalizing monitoring and evaluation activities and research, and supporting a comprehensive information and education communication strategy. This Strategic Plan also focuses on gender-specific vulnerabilities and the appropriate responses needed to ensure that gender equality is incorporated in the national response to HIV and AIDS.

In September 2000, 189 governments including Grenada made a commitment to make 'the right to development a reality for everyone and to freeing the human race from want' and towards the end, the Millennium Development Goals (MDG) were set for 2015. This National Strategic Plan is set to end in 2015 in order for it to be aligned with these goals. A major overarching threat to development is HIV. The severe health impact of AIDS – illness, incapacity and death – are increasingly well documented and understood. But AIDS also affects fundamental developmental effects on many of the other MDG. AIDS will make it difficult if not impossible for many countries to achieve their MDG targets. The goal is for this NSP to contribute much to progress towards the MDG targets between now and 2015. Fighting poverty and achieving basic social goals is a priority. AIDS often the cause of mortality in working-age adults and this can have a tremendous impact at the household level. Without a program to mitigate this impact, the long-term negative impact of AIDS, both at a macro and micro level can be expected to accelerate. HIV has the potential to worsen the nutritional status of children, negatively impact on child mortality and worsen maternal health. The overarching goal is Millennium Development goal 6 being to halt by 2015 and begun to reverse the incidence of major diseases including HIV. Failure to halt and reverse the spread of HIV and AIDS-related illness with a goal to reducing poverty rates including ensuring that all children attend and complete basic education. It is essential efforts be undertaken to scale-up activities for the delivery of existing interventions for HIV prevention, treatment, and mitigation of the social effects of HIV. It is intended that this will reduce the negative effects of the pandemic on the economic development in Grenada.

THE SITUATION ANALYSIS

EPIDEMIOLOGICAL BACKGROUND

HIV & AIDS Epidemic

The first case of HIV infection in the state of Grenada was diagnosed in 1984. The cumulative documented cases of HIV by the end of 2008 were 376, the cumulative AIDS cases were 248 (66.2% of HIV cases) and the cumulative AIDS-related deaths were 185 (74.3% of AIDS cases). Over the period 2003-2008, the cumulative number of HIV infections reported in public health facilities since the beginning of the epidemic increased by 38%, while the number of new AIDS cases increased by 39% and AIDS related deaths increased by 31%. Using the 2001 Census population of 103,137 persons, and UNAIDS accepted modelling and projecting procedures the estimated HIV prevalence rate was 0.42% in 2007 and a reported prevalence rate of 3 per 1,000 at 31 December 2007. By the end of 2008, the reported prevalence rate was 0.36% however a remodelling of the estimated HIV prevalence rate was not undertaken for the same time period.

The HIV reported data in the first decade (1984-1993) of the epidemic, documented 86 cases (25% of all HIV cases) however during the second decade (1994-2003), the number rose to 165 cases (48% of all HIV cases) representing a 92% increase over the previous decade. The annual increase of HIV cases increased from 1 case in 1984 to 23 cases in 1993 with an annual average number of 9 cases from 1984-1993. The annual average number of HIV cases between 1994-2002, was 17, and between 2003-2008, the average annual number of HIV cases reached 24 cases with the highest annual number of new cases since the beginning of the epidemic being 38 cases recorded in 2007.

In the first decade (1984-1993) of the epidemic, AIDS data reported 41 documented cases (18% of all AIDS cases). However during the second decade (1994-2003), 111 cases were documented (48% of all HIV cases) representing a 170% increase over the previous decade. The annual change in AIDS cases increased from 1 case in 1984 to 19 cases in 1993 with an average number of 6 cases between 1984 and 1993. The average annual number of new AIDS cases between 1994 and 2002 was 9 cases and between 2003-2008; the average annual number of new AIDS cases has reached 16 cases with the highest annual number of 23 newly recorded cases since the beginning of the epidemic, being reported in 2003.

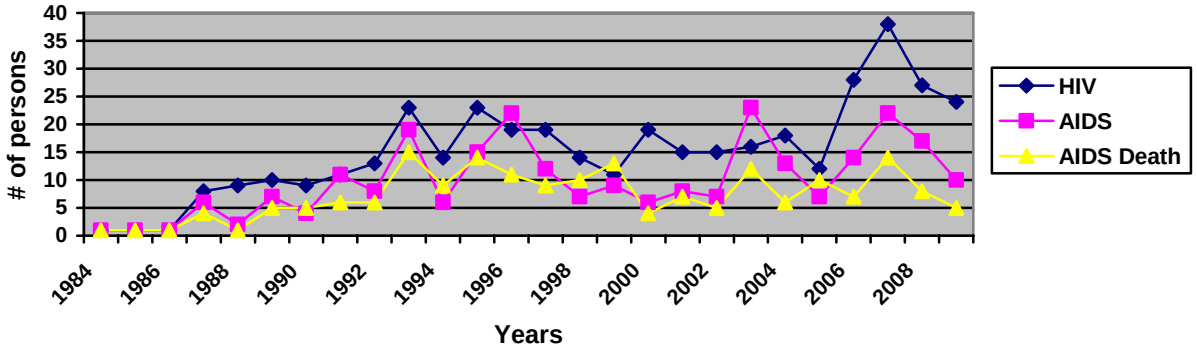
AIDS-Related Death

Reported AIDS-related death data, in the first decade of the epidemic, presented 46 cases (27% of all AIDS-related deaths); however during the second decade, that figure increased exponentially to 94 cases (54% of all AIDS-related deaths) representing a 100% increase over the previous decade. The annual change in AIDS-related deaths, between 1984 and 1993, increased from 1 death in 1984 to 15 deaths in 1993 with an average number of 5 deaths per year. The average annual number of deaths between 1994 and 2002 was 9 and an average of 10 deaths annually for the period between 2003 and 2007. Data also showed a steady increase in annual recorded deaths from 1984-1993 with 15 deaths in 1993 being the highest since the beginning of the epidemic. This annual figure fell to 12 in 2003 but rose to 14 in 2007 and fell to 8 in 2008.

Male AIDS related deaths accounted for 75% and the females accounted for 25% of all AIDS-related deaths in 2008. However, in 2002, males accounted for 74.4% with an average annual number of 5 deaths per year and the females accounted for 25.6% with an average annual death of 2 deaths per year. Between 2003-2008, the percentage for the males dropped slightly to 73.6% but the

average annual number of deaths increased to 7 deaths per year while the females' percentage increased slightly to 26.3% while the average annual deaths increased to 3 deaths per year.

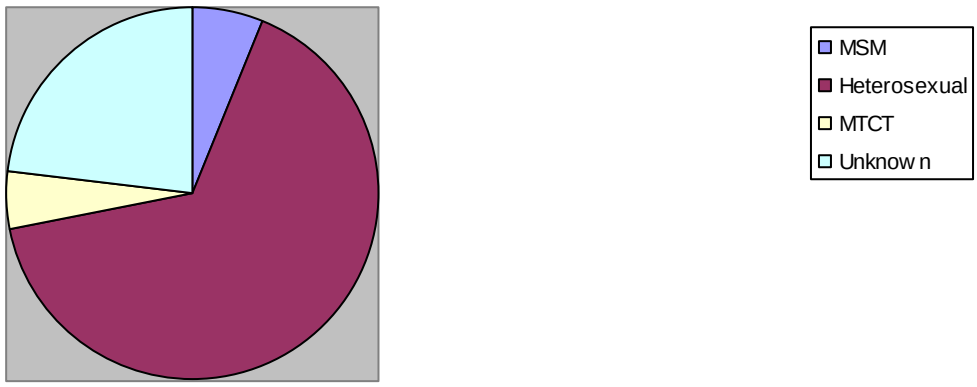
Figure 1: Number of HIV and AIDS Cases and AIDS-Related Deaths in Grenada, 1984-2008



HIV Cases and Mode of Transmission

Heterosexual transmission remains the predominant mode of transmission among newly infected cases. During the period 2006-2007 (data not available before 2006), 66% of transmission was heterosexual with 49% being reported by males and 51% reported by females. Routes of transmission through mother to child transmission and men who have sex with men accounted equally for 5.7% while 23% of cases were reported as route unknown.

Figure 2: Route of transmission of HIV in Grenada 2006-2008



Gender differentiation and Number of Non-Commercial Sexual Partners

From the BSS report, (2006), for the 15-24 year old age groups, within the previous twelve months, the median number of non-commercial sexual partners was 1, with a range of 1-11. The gender differentiation revealed that the median number of partners for the male was 2, with a range of 1-11. For the female, the median number was 1, with a range of 1-6. For the 25-49 years age group, the median number was 1, with a range of 1-60. Gender differentiation revealed that the median

number of partners for the male and female was the same, 1. However, the range was 1-60 for the male but 1-4 for the female. The Situational Analysis (2007) reported that 18% of the respondents indicated that they had more than one sexual partner within the last 12 months across all age-groups.

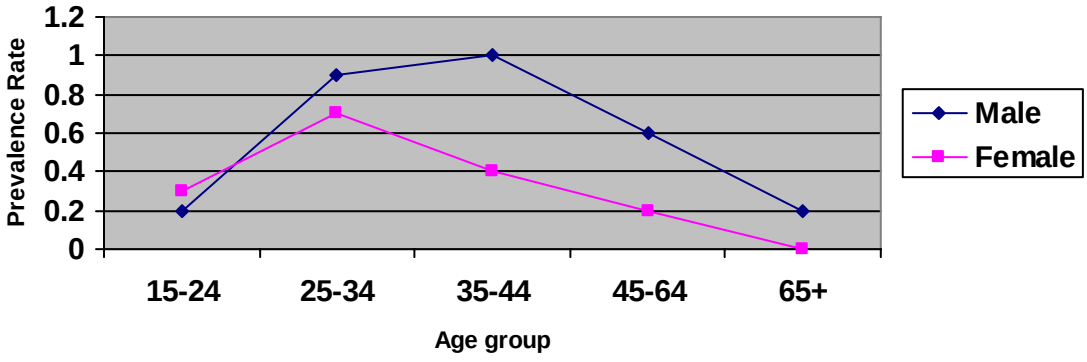
HIV Cases by Age Group

Whilst the overall reported prevalence rate is 4 per thousand, there was marked variation when disaggregated by age. The HIV prevalence among the 15-24 years is 0.3%, 25-34 is 0.8%, 35-44 is 0.7%, 45-64 is 0.4% and 65+ is 0.1%. Over the period 2003-2008, the reported cases of HIV showed that young people in the reproductive age group were being increasingly affected by the epidemic with the 25-34 years age group recording the highest number of new infections per year followed by the 15-24 age-group. Using the 2001 population census data and projections, by 2003, the prevalence for 15-24 years was 0.2% increasing to 0.3% in 2008; the prevalence for 25-34 years was 0.6% increasing to 0.8% in 2008; by 2003, the prevalence for 35-44 years was 0.5% increasing to 0.7% in 2008; by 2003, the prevalence for 45-64 years was 0.2% increasing to 0.4% in 2008; by 2003, the prevalence for 65+ was 0.1% which remained the same in 2007.

HIV Cases by Age Group and Gender

Using the 2001 population census data and projections, by 2003, the prevalence for the 15-24 years age-group was for the male was 0.2% and remained the same for 2008, for the female, the prevalence was 0.2% increasing to 0.3% in 2007; the prevalence for 25-34 year old males was 0.7% increasing to 0.9% in 2007, for the females was 0.5% increasing to 0.7%. By 2003, the prevalence for 35-44 year old males was 0.8% increasing to 1% in 2007, for the female was 0.2% increasing to 0.4%. By 2003, the prevalence for 45-64 year old males was 0.3% increasing to 0.6% in 2007, for the female was 0.2% increasing to 0.4%; by 2003, the prevalence for 65+ year old males was 0.2% and remained at 0.2% in 2007, for the female was 0% and remained at 0% in 2007.

Figure 3: Prevalence rates of HIV infection by age group in Grenada, 2008



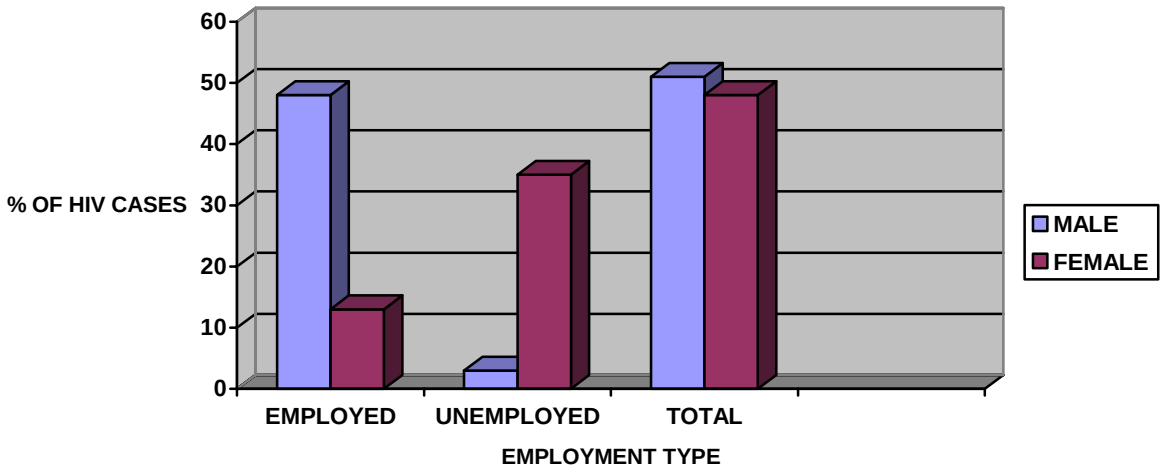
The male to female ratio was 1.9:1 in 2003 and remained at 1.9:1 in 2008, with the majority of new infections occurring among males, especially the 15-44 years age group. Females also had a higher incidence of HIV in the 15-24 years age group over the period 2003-2008, representing 59% of infections in 2003 and fell to 57% in 2008 for the age group 15-24 years. The males dominated the other age categories with males 35-44 representing 80% of infections in 2003 but decreased to 75% in 2007 for the age group. In the 45-65+ age group, the males still dominated the HIV infections with the highest number being recorded in 65+ age group which was 100% male for 2003 and 2008. The male in the 45-54 years category went from representing 71% of the new infections in 2003 to

80% of new infections in 2008 for the 45-54 years age group. In the 55-64 years age group, by 2003, the males accounted for 54% of new infections and by 2008, there was a very slight decrease to 53%.

HIV Cases by Gender and Occupation

During the period 2006-2007(data not available before 2006), most of the women were diagnosed were unemployed (46%), 33% being employed in the public and private sector and 21% not stating their occupation. Most of the men were employed (60% in the public and private sector), 3% unemployed and 37% did not state their employment status.

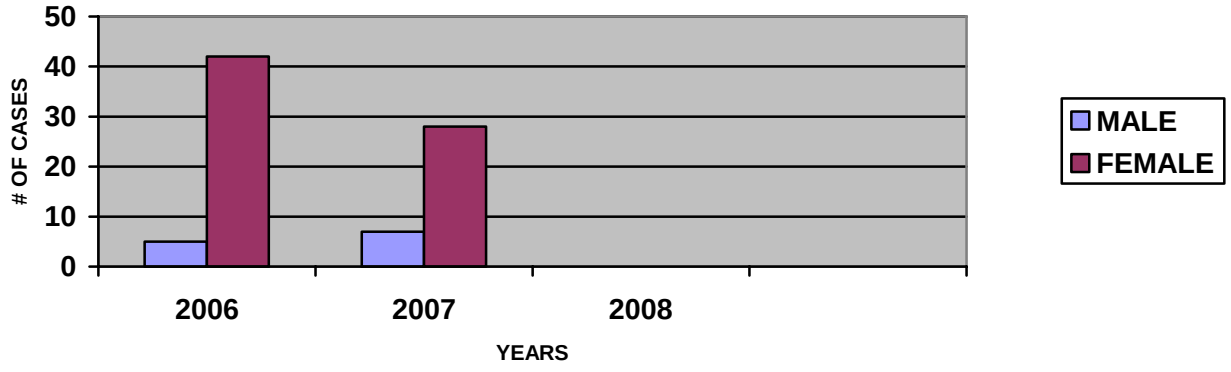
Figure 4: EMPLOYMENT STATUS AND HIV IN GRENADA 2006-2007



Sexually Transmitted Infection Cases

During the period 2006-2007(data not available before 2006), there was 47 reported cases of sexually transmitted infections in 2006 which fell to 35 reported cases in 2007. The gender distribution was mainly among the female (89.4%) in 2006 and 80% in 2007.

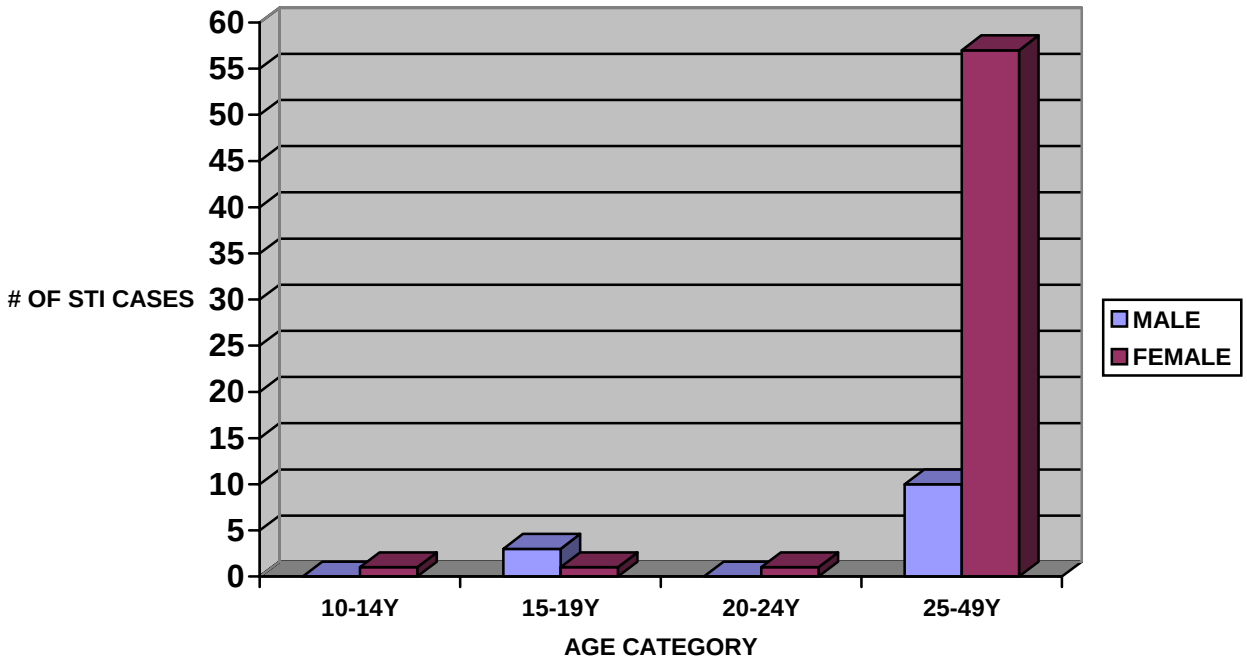
Figure 5: STI CASES IN GRENADA, 2006-2007



Sexually Transmitted Infection Cases by Age and Gender

For the same period, the distribution of sexually transmitted cases by age and gender again showed that for all the age categories with the exception of the 15-19 years, the disease was predominantly in the female. The largest differentiation by age and gender was noted among the 25-49 years age group with the females accounting for 85.1% of the infections

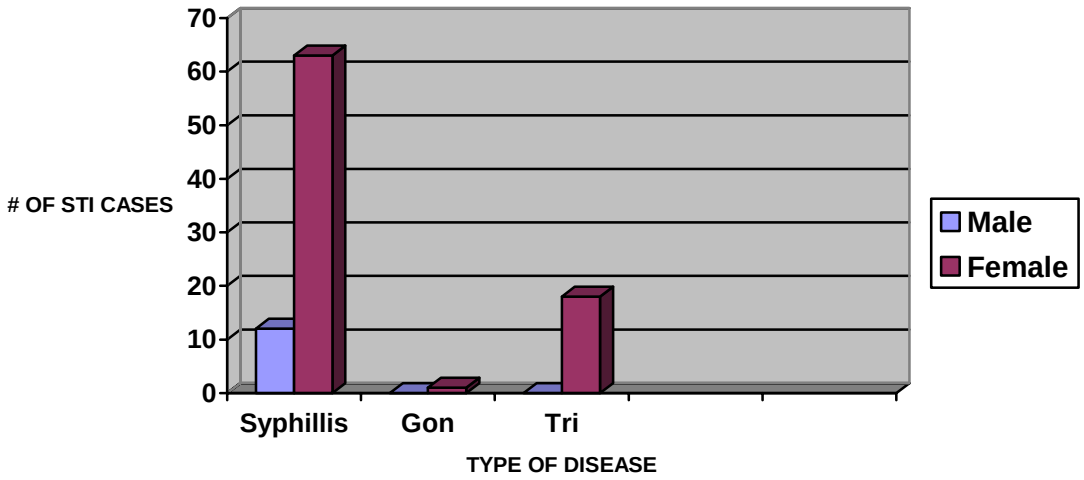
Figure 6: STI CASES BY AGE AND GENDER in Grenada, 2006-2007



Distribution of Sexually Transmitted Infection Cases by Gender

There was a higher incidence reported among females of syphilis, trichomiasis and Chlamydia while the females (84%) were affected predominantly by syphilis.

Figure 6: STI CASES BY DISEASE CATEGORIES, Grenada 2006-2007



Poverty and HIV & AIDS

The 1998/1999 assessment of poverty in Grenada estimated that 32% of the households were poor in spite of the fact that Grenada falls in the middle income category and has an HDP ranking of 82 (among 171 countries) in 2007. The 2005 Core Welfare Indicator Questionnaire (CWIQ) supported by the UNDP sub-regional office for Barbados and the OECS, the Caribbean Development Bank and UNIFEM, also noted similar high levels of poverty. It revealed an intensification of poverty, especially among women and an unemployment rate of 17%. More than one-fifth of rural female-headed households are among the poorest (CWIQ, 2005). The correlation between poverty and vulnerability has long been established but the link between poverty and vulnerability to HIV & AIDS in Grenada is only emerging.

THE RESPONSE ANALYSIS

Civil Society and Line Ministries Response

Prevention Programmes
The National HIV & AIDS Strategic Plan 2003 had targeted various vulnerable and high-risk groups for the promotion of healthy sexual attitudes and practices. Specifically, the HIV prevention strategy aimed to focus on young women, youth in and out of school, men who have sex with men, sex workers, the prison population and substance abusers (NAC, 2003).

Information, Education, Communication Strategy
Information, education and communication are important pillars on which the national HIV & AIDS response was built. IEC activities targeted the general population, with information provided through pamphlets, posters, public service announcements, interviews, plays, calypso and talk-shows. Community outreach activities were also undertaken to keep the general population informed and to obtain feedback on the levels of understanding of the messages.

In order to sustain the current levels of HIV & AIDS awareness with appropriate behaviour change, a national Information, Education and Communication campaign was created in July 2006 called 'How Yuh Playing (HYP)'. The theme focused on information dissemination, fighting stigma and discrimination and promoting voluntary counselling and testing. Information, Education and Communication material which carried messages that promote the prevention of HIV transmission, were produced and distributed. These included pens, pencils, bandannas, pouches, t-shirts, wristbands, posters, and banners. Much of the material was distributed at World AIDS Day 2006 and 2007, training programmes, and carnival events.

Another campaign, the 'Impact of HIV/AIDS' ran on Grenada Broadcasting Network from September-November 2006. It comprised 12 one-hour live television programmes covering a range of topics including stigma and discrimination, youth and HIV & AIDS, gender and HIV & AIDS, faith-based organizations and HIV & AIDS, government response, media response, and the private sector response.

Youth
School Youths
The baseline survey[1] for the HFLE pilot study was conducted in the last quarter of 2005 and included 525 secondary school students. 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 16% students were sexually initiated;
- Twelve percent (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

[1] 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.

- 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 believed 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[2] 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.[3] 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.

During 2006-2007, programmes were offered for **y**outh in-school and out of school. Grenada National Organization of Women hosted the Youth Conferences targeting secondary schools and

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

[3] 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.

Grenada Red Cross Society held the 'Ride the Bus' Campaign targeting in-school and out of school youth who use the public transportation system. Approximately 600 youths were reached in the combined campaigns.

Although the majority of the population understand the ways in which HIV can be contracted many myths are still prevalent. In the 2007 situational analysis survey 14.5% of respondents believe that virgins can avoid HIV by having anal sex. 38% of the respondents thought that there was no way that they can avoid acquiring HIV. These persons believe that they will become HIV positive at some point in the future and there is nothing they can do about it. This is important especially when 56.75% of this group believe that HIV can be transmitted through mosquito bites. On the other hand, 25% of youth respondents had their first sexual encounter before the age of 15 however this is down from 32% 10 years prior.

National AIDS Hotline

The Grenada Red Cross operated the National AIDS Hotline during 2006 with volunteers from Monday to Friday, 5:00 pm - 7:00 pm. An average of 60 calls was received on a monthly basis. The numbers of the National AIDS Hotline are: 435-HOPE and 435-LIFE.

High Risk Groups

The groups of people who are being referred to as high-risk group in this report are sex workers, men who have sex with men, prisoners, uniformed personnel, migrant and tourism workers. The HIV & AIDS intervention sessions focused on HIV & AIDS information, condom distribution and condom management training. A workshop was held in collaboration with UNIFEM under the theme 'Capacity Building for Mainstreaming Gender Analysis in HIV & AIDS Programming in the Caribbean'.

MSM Population

Surveillance data on HIV transmission showed that within the period 2003-2007, the number of HIV+ men who reported having sex with men rose from 1 in 2003 to 2 by the end of 2007. There is no sub-data for men who had sex with both men and women.

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 significant 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 on issues such as referral to care and treatment programs, funding and implementation of community-based projects, and development of data collection instruments for program monitoring and planned surveys. Challenges faced in reaching MSM and sex workers include issues of mistrust, fear of disclosure, uncertainty about the legal status of their activities, and uncertainty regarding confidentiality in the health system.

Sex Workers

A survey of sex workers was conducted in 2006 by Population Services International (PSI) The results of this "TRaC-M" survey indicated a need to (1) focus on personal risk perception, (2) condom use by SW with their paying and non-paying partners, and (3) to increase having SW practice putting a condom on a demonstration model.

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 demonstration model.

Prisoners

The prison population continues to face the risk of increased exposure to HIV as in other countries. In August 2005, 137 male inmates of Her Majesty's Prison in Grenada were surveyed[4] for their HIV serological status. This represented 59% of the incarcerated male population. 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 slightly 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 national population prevalence of 0.42% in 2007. This prison population rate has implication for the design of a national response to HIV & AIDS.

Civil Society Organizations (inclusive of Non-Governmental Organizations, Faith-Based Organizations, Private Sector, Academia and Community-Based Organizations)

Civil Society Organizations have been involved in prevention activities at the local and national level. This component supports HIV & AIDS activities of civil society organizations, non-governmental organizations, community-based organizations, unions, faith-based organizations, the private sector, and non-health line ministries. This initiative is consistent with the Government's strategy of a multi-sectoral and multi-stakeholder response to the HIV & AIDS epidemic.

These activities have included school and workplace sensitization on HIV, AIDS & STI prevention and control activities, condom distribution, gender issues as related to HIV and AIDS, stigma and discrimination, and the establishing of workplace focal points and committees. Support for the CSO was provided by the National AIDS Directorate for training in HIV, AIDS & STI prevention & control and behaviour change methodologies. Limited monitoring and evaluation skills among the CSO is affecting the timely reporting of the activities undertaken. Community health fairs are organized periodically by some of the NGOs where they focus on information dissemination on HIV & AIDS and voluntary counselling and testing. There are plans to scale up the number of condoms distributed annually from 170,254 in 2005 to 370,000 in 2010 with special emphasis on distribution in the private sector and the community.

Workplace Programmes

During the period 2006-2007, the National AIDS Directorate worked in partnership with government agencies, private sector and labour unions and in collaboration with the International Labour Organization, to develop a model workplace policy for the Caribbean. This was intended to reduce stigma and discrimination associated with HIV & AIDS and to create a supportive environment for employees with HIV & AIDS related challenges. The Caribbean workplace policy

[4] Report on an HIV seroprevalence survey among male inmates in Her Majesty's Prison in Grenada conducted on April 12-13, 2005. CAREC, July 2005.

was developed in 2006 and is expected to be adapted to the Grenadian workplace environment, forming part of the national HIV & AIDS workplace response.

Line Ministries

Line Ministries Involvement

The National AIDS Directorate is supporting Line Ministries' involvement in HIV & AIDS through the hiring of HIV & AIDS Focal Point (Ministry of Education) and a Line Ministry/Civil Society Coordinator. 'Guidelines for Managing HIV & AIDS in the Public Sector' was drafted and submitted to the Cabinet Secretariat in early January 2007.

Ministries of Education and Youth

The Ministry of Education is responsible for the Education Sector Response on HIV and AIDS for all children in schools up to tertiary level. Ministry of Education drafted an Educator Sector Policy on HIV and AIDS in 2007 and is expected to be presented to Cabinet in early 2009. The Ministry is also implementing the Health and Family Life Curriculum in secondary schools which address sex education, morals and values. In the formal education system, 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 1-3. 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 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.

In both the Ministries of Education and Youth, the main emphasis will be on reducing the percentage of young men and women who have had sex before the age of 15 years from 25% (BSS 2006) to 10% in 2010. The focus will be on reducing the rate of HIV infection among the 15-24 years age group with special emphasis on the female youth. Also, according to the BSS (2006), only 39% of young people (15-24) years could correctly identify ways of preventing transmission of HIV. The intention is to increase the knowledge level among this target group to 95% by 2010. Hence, there are plans to expand the IEC campaign targeting youth.

Health Sector Response

National Blood Transfusion Services

The National Blood Transfusion Services screens all donated blood for HIV and other STI according to CAREC regional guidelines. Another critical area of HIV prevention is in the delivery of safe blood and blood products for transfusion. The National Blood Bank of Grenada performs screening tests for HIV on-site. All donated blood testing positive in the screening step is discarded, regardless of the result 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. 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 transfusion.

VCT & PMTCT programmes

Voluntary Counselling and Testing is another important step in the HIV & AIDS Prevention and Treatment Strategies. It allows persons to make the appropriate HIV prevention decisions once they are aware of their HIV status. In an effort to raise the population's awareness regarding the importance of knowing individual HIV status, the public health sector scaled up voluntary counselling and testing services (VCT). The introduction of a National Programme of the Prevention of Mother-to-Child Transmission (PMTCT) promoted HIV testing for all pregnant women attending public health antenatal clinics. As a result, during the 2003-2007 period, samples sent for HIV testing by public facilities increased by 37%. In order to reach the target of 50% by 2010, there are plans to expand the outreach campaign and introduce rapid VCT.

The improved availability and access to HIV testing by pregnant mother provided by the PMTCT programme led to an increase in testing from 78% in 2003 to 90% in 2007. Access to anti-retroviral therapy is provided without charge. Follow up care for all HIV+ mothers and their babies include testing of the HIV-exposed infant up to 18 months, counselling on the avoidance of breast-feeding, and the provision of infant formula without charge up to six months. In order to reach the target of 90% by 2010, the outreach programme for the PMTCT campaign will be expanded.

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 0.65%. 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 agreed 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 being 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 number of HIV+ mothers who have given birth was 13 (46%) by 1999 and increased to 15 (54%) by 2006. Out of the 28 HIV+ mothers diagnosed by 2006, 8 (29%) mothers died by 2006, 5 mothers (18%) had died by 1999 and the remaining 3 mothers (11%) by 2006. Thirty-two (32) babies were born to HIV+ mothers whereas 11 children (34%) were born by 1999 and 21 babies (66%) were born by 2006. Eight babies/children had died by 2006: 5 babies had died by 1999 and 3 more babies by 2006.

The steering committee for PMTCT was strengthened with the inclusion of relevant partners. A PMTCT Coordinator was recruited for the programme. Regular meetings were held to discuss, plan and evaluate activities and to plan the way forward. Infant formula was provided to all babies of 5 HIV+ mothers and anti-retroviral therapy was provided to four out of five of the mothers.

Voluntary Counselling and Testing

In the scaling up of the Voluntary Counselling and Testing Programme, VCT providers and trainers have received extensive training, both locally and abroad. Since then, several workshops have been organized and 33 health care workers and members of civil society have been trained to deliver VCT services.

In 2006, 1,504 persons were tested through the VCT program of whom 1/3 of the persons were male. Outreach activities were organized in every parish, including Carriacou and Petite Martinique. On November 30, 2006, in commemoration of World AIDS Day, a National Testing Day was held where almost 500 persons came forward for testing.

In the 2007 survey, 40% of respondents were not sure that they could get a confidential test in Grenada. This is important as 74.5% of respondents wanted to know their HIV status but said they might not get tested if they were unsure of the confidentiality of the results. Greater emphasis should be placed on confidentiality and the systems in place for conducting a confidential test to raise public confidence in the system

Condom Management

Condom management involved awareness meetings at which the use of both male and female condoms was promoted. At the end of 2006, 188,000 condoms were distributed mainly through the public health care system. Population Services International recommenced the condom social marketing campaign in November 2006. Condom promotions have also commenced in public entertainment areas such as clubs. By the end of 2006, twenty-four (24) retail outlets were trained to sell condoms with twenty (20) of them being new condom sales outlets and a total of eighty-one (81) employees sensitized about the 'Got It, Get It' campaign for condom social marketing.

In the 2007 survey, 66% of respondents admitted to having acquired/purchased condoms on their own, 74% believed that condoms can prevent HIV transmission. In addition 95% knew where to get condoms, 88% were willing to use that knowledge of where to get condoms to go out and purchase condoms if needed and 80.5% knew how to use a condom correctly. Given the large number of persons with multiple partners and the early age of first sexual encounter, the inconsistency of condom use is a reason for concern. Only 15% of the respondents stated that they always use a condom while 18% never use them. Condom use has very cultural dimensions. 44% of females reported refusing to have sex without a condom while 24.5% reported refusing to have sex with a condom while the others either asked occasionally or never requested condom use. However 22% of respondents are aware that their partners have other sexual partners. With regard to the

Female Condom, 43% of respondents have heard about the female condom, 24% know where to obtain one and 23% is unwilling to use one. There is scope for a lot work to be done in education and behaviour change related to condom use.

Laboratory
The Pathology Laboratory was able to procure HIV kits and CD4 tests were done locally with the assistance of the donation of a CD4 count machine. Six (6) new air-conditioned units were installed in the laboratory.

Pharmacy
The Chief Pharmacist was provided with a computer and printer to assist with the enhancement of the processing of relevant information.

Treatment and Care Programmes
The Ministry of Health is responsible for all aspect of the Health Sector Response to HIV and AIDS. The health sector response to the HIV & AIDS epidemic which includes antiretroviral therapy, strengthening the management of sexually transmitted infections, strengthening laboratory services and blood safety, prevention of mother-to-child transmission, management of HIV & AIDS related opportunistic infections, voluntary counselling and testing, distribution of condoms, and management of biomedical waste.

The quarterly STI reports from the Caribbean Epidemiology Centre show a high level of STI. There is a high level of Candida infections among women and respondents reporting genital discharge. 94% of respondents heard of diseases other than HIV that can be transmitted through sexual intercourse however 24% were ever tested for an STI.

Anti-retro-viral therapy is provided free of cost at the public HIV & AIDS treatment centre. Anti-retroviral therapy has been shown to reduce mortality and morbidity among persons diagnosed with HIV. All HIV+ individuals have access to diagnostic testing including CD4 and viral load assessment and constant supply of anti-retro-viral drugs (ARV). However, HIV drug resistant testing is not done within Grenada. Twenty-eight (28) clients were receiving ARV at the end of 2006. Forty-seven (47) clients were attending clinic in 2007, 12 of them being new clients for 2006. In 2007, 40% of newly diagnosed persons were receiving care and treatment in the identified treatment centres and 23% of them were receiving ARV.

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 services are centralized and operate from one public facility in the country's capital, St. George. This programme provides all services, including triple ARV therapy to patients with advanced HIV disease, at no cost.

In accordance with national PMTCT protocols, HIV positive pregnant women are provided with ARV to prevent transmission to their infants. 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 are accessed under the Global Fund 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 of 2007. This figure represents over 90% of persons with advanced HIV disease who were under active care and follow-up with the programme. Figure 5 shows the increase in treatment provision since the programme started in October of 2003. Table 3 shows provisional[5] 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.

60% of the respondents to the 2007 survey believed that facilities for HIV management in the urban areas are better than those in the rural areas and only 18% believed that there were enough health care providers to deal with the number of HIV positive cases. At the same time 23.5% believed that Health Care Workers who currently deal with HIV are sufficiently trained and only 11% believe that there are enough HIV programmes conducted in their community. In addition 56% knew where to access treatment if they were positive.

Figure 8: Number of persons with advanced HIV disease on antiretroviral therapy at the end of each year, 2003 to 2007.

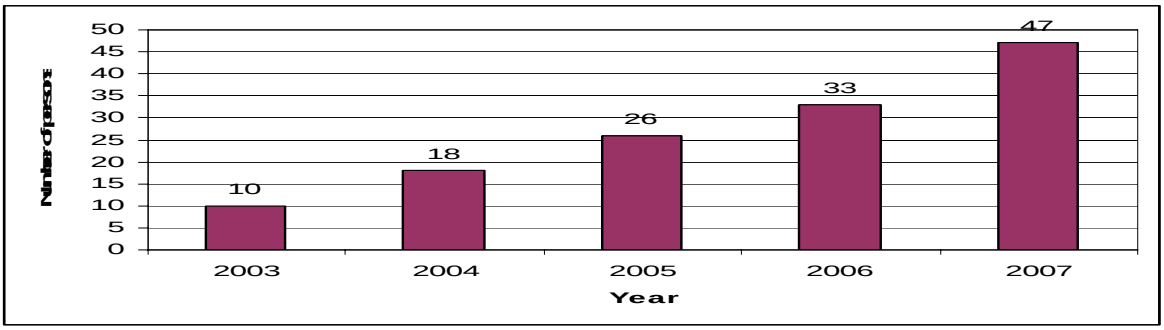


Table 2: 12-month patient survival after commencement of antiretroviral therapy (ART) for advanced HIV disease, 2003 to 2006

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), there were an estimated 194 men and 119 women aged 15 to 49 years living with HIV &

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

AIDS at the end of 2007. If a further assumption is made that 20% to 40%[6] of persons with HIV have advanced disease, then there were between 63 and 125 persons in need of treatment. Using these estimates, the 47 persons 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, that 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 was and will be unmet needs for antiretroviral therapy.

Access to ARV Therapy

The 38 reported AIDS cases for 2007 represents the highest annual total reported thus far in Grenada. There have been improvements in access to ARV therapy as shown in Tables 4 and 5 below. In terms of programme implementation, the NIDCU has recorded a total of 47 persons with advanced HIV disease who were receiving antiretroviral therapy (ART) by the end of 2007. This figure represents over 90% of persons reported with advanced HIV disease who were under care with the programme. It should be noted however that the concern should be with the number of persons who are not coming forward to receive treatment. Moreover, it is clear that many persons do not access services until it is too late and that this accounts for the high mortality rate. There must therefore also be more education with regard to the treatment regimes that are available and their success rates, so that infected persons can be reassured about the quality of life that is possible.

Table 3: Percentage of Adults and Children with Advanced HIV receiving ARV Combination Therapy, UNGASS Report 2008

Adults and children with advanced HIV infection receiving ARV combination therapy			Estimated number of adults and children with advanced HIV infected			Percentage of adults and children with advanced HIV infection receiving ARV combination therapy		
Age	**Male**	**Female**	**Age**	**Male**	**Female**	**Age**	**Male**	**Female**
Under 15	1	1	*Under 15*	**Not Available**		*Under 15*	**Not Available**	
15 & Over	23	20	*15 & Over*	78	48	*15 & Over*	29%	42%
Total	24	21	**Total**	-	-	**Total**	-	-

Table 4: Distribution of Persons with Advanced HIV on ARV Therapy 2003 To 2007.

Year	Number of persons with Advanced HIV on ARV
2003	10
2004	18
2005	26
2006	33
2007	43

Protocols

The document for the protocols for VCT, PMTCT, Treatment and Care and Contact Tracing were completed in 2007.

Support for PLWHA

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

A workshop was held for PLWHA to increase their awareness of the important issue of treatment preparedness (how to secure medication) and response to a disaster. Seven (7) homes are being remodelled under funding from World Bank. Global Fund provided funds for ancillary support. A Care Attendant was hired to visit and give support/advice with regards to medication adherence and other required support to other PLWHA (who need support) in the community.

In the 2007 survey 67% of respondents believed that children who are themselves HIV positive should be allowed to continue in the school system. This has increased from 68% in 2006. On the other hand 83% believed that children whose parents are HIV positive should be allowed to continue in school. In the same survey, 20% of respondents were aware of facilities providing support for HIV positive persons while 13% were aware of facilities providing support for HIV positive children and 10.5% were aware of any support given to families of persons who are HIV positive. 21% taught the support given to people living with HIV is appropriate. Only 4% of respondents in the 2007 survey knew who cares for Orphans and Vulnerable Children while 81% believed that there should be special facilities to take care of these children. There is a need for a system to provide and track support given to Orphans and Vulnerable Children.

Bio-medical Waste Management
Legal consultants were hired to start the process of preparing the legal document to support biomedical waste management in Grenada. Technical guidelines, national policy, and action plan were developed however training and procurement of equipment are still outstanding.

Information Technology Platform
The HIV & AIDS Prevention and Control Manual identified the need for the establishment of an Information Technology Platform in 2004. Due to many constraints, work to the platform did not commence in the lifetime of the previous strategic plan.

Research
There is the need to strengthen the national response to HIV & AIDS by increase attention being paid to evidence-based decision-making. Caribbean Epidemiology Centre presented quantitative findings (2006) on HIV-related behaviour among the Grenadian population that focused on knowledge, condom use, voluntary counselling and testing and stigma and discrimination.

Monitoring & Evaluation
The NAD, working together with CHRC is in the process of developing a national monitoring and evaluation system. The National M&E system will include a multi-sectoral M&E taskforce. Implementers will be mobilized to sensitize them to support the M&E system by holding consultative meetings to appreciate the need to report to the NAC on a monthly basis. The National M&E system will be supported by an electronic database. Training will be conducted for all relevant stakeholders on database management and the principles of monitoring and evaluation.

National Expenditure and Financing
The source of government health expenditure is through general taxation revenues. The Ministries of Health and Education are the largest consumers of government financial resources. Government spending on health averaged 12% of the annual recurring budget for the period 2000–2005, representative of between 3.5% and 4.5% of the Gross Domestic Product (GDP). Information on private health services is extremely limited. However, the Ministry of Health estimated that, for

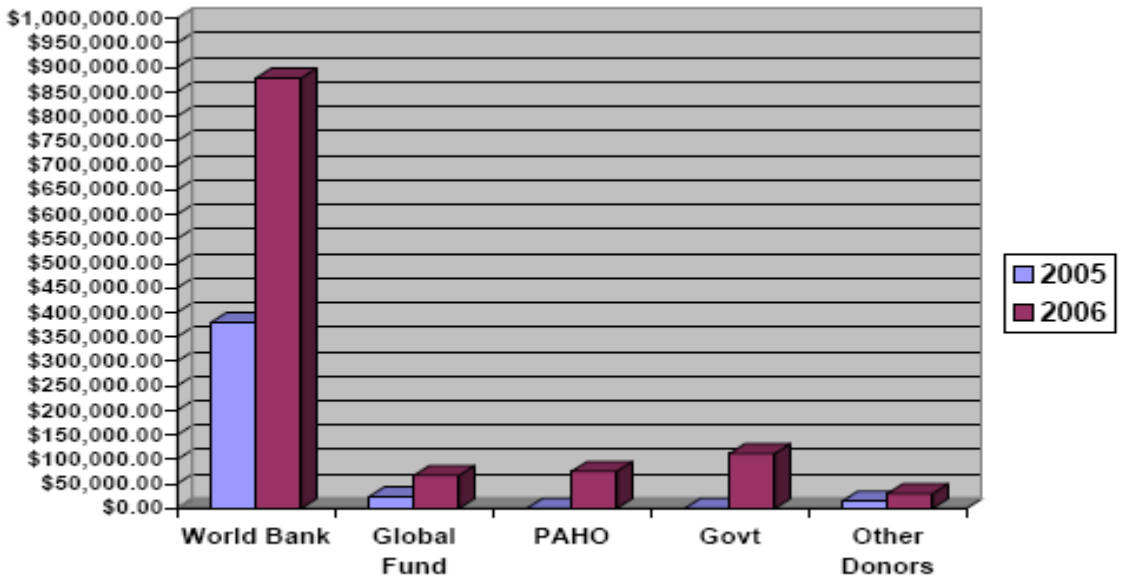
2002, private health expenditure was 1.7 percent of GDP, with total health expenditure (public and private) at 5.7 percent of GDP.

By 2010, it is expected that the amount of funds committed by the government to address the national response to HIV and AIDS will increase to XCD$4M from the commitment of XCD$1M in 2005. Activities will include the incorporation of HIV & AIDS into the medium term economic and poverty reduction strategies and by the line ministries submitting work plans and budgets to tackle HIV and AIDS within the respective sectors.

Technical Cooperation and External Financing

A variety of United Nations agencies, bilateral agencies and financial institutions, and NGO partners with the Government of Grenada utilized a diversity of technical and economic mechanisms to further the implementation of the National HIV & AIDS Strategic Plan 2003. Two prominent financial institutions working in the area of HIV and AIDS in Grenada are the World Bank and Global Fund against AIDS, Tuberculosis and Malaria. The first, World Bank, provided a loan of US$6M in 2004 which was reduced to US$5.3M in 2006 for the HIV & AIDS Prevention and Control Project which will run until June 2009. The second, GFATM, provided a grant of US$950,711.00 until February 2010. The International Labour Organization contributes to the project with programmes on HIV & AIDS targeting the workplace. Pan Caribbean Partnership on HIV & AIDS provided technical and financial support also addressing HIV & AIDS in workplace, stigma and discrimination reduction and capacity-building training in various areas related to HIV & AIDS prevention and control.

Figure 9: Donor funds provided to Grenada for the HIV/AIIDS response, 2005 and 2006.



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.

CHALLENGES

While the national response to HIV has significantly expanded from 2003 to 2008, Grenada still faces a number of challenges which the new National HIV & AIDS Strategic Plan 2009-2015 will need to address.

Prevention
The epidemiological data showed that reported cases of HIV is mainly occurring among the adult employed male, 25-34 years, a sub-population in which behavioural change strategies have not sufficiently addressed in the past. Neither has there been a sufficient focus on the vulnerable population, including young people who are sexually active, sex workers and orphans. Another gap identified was the need to address not only risk factors but underlying factors of vulnerability such as harmful societal norms, gender inequality, poverty and stigma and discrimination. These gaps require responses and for this reason, there is a need to strengthen the full range of technological, behavioural, cultural and structural prevention approaches.

Mitigating the Impact
Mitigating the impact of the epidemic on individuals, households and communities has become increasingly important in recent years. A national home-based care programme is necessary to support HIV+ persons and OVC. Through the type of programmes, as has been demonstrated internationally, over 80% of HIV+ persons and OVC can be reached through various interventions, including medical, legal and psychosocial assistance by partners in the multisectoral response.

Management, Co-ordination, Monitoring and Evaluation
Management, co-ordination, monitoring and evaluation of the national HIV & AIDS response have improved since 2003 but more needs to be achieved. In its coordination role, the NAC will be strengthened with coordination forums that provide a clearer mandate for accountability of all stakeholders. Both public and private sector responses need to be strengthened. Initiatives taken by ILO and PANCAP to develop workplace policies and strategies will be strengthened and integrated as part of the National HIV & AIDS Strategic Plan 2009-2015. The M&E plan will be completed after the NSP and instituted with the requisite financial and technical resources to support its implementation.

International donors are the major sources of funding for the national HIV & AIDS response. The World Bank loan, the main funding source is expected to conclude by June 2009 and funding from GFATM by February 2010. Based on the issues raised in the situation and response analyses, there is a call for significant increase in the allocation of government and international funds for the national HIV & AIDS response, and for more aggressive efforts to attain this objective.

This new strategic plan must be placed on a stable foundation that engages government, the labour movement and the private sector. Strategic partnering in a multi-sectoral approach is the ethos of the Grenada strategic planning process. The meticulous refinement of the role of all stakeholders, sectors and the governance mechanism will enable delivery of a sustainable and accessible HIV & AIDS management and implementation programme. Currently, the public sector is building that capacity by consolidating the commitments made in the National Policy on HIV & AIDS (2007). Focal points have been established in key line ministries and work programmes are being designed to increase outreach. There is a high level of commitment among civil society stakeholders and there are several organizations that already active in marginalised communities. Increased emphasis on capacity building and a greater understanding of their roles in the up-scaled process will give more legitimacy to the work undertaken especially in the rural and more remote communities. Additionally, a strategic and coordinated approach will be employed to facilitate the contribution of the private sector who can no longer be viewed simply as sponsors of campaigns.

The national response will only succeed if all stakeholders are dedicated to the process hence emphasis was placed on assessing that commitment through interviews and focus group meetings with sectors such as Government Ministries, Non – Governmental Organisations representing PLWHA, the MSM community, sex workers and women's groups; International Organisations, Academic Institutions, the Private Sector, Employers Organisations, Faith Based Organisations and the Private Sector.

It is critical that the implementing partners of the multi-sectoral team are linked to the core building blocks of the national response, the "Three Ones" – one national coordinating authority, one national strategic plan and one national monitoring and evaluation system. Indicators to measure outcomes and impact are harmonized to encompass commitments and priorities at divers levels.

Box 1: The Three Ones principle
- One national coordinating authority
- One national strategic framework
- One monitoring and evaluation system.

Sustainability must be built into the design and implementation processes through a process of local resources being allocated to the programmes along with mainstreaming programs into existing operating mechanisms in order to ensure service continuity after the expiration of international funding commitments. The strategies and priorities also reflect local peculiarities and special needs. This commitment also extends to the capacity building and institutional strengthening needed to guarantee that the structures and human capacity can contend with the demands of the pandemic on the ground. The Plan stresses required efforts to incorporate cross cutting issues like gender, vulnerability, empowerment, youth and poverty into the programme design and management. Access to and up scaling of services will be affected by funding considerations and linked cross cutting issues, social marketing and the need for positive behavior change. This strategic plan seeks to create a platform for mainstreaming HIV into service delivery and operating mechanisms toward ultimately eliminating the provision of HIV services as distinct from other services.

VISION, MISSION, GOALS STATEMENT, OBJECTIVES, GUIDING PRINCIPLES AND VALUES

Vision

A nation committed to an effective and sustainable integrated response to HIV & AIDS, where information, prevention, treatment, care and support services are accessed by all without fear of stigma and discrimination.

Mission Statement

To provide quality preventative intervention and care services whilst ensuring the effective use of available resources and research by providing leadership through a collaborative process of policy and programme development, implementation and evaluation.

Goal

Reduce the incidence of new HIV infection whilst reducing the impact of HIV & AIDS on individuals, families and communities.

Objectives

Within the next 7 years, the strategies identified in National HIV & AIDS Strategic Plan are intended to achieve the following objectives:

- Reduce the number of new infections in the general population and vulnerable groups by 50%
- Increase the level of accepting attitudes in the general population towards PLHIV by 75%
- Increase access to treatment, care and support services for PLHIV by 75%
- Reduce the mitigating impact of HIV & AIDS on PLHIV and persons affected by HIV & AIDS by 80%
- Increase level of sustainability of HIV & AIDS programmes within the government developmental framework by 75%
- Increase the level of effective and efficient generation and use of Strategic Information by government agencies by 70%.

Strategic Approaches to be employed in achieving the objectives

1. Effective implementation of HIV & AIDS prevention-related initiatives targeting general population and vulnerable groups
2. Reduction in Stigma and discrimination through the human rights approach
3. Increase in access and utilization of HIV & AIDS-related treatment, care and support services
4. Increase in support for PLHIV and persons affected by HIV & AIDS
5. Effective management and coordination of National HIV & AIDS response including resource mobilization and utilization.
6. Effective and efficient use of HIV & AIDS-related Strategic Information

Guiding Principles

UNIVERSAL ACCESS

The National HIV & AIDS Strategic plan 2009-2015 aims to achieve universal access while allocating resources and designing programmes equitably according to a transparent and coordinated policy. Scaling up of services will therefore be in stages, gradually covering the entire target population. The principle of universal access will include gender equality. Monitoring and evaluation during the lifetime of this strategy would reflect progress towards achieving equitable distribution of access to services by the population.

The Universal Access Targets set in 2007 set a target of 90% of the number of HIV+ persons, (inclusive of men, women and children) receiving ARV by 2010. The target will be mainly achieved through the expansion of treatment clinics to other districts and to Carriacou. The number of HIV+ persons who are still alive one year after initiating ARV is expected to reach 90% through the introduction of a client unique identifier coding system and a national home-based care programme. Provisions for support will be developed for households with orphans and vulnerable children. The emphasis will be developing appropriate programmes so that orphans and vulnerable children can receive a basic external support programme.

MULTI-SECTORAL APPROACH

A number of sectoral strategies and policies currently exist. The revised national HIV & AIDS Strategic Plan 2009-2015 will guide the strategic development of all efforts to strengthen the important role of NGOs, FBOs, the private sector and the PLHIV community in the national HIV & AIDS response over the next 7 years. This will include reviewing sectoral strategies where they exist, revising as necessary and creating where none exist.

GENDER

This principle provides a framework for mainstreaming gender into the overall HIV and AIDS response, to ensure that all prevention and advocacy strategies and programmes are gender-sensitive in order to reduce vulnerability and risk. The particular relationship between women's vulnerability to HIV transmission, pregnancy and the well-being of newborns as well as the impact of existent ideologies on gender roles on the vulnerability of one gender as opposed to another will be included in research, policy formulation and service development and deployment.

MEANINGFUL PARTICIPATION OF PLHIV

The national response to HIV & AIDS intends to fully implement the GIPA principle throughout all components of the national HIV & AIDS Strategic Plan 2009-2015. Active engagement of PLHIV in strategic planning, implementation and monitoring and evaluation will be incorporated in the implementation of the strategic plan.

EVIDENCE AND RESULTS-BASED STRATEGIES

Evidence on the output and outcome of the epidemic and the effectiveness of interventions as a product of research activities is growing. The National HIV & AIDS Strategic plan 2009-2015 will be regularly reviewed in light of the best available evidence from monitoring the implementation of the strategy.

ADHERENCE TO REGIONAL AND INTERNATIONAL COMMITMENTS, GOALS AND PRINCIPLES

The National HIV & AIDS Strategic plan 2009-2015 is consistent with the internationally agreed 'Three Ones Principle'. Grenada is a signatory to a number of regional and international conventions which include the Millennium Development Goals (MDG), the United Nations General Assembly Special Session on HIV & AIDS (UNGASS) and the Caribbean Regional Strategic Framework 2009-2015. This NSP will contribute to the assessment of progress towards achieving Universal Access by 2010. The plan supports Grenada's commitment to achieving the 2015 Millennium Development Goals related to poverty, gender and HIV and AIDS. At the regional level, the National HIV & AIDS Strategic plan 2009-2015 is consistent with the Caribbean Regional Strategic Framework 2009-2015.

STRATEGIC AREAS

The strategic areas have been advised by the principle that HIV interventions should be prioritized if poor countries hope to maximize the scarce resources available for reducing the impact of the AIDS epidemic using a multi-sectoral approach. Recognising the limitations caused by scarce resources and with the knowledge that incremental accomplishments will yield the most sustainable results the priorities, as established, clearly articulated the call for all PLHIV to have greater and more meaningful involvement all levels of the response. In addition they promote the strengthening and maintenance of and enabling environment to facilitate the ease of implementation of these strategies. The strategic areas place special emphasis on the inclusion of gender consciousness.

The Strategic Areas for 2009 – 2015

- Strategic Area 1: Prevention
- Strategic Area 2: Stigma and Discrimination Reduction
- Strategic Area 3: Universal access to treatment and care services
- Strategic Area 4: Support for PLHIV and persons affected with HIV
- Strategic Area 5: Governance and Institutional Systems
- Strategic Area 6: Strategic Information.

Targets to measure success of this plan

- Decrease in the reporting of HIV infection, AIDS and AIDS-related deaths
- Decline in rate of Sexually transmitted infections especially among the females 25-49 years
- All line ministries have a focal point for HIV & AIDS
- The existence of institutional support and enabling environments to support for generation and use of Strategic Information to monitor and evaluate the national response to the HIV & AIDS epidemic

Priority Area 1: Prevention

Prevention will be promoted on a platform of targeted behaviour change interventions that are community focused and that are supported by strategic partnerships as the first priority. Behavior change is a major focus of HIV prevention efforts and success in this area determines the path of the epidemic and the policy direction for the country. In addition, an enabling environment must be consistently created and maintained to facilitate the ease of implementation of these strategies.

Targeted behavior change will commence through:

- Age appropriate programming at all grade levels in the Education Sector
- Age, gender and target-group appropriate programming in the general population to address the sector-specific challenges and risk factors identified in the situation and response analysis
- Education in private sector
- Community Education targeted at specific population groups
- The situation analysis and requisite strengthening of support mechanisms to facilitate behaviour change
- Response programs to address the gender ideologies and issues in the causes and consequences of risky sexual behaviour

Prevention

In 2009-2015, prevention of new infections will remain a cornerstone in the national HIV response. The Grenada National HIV & AIDS Strategic Plan 2009-2015 will promote the re-focusing and intensifying of behaviour change approaches and programmes. The behaviour change focus will be supported by increased access to and availability of commodities and services including Information, Education and Communication material. Behaviour change approaches will be further refined. The provision of Voluntary Counselling and Testing services, prevention of sexually transmitted infections and prevention of mother to child transmission services and their utilization will be further increased; and blood safety will be maintained. Post exposure prophylaxis will be made available for occupational exposure and persons who were sexually abused.

Education Sector

The point of entry will be the Health and Family Life Education program (HFLE) which is on the curriculum of the primary schools and some secondary schools. The Health and Family Life Education Programme will be expanded with emphasis on the development of life skills. The aim will be to introduce this programme in all schools, from pre-schools to tertiary institutions and provide a minimum of 30 hours of age-appropriate HIV, AIDS, STI and Life Skills education at each grade level.

The focus over the next 5 years will be the promotion of primary and secondary abstinence and delay of sexual debut before the age of 15. The Education Sector HIV & AIDS Policy will be approved and implemented by the Ministry of Education. Its mandate will be widely implemented to reach 95% of in-school young people and teaching and ancillary staff.

HIV & AIDS Education in the Private Sector.

A strong, healthy workforce is one of the key assets in any country's development mechanism. To respond to the increase in persons of working age affected by HIV, the private sector will develop

and implement a workplace response to HIV and AIDS that focuses on education, employment facilitation for PLHIV and support mechanisms. Moreover, with the greater reliance on the tourism and service industries it is imperative that companies consider prevention, stigma and discrimination, human rights, gender equity and equality, and care and treatment education and support as part of their remit.

Strategies designed to facilitate commitment from the private sector, in the context of an appreciation of a comprehensive workplace response as the foundation of their risk management plan, will be deployed. Senior management will be encouraged to demonstrate genuine support and advocacy, having regard for the need to ensure that they are able to sustain client service delivery, thus setting the tone for the rest of the company and other businesses in their sector**.**

Community HIV & AIDS Education

The foundation of the behavior change education for the communities will be built on the dismantling of cultural barriers to changing behavior. Simply telling persons that certain behaviours put them at risk for STI's or HIV is generally insufficient since changing behaviours, especially intimate and private behaviours, is a complex process. Persons living with and affected by HIV & AIDS will be engaged as part of the advocacy program to ensure the commitment to behaviour change. There will be an analysis of the value systems and cultural barriers that predispose persons to risky behaviour and evidence driven response initiatives will be deployed.

In the next 5 years, programmes and interventions will go beyond the promotion of primary abstinence and also focus on secondary abstinence, faithfulness to one faithful partner and condom use. Programmes will also be developed to address underlying factors relating to vulnerability in the context of HIV & AIDS. In order to achieve behaviour change at the community level, an enabling environment for such a change will be created by disseminating appropriate messages through the mass media, printed material, peer to peer education, recreational activities and other group activities; and by enrolling community icons and political leaders to advocate and model desired behaviour. Risk behaviour rooted in culture and tradition will be openly discussed and addressed at all levels, and open discussions at community level will be specifically promoted. Persons living with and affected by HIV & AIDS will be encouraged to become strong advocates for prevention programmes.

Specific Prevention Programmes will include the following:

<u>Peer Education Support Programmes</u>

Existing programmes will be strengthened to increase the utilization of members of vulnerable groups as peer educators and counsellors, especially in the remote and rural areas. Minimum service packages that will be provided through peer support programmes include IEC material, male and female condoms, STI treatment and where feasible other appropriate social support. Outreach programmes will be encouraged and central to the outreach programmes will be training to disseminate information on safe sex, to distribute condom supplies among peers, organize skill-building workshops, promote healthy alternatives to sex, and to conduct referrals to other HIV & AIDS services.

Since prevention on a platform of targeted behaviour change intervention cannot be undertaken by any single institution, mechanisms for stakeholder collaboration will be reviewed and strengthened and relevant sectors will lead in activities for which they are best skilled and suited. Peer education

will not just be for young people. Age-appropriate peer education programs will be developed for all age-groupings with a special emphasis on Males 25-34 and 35-44 who have not been reached by behavioural change communication in the past.

Abstinence

Primary and Secondary abstinence will be promoted as an effective means to prevent HIV transmission not just for young persons but for persons in all sectors of the population. Civil Society especially the Faith sector will be engaged to develop approaches that can facilitate primary abstinence by delaying sexual debut and secondary abstinence as a behavioural change option for persons who are already sexually active. Safe and healthy alternatives to sexual activity will be promoted. These will include the promotion of friendly centres and community activities that facilitate recreation in an environment that is not sexually charged.

Faithfulness

Faithfulness to a faithful partner is the ideal moral value on which the continuation of our common existence depends. It is responsible not just for the reduction of HIV transmission but also for the continuation of the human species. This strategic plan will tackle this complex behavioural challenge through a process of analysis of the issues that pre-dispose persons to unfaithfulness and work with civil society especially the faith based sector to develop initiatives that promote and facilitate faithfulness and create enabling environments for it to thrive. This will include the promotion and modelling of monogamous family life and initiatives designed to tackle societal norms relating to gender identities. Vulnerabilities that hinder faithfulness will also be identified and analysed. Given the complex nature of this issue this strategic plan will seek to lay the foundation and build the necessary partnerships in its lifetime.

Promotion of Condoms

Condoms will be made more widely available in rural and remote areas using new and innovate outlets. A major effort will be made to make female condoms more available especially to vulnerable groups. Current procurement and supply systems will be strengthened and more systematic procurement and supply management scheme will be implemented. Free condoms will continue to be distributed through public facilities, as well as special functions such as festivals and carnival, and civil society organizations however the role of commercial condom importers and retailers will be strengthened. This will be done in the context of increasing the number of outlets that have staff trained to distribute condoms and are labelled as safe places to access condoms. Promotional activities will continue to be developed to support the social marketing of condoms.

Voluntary Counselling and Testing

Testing is one of the most important components of the prevention of HIV transmission. Nation-wide provider initiated voluntary counselling and testing will be implemented, a policy decision will be taken at the appropriate level to that effect. The training of health workers certified to perform rapid testing will significantly expand and efforts will be made to include VCT training as an entry requirement for new medical staff. Test kit procurement, supply and dissemination systems will be periodically reviewed and strengthened. Selected public health facilities will be upgraded and VCT and HIV treatment related concerns will be considered in the designs for new construction and/or renovations undertaken to health facilities in this period. Training of existing nurses, counsellors, private and public health doctors will continue. Campaigns to promote VCT will be expanded supported by the production of appropriate IEC material. The correlation between certain infections and HIV will be actively promoted throughout the health care system so that they can be seen as

early warning indicators and the basis for referring patients routinely for HIV testing. In addition, civil society actors will be empowered to provide a referral system for testing in order to promote early diagnosis and treatment of HIV infection.

Community Education and Empowerment

Community education and empowerment is a critical component of the national response to HIV and AIDS and every stakeholder has an active role to play in providing age, gender and target group appropriate opportunities for education and empowerment in communities. These are designed to reduce vulnerability and susceptibility to HIV risk factors. In the life of this strategic plan efforts will be made to address poverty, gender interactions, societal defined roles and norms as well as taboos. This will aid not only in prevention but also in treatment, care and support.

Prevention of Mother to Child Transmission

The national PMTCT programme will be further strengthened through geographical expansion, improved quality of services and an increase in the package of services provided. HIV testing will be routinely offered in all ante-natal clinics, with special emphasis on rural and remote areas. PMTCT services will be further integrated in, linked with and supported by training of health service providers, treatment of HIV+ mothers and babies, and provision of infant formula for six months if the mother is HIV+. Health care providers will be trained in comprehensive PMTCT, including rapid testing and the provider initiated approach. The uptake of PMTCT will be promoted among the male partners. Support will be increased for the promotion of optimal and safe infant feeding practices. Tracking of babies born to HIV+ mothers will be strengthened so that the children can be tested as early as possible. Efforts will be made to integrate PMTCT into the Maternal and Child Health programme. IEC material will be produced to market PMTCT services with special emphasis on remote and rural communities. HIV+ mothers and their babies will be provided with antiretroviral drugs to prevent the transmission of the HIV from mother to child.

Prevention and Control of Sexually Transmitted Infections

STI control services will be made more available to at risk groups. The syndromic management approach will continue to be implemented in the public and private health care system. IEC/BCC material on STI prevention and treatment will be produced and distributed throughout the health facilities, and other public places. Health care providers will be trained in the revised protocols for managing STI and providing more youth-friendly services. Age-appropriate STI education will be provided in the HFLE and Community Education Programs. This will seek to increase education and awareness of the signs and symptoms of STI so that persons can seek medical attention and HIV testing earlier. The protocols for double-testing will be revised and implemented.

Blood Safety

Blood bank quality control will be strengthened by the conducting of HIV testing on 100% of blood accepted for transmission including the provision of VCT to regular and ad hoc donors.

Prevention Indicators

Education Sector

1. % of schools that provided life-skills based on HIV & AIDS education during the last academic year

Private sector

2. # of organizations implementing work plans related to HIV & AIDS and submitted programme monitoring forms in the last 12 months

Community Education

3. % of population (15-49) who correctly identify ways of preventing transmission of HIV and reject major misconceptions
4. % of young persons who had sex before the age of 15
5. % of the population reached with HIV & AIDS/STI interventions and community-based programmes
6. % of organizations involved in the response to HIV & AIDS that receive technical and financial support

Condoms

7. # of free condoms distributed in the preceding 12 months
8. % of women and men who had more than one partner in the last 12 months reporting the use of condoms during the last sexual intercourse
9. % of the sexually active population reporting consistent condom use during sexual intercourse within the last 12 months

Voluntary Counselling and Testing

10. % of persons who receive an HIV test, the results and pre and post test counselling
11. # of counselling and testing sites

Prevention of Mother to Child Transmission

12. % of pregnant women in ANC accessing PMTCT, counselled and tested for HIV & know their results
13. % of pregnant women receiving a complete course of ARV prophylaxis

Sexually Transmitted Infections

14. # of public health facilities providing diagnosis, counselling and treatment for STI according to national guidelines

Blood Safety

15. % of donated blood screened for HIV in a quality assured manner

Vulnerable groups

16. % of sex workers reporting condom use during the last sexual intercourse with their clients
17. % of men reporting the use of condom the last time they had anal sex with a male partner
18. % of the population reporting multiple sex partners in the last 12 months

Strategic Area 2: Stigma and Discrimination Reduction

Enabling Environment and Human Rights

An enabling environment can assist in the achievement of the goal of universal access to prevention, treatment care and support. It is therefore necessary to establish and sustain policy positions supported by legislation that create a more enabling environment. There are however many impediments that can hinder such access. An enabling environment can be strengthened through Grenada's adherence to international Conventions and Protocols to which it is a signatory. Particular attention must be paid to the implementation of CEDAW, Human Declaration of Human Rights, UNGASS Declaration and the Convention of the Rights of Child.

The recommendations of the report on the "National HIV & AIDS Assessment-Law, Ethics and Human Rights Project Grenada, 2009 are accepted as activities for this strategic plan:

- General legislation enforcing confidentiality by health workers and others which takes into consideration situations in which information could be divulged in the interest of the protected person or for some other reason;
- Provision of free medication for PLWHA and other persons who, whether through rape occupational exposure or other cause, were exposed or suspected to have been exposed to HIV;
- Legislation outlawing all forms of discrimination and provision of redress against persons who discriminate;
- Legislation making provision for all the rights expressed in the Convention on the Rights of the Child;
- Psychological and Psychosocial support including counselling for all PLWHA, their families and all persons affected by HIV & AIDS;
- Amendment to Prison Act specifying who shall have access to inmate's medical records;
- Amendment to the Public Health Act taking into consideration HIV & AIDS, its transmission and treatment;
- Amendment to the Quarantine Act taking into consideration HIV & AIDS, its transmission and treatment;
- Amendment to the Immigration Act removing the possibility of a person being denied entry into Grenada because of that person's HIV status;
- Review of the law of evidence as it relates to rape cases taking into consideration the corroboration requirement;
- General strategy to empower women so that they could negotiate safe sex;
- Legal Support for PLWHA and their families;

- Job security for PLWHA and their families;
- Massive education campaign on HIV & AIDS, prevention, treatment, care and the related stigma and discrimination;
- Greater involvement of PLWHA in all decisions affecting them;
- Behaviour change communication by the media and others;

Discrimination however is more than a legal issue; it is cultural and social practices based on beliefs and norms. The suggested education programmes, policy, laws and social and cultural support systems will therefore address the need for change in attitudes that are needed to support this value and an adherence to human rights to reduce discrimination and the other human rights violations. Stigma and discrimination will be addressed through targeted IEC material, HFLE, Community Education Programs, and the review of policies and legislation to ensure the protection of rights of persons living with and affected by HIV and AIDS. The existence of a human rights desk staffed with persons who are appropriately trained is an essential component of this component of the response.

Stigma and Discrimination Reduction Indicators

1. The existence of mechanism to respond to complaints of discrimination by PLHIV and affected persons
2. # of reports of human rights violations documented by PLHIV reached and referred to appropriate agency by the Human Rights Desk
3. % of persons with accepting attitudes towards PLHIV

Strategic Area 3: Universal access to treatment and care services

Treatment

There have been improvements in the programme for the treatment, care and support of PLHIV. Improvements have been demonstrated in the diagnosis, treatment and care for PLHIV by meeting their clinical and emotional needs, reducing opportunistic infections, reducing work disability, and improving their quality of life and life expectancy. Laboratory system capacity for HIV screening and testing will be strengthened. Grenada will continue to make use of out-of-country facilities such a as CAREC for viral load testing. The intent is to reduce the number of PLHIV who progress to AIDS as well as AIDS-related mortality.

Availability of Services and Service Providers

Over the next 5 years, training of health care workers in HAART will continue. The Government of Grenada will continue its agreement with OECS/PPS for procurement of ARV. Training in the timely selection, procurement, distribution and use of ARV will continue, along with training in the monitoring and follow-up of patients and the management of side-effects.

Opportunistic Infections

Management of OI will continue through monitoring of clinical protocols for HIV treatment and care, training of health workers in HIV & AIDS treatment and purchasing of basic drugs for OI.

Universal access to treatment and care Indicators

1. % of population with advanced HIV infection receiving antiretroviral combination therapy
2. % of adults and children on ART who still alive after one year of initiation of ARV
3. % of PLWHA who have been clinically staged in accordance with Caribbean guidelines
4. % of deaths attributable to AIDS
5. % of pregnant HIV+ women receiving a complete course of ARV prophylaxis to reduce mother-to-child transmission
6. % of infants born to HIV+ mothers who have been tested for HIV infection in accordance with Caribbean guidelines
7. Average # of days of hospitalization for HIV & AIDS related conditions per quarter
8. % of estimated HIV+ incident TB cases who received treatment for TB and HIV in the last 12 months
9. % of persons reported to be HIV+
10. # of public health practitioners trained
11. # of facilities carrying out comprehensive clinical staging of PLHIV as per Caribbean guidelines

Strategic Area 4: Support for PLHIV and persons affected by HIV & AIDS

Disaster Preparedness

A comprehensive Special Needs and Disaster Preparedness Plan will be developed and implemented in collaboration with relevant stakeholders in order to provide a coordinated response for the benefit of the PLWHA community in times of disaster.

Home-Based Care

A national home-based care program will be implemented to improve care for persons living with and affected by HIV & AIDS. A training programme will be developed and to enable care-givers to work more effectively, home-based care kits will be regularly replenished through a distribution system coordinated by the NAD. Community-based counselling to help PLWHA and their families cope with the impact of HIV will be strengthened. Counselling skills to raise awareness on ARV and adherence support will be promoted.

Orphans and Vulnerable Children

A program to document, track, conduct needs analysis and provides support for Orphans and Vulnerable Children will be designed and implemented. There will be active participation of all relevant stakeholders in all aspects of the program. Orphans in this case will include all orphans however there will be provision for the analysis of data related to HIV related orphans as necessary. Efforts in this regard will also focus on assessing dependents of PLHIV and deceased HIV positive persons.

Support for PLHIV and persons affected by HIV & AIDS Indicators

1. % of infected and affected children whose households received a basic external support package in caring for children in the last 12 months
2. Current school attendance among orphans to that among non-orphans
3. # of PLHIV receiving care and support

Strategic Area 5: Governance and Institutional Systems

This will be supported by a comprehensive monitoring and evaluation system. A comprehensive institutional review will be undertaken (See Appendix 3 for the Existing Governance Structure). The review process will seek to create a national HIV response that is country driven and not donor driven and will consider the following:

- The review of the structure of the National Response to HIV and AIDS to
  - Address sustainability and adequacy to coordinate the national response and the appropriate staffing configuration and organizational identity and authority.
  - Promote prevention, improve adequacy to support the needs of HIV+ persons and provide other relevant services for the general population.
- The creation of greater levels of transparency in the selection of representatives of the NAC including a constituent feedback mechanism for members.
- Resource sharing in the public sector especially between HIV and other infectious diseases.
- The GIPA Principle of meaningful participation by ensuring that positive persons are part of the governance structure.

Financing Mechanisms

The National HIV & AIDS Strategic Plan 2009-2015 has been costed at a total of US$10.5M for the implementation of the plan through the implementation of initiatives in the 6 strategic areas. These costs mainly reflect the cost of implementation through research activities, workshops, training, and the provision of technical and financial support to public and private sector agencies and civil society.

In the efforts to scale up the HIV response, the National HIV & AIDS Strategic Plan 2009-2015 will be highly dependent on donor funding but increased allocation from national government consolidated funds. It is recognized that Grenada will be facing competing priorities over the next year (education, infrastructure, social welfare and agriculture) therefore there will be a need to seek additional external funding to bridge the financing gap of the HIV and AIDS response. World Bank has committed funds of US$5.3M until June 2009 and GFATM grant is US$950,711.00 until February 2010. Additional financial and technical support is expected through PAHO Caribbean HIV/STI Plan 2007-2011.

Governance and Institutional Systems Indicators

1. National Composite Policy Index
2. Country AIDS Spending

Strategic Area 6: Strategic Information

Strategic Information

Grenada will fully institutionalize the Three Ones Principle to which subscribes. Monitoring and evaluation (M&E) will be incorporated at the program design stage as an essential element of ensuring that M&E activities will support the national response in tracking the achievement of useful results and developing early warning systems. Planning a national HIV & AIDS response and developing an M&E strategy to monitor progress and achievements are seen as seamless. The National HIV & AIDS responses will have an M&E Plan for assessing the progress of the program in achieving program goals and objectives and informing key stakeholders and program designers about the results of their efforts. An M&E framework has been developed and incorporates the national harmonized indicators of this strategic plan. A results framework has also been completed and will be an anchor for the M&E plan and the NSP. The M&E plan will be written on approval of this strategic plan. It will be designed to support the objectives and priorities of this plan. This is critical since this plan places tremendous emphasis on the acquisition and use of strategic information to ensure evidence based decision making and advised program planning and implementation.

The M&E plans will guide the design of M&E, highlight what information or data need to be collected, how best to collect it, and how to disseminate and use the results. This will be to ensure the relevance and sustainability of M&E activities and as such programme managers, in collaboration with national multi-sectoral stakeholders and collaborating donors, will continue to work collaboratively to develop and implement this integrated and comprehensive monitoring and evaluation system. In Grenada it is envisaged that the M&E Plan as developed will be presented and treated as a companion document to the Grenada National HIV & AIDS Strategic Plan 2009-2015.

When completed, this companion document will clearly illustrate how activities contribute to the achievement of the results described in the Results Framework. The success of the NSP is indicated by the data that is reported in the M&E system. In order to arrive at this therefore it is important to outline and identify the elements of an M&E system which will be strengthened. In order to achieve this attention will be paid to the development of a good M&E system. According to the World Bank, an M&E system can be structured into 12 components. The Grenada M&E Plan will act as a road map for strengthening each of the following components. A National M&E assessment, therefore, will be conducted as a part of the process to reduce the M&E Plan to writing

The goal of the National HIV & AIDS Monitoring and Evaluation System is to provide a comprehensive tracking system to collect, enter, analyze and share information on HIV and AIDS that will enhance decision-making at all levels in the implementation of interventions.

The objectives of the National HIV & AIDS Monitoring and Evaluation System are to:

- Measure the progress of implementing the Grenada National HIV & AIDS Strategic Plan 2009-2015
- Track inputs and results of the national response to HIV and AIDS epidemic in Grenada
- Provide programmatic data to meet internal and external reporting requirements
- Continuously identify and resolve any problems arising in the course of implementing the national response

- Ensure greater transparency, effective coordination and communication among different groups involved in the national response to HIV and AIDS
- Promote the importance of monitoring and evaluation, the need for systematic data collection and utilization of results
- Strengthen M&E capacity of the NAC, NAD, NIDCU and other stakeholders in the public, private sector and civil society to collect, analyze and utilize data
- Provide guidance on national reporting requirements
- Make available user-friendly data summaries and key trends to all stakeholders
- Promote the utilization of research findings to govern program implementation by ensuring that the program activities respond to identified challenges to program success by utilizing activities that have been pre-tested and proven to be effective.
- Model and project the trends in HIV to facilitate planning and estimation.

The National AIDS Directorate will continue to have overall responsibility for and oversee the national HIV & AIDS monitoring and evaluation system. A national HIV & AIDS M&E work plan that clearly states agreed indicators and M&E activities will be developed in collaboration with all partners and disseminated to all sectors. The plan will state the responsibility of different stakeholders and will also contain components that require international reporting such as UNGASS and GFATM. A national database will be developed which captures the core output indicators for each programme area. This database will feed into other international databases when required. The M&E component will be supported by staff training in epidemiology, second-generation surveillance, and setting up of an integrated, computerized health information system

Information Technology

The National AIDS Directorate will be implementing the Information Technology Platform over the next 5 years with emphasis on installation of the hardware and software with the necessary training input to support the Information Technology operating capacity required for the national response to HIV and AIDS. This IT platform will be designed to support the M&E plan and its commitments to support the provision of information to drive evidence based decision making processes.

Research Agenda

Future Research Needs

- Survey on NGOs, FBO and CBO involved in HIV and AIDS (Needs Assessment)
- More geographic distribution for STI especially between Grenada and Carriacou
- Surveillance on the MSM specifically focusing on MSMW.
- Further sub-data on the category of heterosexual to identify sub-grouping such as married women, transactional sex
- Situational Analysis of Sex Work in Grenada
- Assessment of the pharmaceutical and non-pharmaceutical supply system inclusive of condom distribution to identify training needs for pharmacists, practices that encourage stock out of drugs and condoms and other supplies that are required for a national HIV & AIDS response in Grenada.
- Conduct a National AIDS Spending Assessment
- Research on the impact of HIV on the lives of OVC

- Evaluation of the PMTCT programme
- Evaluation of the VCT programmes
- Research on the route of transmission to reduce the number reported as route unknown.

The Grenada National HIV & AIDS Strategic Plan places great importance on evidence-based interventions to ensure initiatives are demand-driven and relevant. All stakeholders in the multi-sectoral response will be encouraged to contribute to studies, reviews, assessments and research that will become necessary from time to time in all areas of HIV and AIDS interventions, particularly priority areas of prevention, treatment, care and support. Some topics proposed for future research include the following:

- Factors related to correct and consistent condom use
- Specific risks and vulnerabilities of most-at-risk groups

Other research will be commissioned as needed. Behavioural surveillance on HIV and AIDS activities will be strengthened to ensure that decisions are based on data. NAD will commission periodic formative and summative evaluations to measure impact and document lessons learnt from implementing the interventions in the strategic framework.

Strategic Information Indicators

1. # of completed biological, behavioural and research studies

STRATEGIC FRAMEWORK 2009-2015
STRATEGIC AREA 1: PREVENTION

Strategic Objectives	Strategic Activities	Indicators	Responsible Sectors	Expected Outcome
Reduce the number of new infections in the general population and vulnerable groups by 50%	1. Produce and disseminate IEC material that are age, gender and target group appropriate including materials that comprehensively address the milieu of issues and education needs related to HIV. 2. Conduct training programmes with specific emphasis on the 15-24 females, 25-34 males and females, and 45+ male population 3. Develop behavioural change communication programmes that are age, gender and target group appropriate 4. Develop peer education/ counselling programmes 5. Develop mass media campaigns 6. Implement life-skills education in all primary, secondary and tertiary educational institutions 7. Develop sector-specific policies and plans with specific emphasis on the workplace 8. Expand condom distribution (male and female) through non-traditional outlets 9. Expand VCT services with specific emphasis on the adult male population and the certification of health workers to provide rapid test. 10. Monitor implementation of current guidelines on blood transfusion 11. Expand campaign for PMTCT 12. Implement youth-friendly outreach programmes 13. Provide support to organizations for HIV & AIDS related activities and encouraging them to develop and submit work plans and program	% of the population who both correctly identify ways of preventing of transmission of HIV and reject major misconception about HIV transmission % of the population reached by HIV & AIDS/STI interventions and community-based programmes % of schools with teachers who have been trained in life-skills based HIV & AIDS education and who taught it in the last academic year # of organizations implementing work plans related to HIV & AIDS and submitted programme monitoring forms in the last 12 months % of organizations involved in the response to HIV and AIDS that received technical and financial support in the last 12 months % of sexually active population reporting the consistent condom use during intercourse with a non-commercial partner in the last 12 months % of sex workers reporting condom use during the last sexual intercourse with their clients % of men reporting the use of condoms the last	Ministry of Health Ministry of Education Ministry of Youth, Culture and Sports Ministry of Social Development NGOs Private Sector	50% reduction in the number of new infections in the general population and vulnerable groups (Baseline: total # of new infection for the year 2007: 38)

monitoring forms
14. Expand the management of sexually transmitted diseases including syphilis and trichomoniasis with special emphasis on the female population between 25-49 years
15. Develop and implement a test kit procurement, supply and dissemination system review and strengthening program
16. Upgrade public health facilities for the provision of VCT and HIV treatment
17. Increase the availability of STI diagnostic and treatment services including an expansion of the syndromic management approach.
18. Revise protocols for STI management and double-testing and care and train health care providers
20. Provide services that are age, gender and target-group appropriate for STI education, diagnosis and treatment including IEC campaigns to increase general population knowledge on the symptoms of STI
21. Develop programs to address vulnerabilities that cause increased susceptibility to HIV risk factors.
22. Develop program to promote delayed sexual debut and a reduction in the number of sexual partners
23. Expand the program for Post Exposure Prophylaxis to provide free medical attention and medication for persons who, whether through rape occupational exposure or other cause, were exposed or suspected to have been exposed to HIV
24. Develop a strategy to empower women so that

time they had anal sex with a male partner

% of persons who receive an HIV test, the results and pre and post counselling

% of young persons who has sex before the age

of 15

# of free condoms distributed in the preceding

12 months

% of women and men who had more than one partner in the last 12 months reporting the use of condoms during the last sexual intercourse

# of counselling and testing sites

% of pregnant women in ANC accessing PMTCT, counselled and tested for HIV and know their results

# of public health facilities providing diagnosis, counselling and treatment for STI according to national guidelines

% of donated blood units screened for HIV in a quality assured manner

% of the population who had multiple sex partners in the last 12 moths

they could negotiate safe sex

STRATEGIC FRAMEWORK 2009-2015
STRATEGIC AREA 2: STIGMA AND DISCRIMINATION REDUCTION

Strategic Objectives	Strategic Activities	Indicators	Responsible Sectors	Expected Outcome
Increase the level of accepting attitude towards PLHIV by 75%	1. Monitor violations of human rights of PLHIV 2. Implement ILO Code of Practice in the workplace 3. Encourage the inclusion of provisions for HIV & AIDS in collective agreements 4. Enact appropriate legislation on HIV & AIDS discrimination in the workplace 5. Provide advocacy programmes against stigma and discrimination 6. Develop IEC and BCC campaigns that utilizes education as a key tool in fighting stigma and discrimination 7. Develop and implement general legislation enforcing confidentiality by health workers and others which takes into consideration situations in which information could be divulged in the interest of the protected person or for some other reason; 8. Implement legislation outlawing all forms of discrimination and provision of redress against persons who discriminate; 9. Implement legislation making provision for all the rights expressed in the Convention on the Rights of the Child; 10. Amendment to Prison Act specifying who shall have access to inmate's medical records 11. Amendment to the Public Health Act taking into consideration HIV & AIDS, its transmission and treatment; 12. Amendment to the Quarantine Act taking into	% of persons with accepting attitudes towards PLHIV The existence of a mechanism to record and respond to complaints of discrimination by PLHIV and affected persons # of reports of human rights violations documented by PLHIV reached and referred to appropriate agency by the Human Rights Desk	Ministry of Health Ministry of Education Ministry of Youth, Culture and Sports Ministry of Social Development NGOs Private Sector Ministry of Legal Affairs Ministry of Labour	75% increase in the level of accepting attitude towards PLHIV (Baseline: % of accepting attitude towards PLHIV: 4%, 2005)

consideration HIV & AIDS, its transmission and treatment;
13. Amendment to the Immigration Act removing the possibility of a person being denied entry into Grenada because of that person's HIV status;
14 Review of the law of evidence as it relates to rape cases taking into consideration the corroboration requirement

STRATEGIC FRAMEWORK 2009-2015

STRATEGIC AREA 3: ACCESS TO TREATMENT AND CARE SERVICES

Strategic Objectives	Strategic Activities	Indicators	Responsible Sectors	Expected Outcome
Increase the percentage of PLHIV accessing treatment and care to PLHIV to 95%	1. Provide medication for the treatment of HIV & AIDS 2. Provide appropriate drugs for the treatment of opportunistic infections and related conditions 3. Build capacity of health professionals to provide comprehensive HIV & AIDS/STI/TB treatment and care 4. Standardize a minimum package of treatment and care of PLHIV 5. Implement standards to govern the provision of the standardized minimum package of treatment and care of PLHIV 6. Decentralize the provision of treatment and care services 7. Promote early diagnosis and ongoing clinical staging for PLHIV 8. Implement a treatment preparedness and treatment adherence programme 9. Upgrade public health facilities to provide HIV treatment and care to support and facilitate the decentralization of treatment and care. 10. Expand the PMTCT program to increase the reach for testing as well as the provision of comprehensive support, care and follow-up for children born to HIV+ mothers. 11. Implement a bio-medical waste management program based on the manual that has been developed	% of HIV+ pregnant women who received a complete course of ARV prophylaxis % of infants born to HIV+ mothers who have been tested for HIV infection in accordance with Caribbean protocols % of deaths attributable to AIDS % of PLHIV clinically staged in accordance to Caribbean guidelines % of persons reported to be HIV+ % of public health practitioners trained % of estimated HIV+ incident TB cases that receive treatment for TB and HIV in the last 12 months % of PLHIV receiving combination therapy in accordance with Caribbean guidelines % of persons still alive and on treatment 12 months after the initiation on ARV Average # of days of hospitalization for HIV & AIIDS related conditions # of facilities carrying our comprehensive clinical staging as per Caribbean guidelines	Ministry of Health	95% PLHIV accessing treatment and care (Baseline: % PLHIV accessing treatment and care total of new infection for the year 2007: 91%)

STRATEGIC FRAMEWORK 2009-2015

STRATEGIC AREA 4: SUPPORT FOR PLHIV AND PERSONS AFFECTED BY HIV & AIDS

Strategic Objectives	Strategic Activities	Indicators	Responsible Sectors	Expected Outcome
Increase the level of	1. Support innovative projects for PLHIV with special emphasis on the unemployed females.	% of affected or infected children whose households received external support in caring	Ministry of Social	80% increase in the level of

STRATEGIC FRAMEWORK 2009-2015
STRATEGIC AREA 4: SUPPORT FOR PLHIV AND PERSONS AFFECTED BY HIV & AIDS

Strategic Objectives	Strategic Activities	Indicators	Responsible Sectors	Expected Outcome
support to PLHIV and persons affected by HIV by 80%	2. Provide Psychological and Psychosocial support including counselling for all PLWHA, their families and all persons affected by HIV & AIDS; 3. Provide Legal Support for PLWHA and their families; 4. Develop programs to provide financial and employment assistance for PLWHA and their families; 5. Develop an HIV/AIDS Response to the National Disaster Preparedness Plan	for the children in the last 12 months Current school attendance among orphans to that among non-orphans % of PLHIV receiving care and support	Development Ministry of Health NaDMA	support to PLHIV and persons affected by HIV (Baseline: % of PLHIV and persons affected by HIV: no data)

STRATEGIC FRAMEWORK 2009-2015
STRATEGIC AREA 5: GOVERNANCE AND INSTITUTIONAL SYSTEMS

Strategic Objectives	Strategic Activities	Indicators	Responsible Sectors	Expected Outcome
Increase the level of sustainability of HIV & AIDS programmes within the government development framework by 75%	1. Implementation of the GIPA principle facilitating greater involvement of PLWHA in all decisions affecting them 2. Conduct National Health Accounting Assessment 3. Conduct a program to revise the HIV program management structure and institutional arrangements including empowering relevant agencies with the authority to implement their required work programs and detailing inter-agency collaboration mechanisms 4. Establish a framework for technical cooperation and external funding support to the National HIV response 5. Establish clear policies and mechanisms to govern HIV programming in support of the National AIDS Policy and Strategic Plan	Country spending for HIV/AIDS National Composite Policy Index	Ministry of Health Ministry of Finance Hope PAL Network	75% increase in the level of sustainability of HIV & AIDS programmes within the government development framework (Baseline: % level of sustainability of HIV & AIDS programmes within government developmental framework)

STRATEGIC FRAMEWORK 2009-2015

STRATEGIC AREA 6: STRATEGIC INFORMATION

Objective: Increase the level of effective and efficient generation and use of strategic information by government agencies by 70%

Intervention: Achieve high level of generation and use of strategic information by government agencies

Strategic Objectives	Strategic Activities	Indicators	Responsible Sectors	Expected Outcome
Increase the level of effective and efficient generation and use of strategic information by government agencies by 70%	1. Implement M&E plan 2. Implement strategic information electronic database through an Information Technology Platform 3. Implement research agenda 4. Implement systems for routine data collection and analysis 5. Produce and publish program monitoring and evaluation reports 6. Development and implement early warning systems for program management 7. Promote the use of research findings to govern program activities to ensure that the methodology utilized has been pre-tested and proven to be effective	# of completed biological, behavioural and research studies	Ministry of Health	70% increase in the level of effective and efficient generation and use of strategic information by government agencies (Baseline: % level of effective and efficient generation and use of strategic information)

RESULTS FRAMEWORK 2009-2015
STRATEGIC AREA 1: PREVENTION

Objective: Reduce the number of new infections in the general population and vulnerable groups by 50%

Intervention: Achieve effective implementation of HIV & AIDS prevention-related Initiatives targeting general population and vulnerable groups

Outcome Indicators	Baseline Value (year)	Performance Mid point (2012)	Target End Point (2015)	Type & Reference	Frequency	Source
% of the population who both correctly identify ways of preventing of transmission of HIV and reject major misconception about HIV transmission	39% (BSS, 2005)	90%	95%	UNGASS GFATM	Every 2 years Every 2 years	Behavioural Surveillance Survey Behavioural Surveillance Survey
% of the population reached by HIV & AIDS/STI interventions and community-based programmes	Youth: 13% MSM: 2.7% SW: 13% UP: 0% Prisoners: 0% GP: 10% (BSS, 2005)	Youth: 63% MSM: 10% SW: 50% UP: 10% Prisoners: 10% GP: 30%	Youth: 90% MSM: 15% SW: 80% UP: 20% Prisoners: 20% GP: 40%	World Bank UNGASS	Annual Every 2 years	Annual HIV & AIDS report Behavioural Surveillance Survey
% of schools with teachers who have been trained in life-skills based HIV & AIDS education and who taught it in the last academic year	% of schools: 0%	% of schools: 50%	% of schools: 100%	UNGASS	Every 2 years	School survey
% of organizations involved in the response to HIV and AIDS that received technical and financial support in the last 12 months	90% (Annual NAD Report, 2007)	95%	100%	UNGASS World Bank	Annually	Annual NAD report
% of sexually active population reporting the consistent condom use during intercourse with a non-commercial partner in the last 12 months	15-24: 42% 25-49: 53% (BSS 2005)	15-24: 70% 25-49: 75%	15-24: 85% 25-49: 85%	UNGASS	Every 2 years	Behavioural Surveillance Survey

RESULTS FRAMEWORK 2009-2015
STRATEGIC AREA 1: PREVENTION

Objective: Reduce the number of new infections in the general population and vulnerable groups by 50%

Intervention: Achieve effective implementation of HIV & AIDS prevention-related Initiatives targeting general population and vulnerable groups

Outcome Indicators	Baseline Value (year)	Performance Mid point (2012)	Target End Point (2015)	Type & Reference	Frequency	Source
% of sex workers reporting condom use during the last sexual intercourse with their clients	No data	50%	80%	UNGASS	Every 2 years	Behavioural Surveillance Survey
% of men reporting the use of condoms the last time they had anal sex with a male partner	No data	10%	15%	UNGASS	Every 2 years	Behavioural Surveillance Survey
% of persons who receive an HIV test, the results and pre and post counselling	15-24: 9% 25-49: 10% (BSS 2005)	15-24: 25% 25-49: 40%	15-24: 50% 25-49: 60%	UNGASS GFATM World Bank	Every 2 years Annually Annually	Behavioural Surveillance Survey Annual Ministry of Health report Annual Ministry of Health report
% of young persons who had sex before the age of 15	25% (BSS 2005)	20%	15%	UNGASS	Every 2 years	Behavioural Surveillance Survey
# of free condoms distributed in the preceding 12 months	70254 (2005)	325000	400000	World Bank	Annually	Annual Report
% of women and men who had more than one partner in the last 12 months reporting the use of condoms during the last sexual intercourse	No data	60%	80%	UNGASS	Every 2 years	Behavioural Surveillance Survey
# of counselling and testing sites	No data	44	50	World Bank	Annually	Annual report
% of pregnant women in ANC accessing PMTCT, counselled and tested for HIV and know their results	55% (2005)	80%	95%	GFATM	Annually	Annual Report
# of public health facilities providing diagnosis, counselling and treatment for STI according to the national guidelines	No data	44	50	GFATM	Annually	Annual report

RESULTS FRAMEWORK 2009-2015
STRATEGIC AREA 1: PREVENTION

Objective: Reduce the number of new infections in the general population and vulnerable groups by 50%

Intervention: Achieve effective implementation of HIV & AIDS prevention-related Initiatives targeting general population and vulnerable groups

Outcome Indicators	Baseline Value (year)	Performance Mid point (2012)	Target End Point (2015)	Type & Reference	Frequency	Source
% of donated blood units screened for HIV in a quality assured manner	100% (2006)	100%	100%	UNGASS	Annually	Frame tool
% of persons reporting multiple sex partners in the last 12 months	60% (2005)	45%	30%	UNGASS	Every 2 years	Behavioural Surveillance Survey

RESULTS FRAMEWORK 2009-2015

STRATEGIC AREA 2: STIGMA AND DISCRIMINATION REDUCTION

Objective: Increase the level of accepting attitudes towards PLHIV by 75%

Intervention: Achieve effective implementation of anti-stigma and anti-discrimination HIV & AIDS-related initiatives

Outcome Indicators	Baseline Value (year)	Performance Mid point (2012)	Target End Point (2015)	Type & Reference	Frequency	Source
% of persons with accepting attitudes towards PLHIV	4% (BSS, 2005)	25%	50%	GFATM	Every 2 years	Behavioural Surveillance Survey

STRATEGIC AREA 3: ACCESS TO TREATMENT AND CARE SERVICES

Objective: Increase the percentage of PLHIV accessing treatment and care services to 95%

Intervention: Achieve universal access to treatment and care services for PLHIV community

Outcome Indicators	Baseline Value (year)	Performance Mid point (2012)	Target End Point (2015)	Type & Reference	Frequency	Source
% of HIV+ pregnant women who received a complete course of ARV prophylaxis	70% (MoH, 2007)	80%	95%	UNGASS GFATM	Annually	PMTCT Annual Report
% of infants born to HIV+ mothers who have been tested for HIV infection in accordance with Caribbean protocols	No data	80%	100%	GFATM	Annually	Annual Ministry of Health Report
% of deaths attributable to AIDS	0.9% (MoH and Vital Statistics, 2006)	0.45%	0.25%	GFATM	Annually	Annual Ministry of Health Report
% of PLHIV clinically staged in accordance to Caribbean guidelines	No data	90%	100%	GFATM	Annually	Annual Ministry of Health Report
% of persons reported to be HIV+	0.30% (MoH, 2007)	0.22%	0.17%	UNGASS GFATM	Annually Annually	Annual Ministry of Health Report Annual Ministry of Health Report
% of public health practitioners trained	No data	25%	50%	World Bank	Every 2 years	Training Survey
% of estimated HIV+ incident TB cases that receive treatment for TB and HIV in the last 12 months	0% (MoH, 2007)	0%	0%	UNGASS	Annually	Annual Ministry of Health Report
% of PLHIV receiving combination therapy in accordance with Caribbean guidelines	91% (MoH, 2007)	95%	95%	World Bank GFATM UNGASS	Annually Annually Annually	MoH Report MoH Report MoH Report
% of persons still alive and on treatment 12 months after the initiation on ARV	100% (MoH, 2007)	100%	100%	UNGASS	Annually	MoH HIV Data Tracking Survey
Average # of days of hospitalization for HIV &	No data	Establish	60%	GFATM	Quarterly	Program reports

STRATEGIC AREA 3: ACCESS TO TREATMENT AND CARE SERVICES

Objective: Increase the percentage of PLHIV accessing treatment and care services to 95%

Intervention: Achieve universal access to treatment and care services for PLHIV community

Outcome Indicators	**Baseline Value (year)**	**Performance Mid point (2012)**	**Target End Point (2015)**	**Type & Reference**	**Frequency**	**Source**
AIDS related conditions		baseline	reduction			
# of facilities carrying out comprehensive clinical staging as per Caribbean guidelines	1 (2005)	3	5	GFATM	Annually	Country reports

RESULTS FRAMEWORK 2009-2015

STRATEGIC AREA 4: SUPPORT FOR PLHIV AND PERSONS AFFECTED BY HIV & AIDS

Objective: Increase in the level of support for PLHIV and persons affected by HIV by 80%

Intervention: Achieve effective implementation of support services for PLHIV and those affected by HIV & AIDS

Outcome Indicators	Baseline Value (year)	Performance Mid point (2012)	Target End Point (2015)	Type & Reference	Frequency	Source
% of affected or infected children whose households received external support in caring for the children in the last 12 months	No data	50%	95%	UNGASS	Annually	Annual NAD report
Current school attendance among orphans to that among non-orphans	No data	1:1	1:1	UNGASS	Annually	Annual report
% of PLHIV receiving care and support	30% (2005)	60%	90%	GFATM	Annually	Annual report

STRATEGIC AREA 5: GOVERNANCE AND INSTITUTIONAL SYSTEMS

Objective: Increase the level of sustainability of HIV & AIDS programmes within the government development framework by 75%
Intervention: Achieve high level of sustainability of HIV & AIDS programmes within the governmental framework

Outcome Indicators	Baseline Value (year)	Performance Mid point (2012)	Target End Point (2015)	Type & Reference	Frequency	Source
Country Spending on HIV	1 M	2 M	4 M	UNGASS	Annually	Financial Report
National Composite Policy Index	60% (20008)	80%	90%	UNGASS	Every 2 years	UNGASS report

STRATEGIC AREA 6: STRATEGIC INFORMATION

Objective: Increase the level of effective and efficient generation and use of strategic information by government agencies by 70%

Intervention: Achieve high level of generation and use of strategic information by government agencies

Outcome Indicators	Baseline Value (year)	Performance	Target	Type & Reference	Frequency	Source
		Mid point (2012)	End Point (2015)			
# of completed biological, behavioural and research studies	4 (Annual NAD report, 2007)	8	12	World Bank	Annually	Annual NAD report

ANALYSIS OF PROGRESS FRAMEWORK, 2009-2015

Narrative Summary	Key Performance Indicators	Baseline	Target (2015)	Examples of Results and Comments
Objective 1: Reduce the number of new infections in the general population and vulnerable groups by 50%	% of sexually active population reporting consistent condom use during intercourse within the last 12 months	15-24: 42% 25-49: 53% (BSS, 2005)	15-24: 70% 25-49: 75%	Reports from the 2015Behavioural Surveillance Survey indicated ……
	% of sex workers reporting condom use during the last sexual intercourse with their clients	No data	50%	Reports from 2015 Behavioural Surveillance Survey indicated …….
	% of men reporting use of condoms they last time they had anal sex with a male partner	No data	10%	Reports from 2015 Behavioural Surveillance Survey indicated …….

National HIV & AIDS Strategic Plan Budget 2009-2015

No	Strategic Areas	Estimated Cost in US$
1	***Prevention***	
	Outreach Activities	$60,000.00
	PMTCT	$100,000.00
	Training	$70,000.00
	Youth-Friendly Centres (3)	$20,000.00
	Mass Media Campaigns (3 annually)	$200,000.00
	Community-based (NGO) activities	$250,000.00
	Community-based activities (Vulnerable/High-risk)	$200,000.00
	Condom campaign and distribution	$200,000
	Voluntary Counselling and Testing	$150,000.00
	Prevention of Mother to Child Transmission	$175,000.00
	Medical Waste Management	$50,000.00
		$1,475,000.00
2	***Stigma Reduction***	
	Training	$10,000.00
	Support for Innovative Projects	$15,000.00
	National Anti-Stigma and Anti-Discrimination Campaigns	$50,000.00
		$75,000.00
3	***Access to Treatment, Care and Support***	
	Provision of ARVs	$110,000.00
	Laboratory Support	$810,00.00
	Pharmacy Support	$70,000.00
	Training	$40,000.00
	Protocol Development	$30,000.00
	Health System Strengthening	$255,000.00
	Home-based care	$50,000.00
	Post-Exposure Prophylaxis	$50,000.00
		$1,415,000.00
4	***Strengthening Governance Systems***	
	Capacity Building	$22,000.00
	Research	$20,000.00
	Financial Auditing	$20,000.00
	National Health System Accounting	$15,000.00
	Preparation of annual and biennial reports	$10,000.00
	Information Technology Platform	$200,000.00
	Public and Private Sector Support	$100,000.00
	Technical and Administrative Support for National HIV & AIDS Response	$2,400,000.00
	Monitoring and Evaluation	$25,000.00
	Surveillance	$27,000.00
		$2,839,000.00
	Total	**$5,804,000.00**

The above table demonstrated the emphasis on prevention interventions. All other strategic areas each account for 15%-20% of the total cost.

Cost of the National HIV/AIDS Strategic Plan 2009-2015

The Cost estimates for the National HIV/AIDS Strategic Plan 2009-2015is estimated to be approximately US$6M.

Annual Cost of Implementation
Based on the continuation of the World Bank support of US$5.5M for the period 2003-2009, the annual cost for Year 1-Year 7 are as follows:

Priority Area	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**	**Total**
Prevention								
Stigma and Discrimination Reduction								
Universal Access to Treatment and Care Services								
Support for PLHIV and persons affected by HIV								
Governance and Institutional Systems								
Strategic Information								
Total								**US$6.0M**

The implementation of the National HIV/AIDS Strategic Plan 2009-2015 will be based on the activities already completed from 2003-2009. Most of the needed equipment and training were already undertaken during this period. The issue for capacity building continues in this new phase of 2009-2015.

Activities that require costing under the 6 Strategic Areas are as follows:

Strategic Area 1: Prevention:

- National Information, Education, Communication, Behaviour Change Campaign
- Education Sector HIV/AIDS programme
- HIV & AIDS Education in the Private Sector
- Community HIV/AIDS Education
- Special prevention programmes
    - Peer Education Support Programmes
    - Abstinence Programme
    - Faithfulness Programme
    - Promotion of Condoms
    - Voluntary Counselling & Testing
    - Prevention of Mother to Child Transmission

- Prevention and Control of Sexually Transmitted Infections
- Blood Safety
- Post Exposure Prophylaxis

Strategic Area 2: Stigma and Discrimination Reduction

- Legislation
- Advocacy Programmes against Stigma and Discrimination
- Mechanism for reporting human rights violation

Strategic Area 3: Universal Access to Treatment and Care Services

- Anti-retroviral therapy
- Medication for Opportunistic Infections
- Training
- Programme for treatment preparedness and treatment adherence programme
- Upgrading of health facilities
- Protocols for comprehensive clinical staging of PLHIV

Strategic Area 4: Support for PLHIV and persons affected by HIV & AIDS

- Support for Disaster Preparedness activities
- Support for Home-based care programme
- Support for orphans and vulnerable children
- Support for care and support programmes

Strategic Area 5: Governance and Institutional Systems

- National Health Accounting Assessment
- Framework for technical cooperation and external funding
- Management of the National Response to HIV & AIDS
- Financing mechanism for National Response to HIV & AIDS (health and non-health sectors and civil society)

Strategic Area 6: Strategic Information

- Monitoring and Evaluation activities
- Development of Information Technology Platform
- Implementation of Research agenda

METHODOLOGY

Each partner is integral to the national response with specific rights and responsibilities. The integration of partners and stakeholders into the National HIV & AIDS Response is a core strategy for achieving true multi-sectoral participation. Partners vary from government to civil society from individual to group, and from persons living with and affected by HIV and AIDS to service providers and policy makers. Influences at every level are also important to the national response to build and maintain strong leadership**.** A participatory approach was therefore employed to get buy in and involvement that will be necessary in the design and implementation of the new strategic plan.

An Oversight Committee was set up to ensure that the input into the plan reflects the peculiar needs of the country. This group consisted of:

- Director, National AIDS Directorate
- Director, National Infectious Disease Control Unit
- Representative, Ministry of Finance (Budget)
- Representative, Project Coordination Unit (Procurement and Supply Management)
- Monitoring and Evaluation Officer (Indicators and M&E activities)
- Representative, NGO sector
- Representative Network of PLWHA

Their role was primarily to:

- Supervise the process, including the production of deliverables based on the agreed upon time frame
- Ensure that the required technical and financial support is obtained within a reasonable time frame
- Ensure the National Strategic Plan is endorsed by the National AIDS Council and forwarded to the Cabinet for ratification

A series of Principals and Partners meetings were convened to encourage input into the Grenada National HIV & AIDS Strategic Plan 2009–2015. During those meetings consensus was achieved on many different issues including the vision, goals, priorities and the way forward with the national response. Overall it was established that a truly multi-sectoral approach would render better results in the Grenada National HIV & AIDS Strategic Plan 2009–2015, with proper reporting strategies which are clearly defined for each Ministry, the Private Sector and the community stakeholders through a robust monitoring and evaluation system.

The consultations were held with community groups and NGOs including PLWHA, representatives of marginalized groups such as men who have sex with men and sex workers, as well as service providers, a wide cross section of the faith based community, community leaders, programme managers, international agencies and policymakers. Stake holders were given the opportunity to review the findings of the Situation Analysis Report 2007, the UNGASS Report 2008, to receive information on the NAD and NIDCU, to review epidemiological data and existing initiatives to identify challenges and solutions to preventing and controlling HIV and AIDS. A first draft was prepared and reviewed and this revised draft was written by the oversight committee to address the short comings of the first draft.

Stakeholder Participation

In Grenada a stakeholder forum was conducted to ensure widespread public participation in the strategic planning process. The members of both the National AIDS Directorate (NAD) and the National Infectious Disease Control Unit (NIDCU) were intimately involved in providing input in the process. The sessions revealed that there was an opportunity for greater involvement of all sectors and that they were organizing themselves to fully participate in the national response.

Appendix 2: Universal Access Issues

Issues	Obstacle	Reasons
Bilateral and multilateral financing mechanisms need to be more predictable and sustainable		A truly multi-sectoral approach with a budget line established in each ministry will in the medium to longer term diminish dependence on outside funding.
Governments need to set aside set aside money in the national budgets		Government is finding difficulties in providing funding for all areas.
HIV strategic plans should have detailed targets		This is necessary and should be encouraged to facilitate robust monitoring and evaluation.
An HIV & AIDS policy linked to the National Strategic Plan		This is already actively being pursued.
Presently the country does not have the human capacity in place to mount comprehensive HIV services on the scale required		Steps must be taken to encourage training and attract more human resources.
National laws and regulations governing the training, roles and responsibilities of different health and social service professionals need to be amended to permit nurses, health assistants, counsellors and other professionals and non-professionals to carry out the greatest scope of work consistent with their professional capacities and expertise		The legal reform and drafting process can be protracted due to the limited human capacity as these laws are not assigned the highest level of national priority
Confidentiality within the public service.		This is hindered by cultural norms
Delivery of Service		This will improve with training and improved access to knowledge
Strengthening processes such as planning, systems management, procurement and supply management, coordination, and monitoring and evaluation		This can be improved if systems are reviewed and upgraded.
Maintaining a reliable, affordable, adequate supply of condoms, Other prevention technologies, quality medicines and diagnostics, and nutritional support to children and adults affected by AIDS.		This can be achieved though effective partnering.
Affordability and accessibility of current and emerging prevention and treatment commodities accessible		A very difficult issue for countries that do not have enough financial resources to invest in research and development and to procure the most up to date technology commodities.

Issues	Obstacle	Reasons
Strengthening procurement, supply and distribution systems to ensure continuous supplies of prevention and treatment commodities.		This can be improved if systems are reviewed and upgraded.
Ensuring adequate nutritional support is available for people affected by AIDS, in particular children and the most vulnerable		Unless there is a nutritional support programme for PLWHA
Silence, violence, and disparate power relations within the society		A major cultural shift will be required
Gender disparities and the low status of women		Women continue to empower themselves. No legal disparities.
Stigma and discrimination severely impede responses to AIDS, and deter people in need, and often those in greatest need, from gaining access to HIV prevention, treatment, care and support commodities and services on an equitable basis		A major cultural shift will be required
Criminalization of homosexuality		A major cultural shift will be required supported by revised laws
The perception that groups such as sex workers, drug users, prisoners and migrants do not deserve to have human rights		A major cultural shift will be required
Negative attitudes among health and social sector workers towards people living with HIV		A major retraining exercise focused on ethics could change this practice.

Appendix 3: Existing Governance Structure