Rapid Assessment of Sexual & Reproductive Health & HIV Policies, Systems & Services in Grenada

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Acronyms & Abbreviations

AIDS	acquired immunodeficiency syndrome
ANC	antenatal clinic
ART	antiretroviral therapy
ARV	antiretroviral
BCC	behaviour change communication
CARICOM	Caribbean Community
CBO	community-based organization
DMO	District Medical Officer
GNOW	Grenada National Organisation of Women
HFLE	Health and Family Life Education
HIV	human immunodeficiency virus
HRBA	human rights-based approach
IEC	information, education and communication
IPPF	International Planned Parenthood Federation
KAPB	knowledge, attitude, belief and practices
LACC	Legal Aid and Counselling Clinic
LGBTT	lesbian, gay, bi-sexual, transgender and transsexual
MoE	Ministry of Education
MoH	Ministry of Health
MoSD	Ministry of Social Development
MSM	men who have sex with men
NGO	non-governmental organization
NIDCU	National Infectious Disease Control Unit
NSP	National Strategic Plan
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PHC	primary health care
PITC	provider initiated testing and counselling
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
RHI	regional health institute
PSI	Population Services International
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TASO	The AIDS Support Organisation, Uganda
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organization

I. Introduction

1. Background

> The spread of the human immunodeficiency virus (HIV)—a pathogen transmitted in most cases by sexual activity—is a clear example of the urgency of tackling the issue of sexuality head on and understanding how it relates to the health and well-being of women and men and the population as a whole. *(PAHO, 2010)*

The lack of recognition of sexual health as important to health achievement has resulted in an uncoordinated approach to the prevention of sexual and reproductive ill health and morbidity. To date, responses to the HIV epidemic by both the international development community and national governments are still primarily biomedical. Specifically there is a concentration on treatment and care rather than on prevention and support services, which would both require increased emphasis on psychosocial programming for vulnerable groups.

The biomedical approach focuses on risk behaviour rather than on the social determinants or root causes of the HIV epidemic. It has not been widely recognized that the epidemic is in fact a product of a problematic approach to sexual and reproductive health – one that creates and perpetuates vulnerability. Cultural beliefs and attitudes related to gender and sexuality continue to permeate the fabric of social systems including the health sector, legal systems and governance frameworks in general.

With HIV infection rising to epidemic proportions around the world, including in the Caribbean, data clearly illustrate that its transmission is greatly influenced by – and in most cases primarily due to – socio-economic factors. These include gender inequalities, lack of respect for human rights and the corresponding complexity of issues related to sexual and reproductive health and rights (SRHR) and lack of access to comprehensive, gender-responsive and client-centred health care.

Primary health care (PHC) systems are tasked with responding to gender inequity and inequality and destructive gender norms and stereotypes that contribute to sexual and domestic violence, child sexual abuse, stigma and discrimination against people living with HIV/AIDS (PLWHA), homophobia, alcohol and marijuana misuse and other factors that promote vulnerability and increase the risk of sexually transmitted infections (STIs) including HIV. In this climate of sexual ill health, HIV transmission will not be stemmed without a comprehensive approach to SRHR policies, systems and service delivery.

The Programme of Action of the 1994 International Conference on Population and Development (ICPD) calls on countries to integrate comprehensive sexual and reproductive health (SRH) services into PHC systems. Subsequently, various definitions of integration have been proposed and corresponding operational concepts for integration have been suggested.

In 2009 evidence was published, as established through the Cochrane review, for the benefits of linking SRH and HIV and promoting bi-directional integration of SRH and HIV services (IPPF and others, 2009). The study, which was supported by UNFPA and the World Health Organization (WHO), serves as the foundation of UNFPA's work in the area.

The rationale for integration and/or 'linkages' is to increase the effectiveness and efficiency of the health system and to meet people's needs for accessible, acceptable, convenient, client-centred and comprehensive care. This should include prevention of ill health, provision of information and counselling, screening, diagnosis and curative care and/or referral for a full range of SRH and other health-care needs.

To support the above, UNFPA Sub-Regional Office for the Caribbean facilitated a regional consultation 'Caribbean Partnership for Achieving Universal Access to Reproductive Health by 2015: Linking SRH and HIV/AIDS', held from 29 September to 1 October 2008 at the Knutsford Court Hotel, New Kingston, Jamaica.

The objectives of the consultation were to:

1. Develop strategies to achieving universal access to SRH in the Caribbean;
2. Build capacity in SRH and HIV linkages;
3. Determine the most appropriate strategies and approaches to strengthen bi-directional linkages of SRH and HIV.

The consultation also included a review of the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages.[1]

In the follow up to the regional consultation, at which Grenada was represented, the UNFPA Sub-regional Office for the Caribbean undertook this rapid assessment of SRH and HIV policies, systems and services in that country.

2. Methodology

Introduction

This rapid assessment was undertaken from August to November 2010 and included within that period research, interviews and report writing.

The goal of the assessment was to assess and document:

1. Country progress towards universal access to sexual and reproductive health (SRH) achievement in Grenada, including the status of bi-directional integration of SRH and HIV services;
2. The policy, systems and services challenges to achieving universal access to comprehensive SRH services; and

[1] The Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages can be found at several Internet sites including: http://www.unaids.org/en/AboutUNAIDS/PolicyAndPractice/SexualAndReproductiveHealth/

3. Recommendations to assist policy makers, planners and service providers in the development of a National Strategic Plan on Sexual and Reproductive Health and Rights Achievement for Grenada

Adjustment in the focus of the assessment

Given the preliminary findings garnered from interviews with policy makers and planners at the Ministry of Health (MoH) and through the desk review, it became clear that universal access to SRH in Grenada required further support. As a result, bi-directional integration of SRH and HIV services was limited. It was therefore agreed that a comprehensive review of primary health care (PHC) policies, systems and services for supporting universal access to SRH services should be the main focus of the assessment.

Data collection process

A consultant was hired to conduct a literature/desk review, undertake country-based field research and write the corresponding report. The UNFPA Technical Advisor on Reproductive Health collaborated with the contracted consultant to conduct interviews and focus groups with health practitioners to determine the quality of SRH and HIV clinical services delivery in Grenada.

Preliminary findings from the desk review informed further assessment of the clinical service delivery context. The desk review included analysis of data collected from relevant documents and feedback from semi-structured interviews with policy makers and planners in the MoH and persons from the non-governmental sector. This was to determine (1) the current policy, systems and services context in Grenada for SRH and HIV services and (2) whether bi-directional integration of these services was part of the written policy and planning framework at the MoH.

A total of ten health facilities were visited in four of Grenada's six parishes to further support information gathered on the clinical services delivery context in the preliminary findings. Six of these facilities were located in St. George, two in Carriacou, one in St. Patrick and one in St. John.[2] Of these four were operated by the MoH, one was private and one was a non-governmental organization (NGO). The MoH operates thirty-three medical stations, six health centres and two hospitals on Grenada, and one health centre, one medical station and one hospital on Carriacou. The number of privately operated health facilities in the country was not ascertained for the conducting of this report. No NGOs currently provide in-patient care.

A total of 15 clients were surveyed, whose ages ranged from 23 to 47 years and who were primarily women receiving prenatal care. Four clients were accessing services in St. George, four in St. Patrick, three in Carriacou, two in St. John and two in St. David. All clients receiving care were living in the parish in which the health facility was located except one person accessing care in St. David who was from St. Andrew, the neighbouring parish.

[2] Grenada is divided into seven parishes: St. Andrew, St. David, St. George, St. John, St. Mark, St. Patrick and Carriacou. The capital city, located in St. George, is St. George's.

Two focus groups were also conducted with health practitioners (primarily nurses), one in St. George and one in Carriacou.

Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages

Guidance for the acquisition and analysis of data included the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages. This tool was developed through a consultative process that included feedback from the International Planned Parenthood Federation (IPPF), UNFPA, WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Network of People Living With HIV and AIDS (GNP+) and Young Positives.

The 2008 regional consultation mentioned in the previous section included a review of the tool with the goal of familiarizing participants with its use at national level.

The tool defines three areas of assessment:

1) POLICY: Aim to determine the level and effectiveness of linkages between SRH and HIV-related policies, national laws, operational plans and guidelines. This should also indicate the political commitment to SRH and HIV services integration.

2) SYSTEMS: Aim to determine to what extent systems support effective linkages of SRH and HIV. Systems include: (i) partnerships between national (including civil society), regional and international bodies; (ii) planning, management and administration; (iii) staffing, human resources and capacity development; (iv) logistics/supplies; (v) laboratory support; and (vi) monitoring and evaluation

3) CLINICAL SERVICES: Aim to determine the extent to which HIV services are integrated into SRH services and SRH services are integrated into HIV services. Services should include those run by government, AIDS organizations, faith-based organizations, NGOs and the private sector. Are there gender-specific targeted programmes?

Each area of assessment includes guiding questions and recommends specific documents for review and analysis.

At the onset of this assessment, the consultant undertook a gap analysis of the Rapid Assessment Tool and adapted Health Services Checklists for LGBTT [lesbian, gay, bi-sexual, transgender and transsexual] and non-gay identifying men who have sex with men (MSM) and for Youth Communities, including youth with disabilities, to address the gaps noted in reference to access to quality of care for these populations (see Appendix 2).

In-country data collection

A desk review was conducted and semi-structured interviews were held with persons in policy, planning and management of service delivery. Interview respondents were primarily from the MoH, followed by input from persons in the Ministry of Education (MoE) and the Ministry of Social Development (MoSD). Interviews were conducted over a four-day period.

Clinical service delivery was assessed through structured interviews with doctors, nurses and other health-care providers, client exit interviews and focus groups. Interviews were conducted over a four-day period.

Data collection instruments

1) The Health Services Checklist for the LGBTT Community and Health Services Checklist for Youth, administered to health service personnel at health centres and medical stations;
2) Data collection questionnaire from the Rapid Assessment Tool for SRH and HIV Linkages, administered to district medical officers (DMOs) and nurses for clinical service delivery;
3) Data collection questionnaire from the Rapid Assessment Tool for SRH and HIV Linkages Client Exit Interviews administered.

National documents reviewed included: national policy, legislation, protocols and assessments; and governmental and non-governmental service provider reports, policies, protocols, ethical guidelines and assessments. For a more expanded list see Appendix 3.

Analytical approaches

Human rights-based analysis and approach

A human rights-based approach (HRBA) to health reflects the principles of respect for the dignity and worth of each person and the universality of human rights. This approach requires that human rights legislation and principles be fully integrated into the design and implementation of all health projects. This includes, for example, incorporating the empowerment of poor people into approaches to tackling poverty (Molesworth and others, 2005).

Human rights-based analysis will identify the gaps that create vulnerability and/or limit the access of vulnerable groups to services as a result of either (i) social sanctions in the form of stigma and discrimination or (ii) legal sanctions in the form of legislation and adopted policy and will promote an HRBA to SRH and HIV services integration.

Vulnerable groups addressed in this rapid assessment were:

a. Sexual minorities (non-gay identifying men who have sex with men (MSM); self-identified transgender
   women and men; self-identified gay, lesbian and bi-sexual women and men; sex workers)
b. Women and girls
c. Young boys and girls (in and out of school)
d. Differently-abled persons (people with disabilities)

Gender analysis

As gender inequality and gender relations are structural determinants of HIV and sexual and reproductive ill health, gender analysis is critical. This means the identification and examination of the differential needs and vulnerabilities of women, men, girls and boys and the relationships between and among them. For the purpose of this assessment, gender analysis focuses on the identification and

examination of differential needs and vulnerabilities of groups that are marginalized in the provision of and access to SRH and HIV services as a result of their gender, expressions of their sexuality and sexual practices.

Gender analysis will be used in the report to:

- Examine the policy, systems and clinical service delivery approaches to service provision as these pertain to the SRHR of HIV-positive and non-HIV-positive women, men, girls, boys, self-identifying and non-self-identifying sexual and gender minorities who engage in diverse sexual activities/practices, injecting drug users, sex workers and persons who are physically and/or mentally differently-abled

- Examine the gender-based differentials to be taken into account in the process of integration of SRH and HIV services

3. Limitations and Challenges

Desk review

The desk review was characterized by a fragmented response to requests for documentation on the SRH and HIV policies, systems and service delivery context in Grenada. In some cases strategic planning documents were being reviewed and so there were no current documents; in other cases written policy was not available and reports were either in the process of being written or data had not been collected that could provide accurate information. Some requests were not followed up.

Additionally, several documents stated advancements in the delivery of PHC and HIV services that were found to be inaccurate during the research. More specifically, there was a greater emphasis on quantitative assessment of clinical service delivery in national and donor-driven reports than on qualitative assessment. For example, in a report on the status of scaling up universal access to SRH and HIV services, value is placed on the number of sites available for service provision rather than on the efficient functioning of those sites as a measurement of success. Reports have not included capacity needs assessments of health centres and medical stations, and there was limited to no information accessible on the consistency and quality of service provision.

Semi-structured interviews

Interviews were conducted during working hours and persons were limited in the time they could take away from their job responsibilities.

Challenges with data collected in interviews included receiving conflicting information at times from respondents, and in some cases persons were reluctant to speak about the policy development and adoption process. Some individuals were guarded about providing job descriptions and giving critical perspectives on decision-making and general systems-related processes. People often provided referrals to others who in turn would refer back to the person originally identified to provide information requested. In some cases persons articulated feeling overwhelmed at having to provide

documentation on policies and procedures. This seemed most common with those who had recently assumed positions, reportedly with little orientation. Some respondents also reported uncertainty about what policies they were supposed to be implementing, especially as these pertained to the clinical service delivery context. Generally, there was a lack of comprehensive information given and limited time for in-depth interviews and the pursuit of additional sources of information.

Clinical service delivery interviews

a) Client exit interviews

As the data collection tool had not previously been tested in Grenada, it is arguable that interview responses were influenced by the interviewer's increasing comfort using the tool. Questions were repetitive, making the process time-consuming, and the language used was not always accessible. For example, although questions asked about service delivery according to facility and according to service provider, it became apparent that clients interpreted these as the same thing. Indeed, in the Grenada context the distinction is not clear. As the tool had not been modified for country-specific use, it was not known at the outset what components were more or less applicable. Additionally, spaces for conducting client exit interviews in most cases were not private.

b) Health practitioner interviews on the service delivery context

As above, the tool was found repetitive and therefore made the process unnecessarily time-consuming.

c) Focus group interviews on the service delivery context

The focus group interviews garnered unreliable data as (1) only one interview questionnaire was used per group, which suggests the unlikely possibility that there was group consensus on all questions, and (2) the same data collection tool was used for the focus groups was used for health practitioners. Therefore while the goal of conducting the focus groups was to facilitate deeper inquiry into service delivery, the data appears simply as another individual response from another health practitioner.

Representation of marginalized populations

The Rapid Assessment Tool did not adequately address service provision for marginalized groups. Client exit interview questions did not address issues of sexual practice, and as targeted clinical services are not provided for sexual minorities, for example, it was not possible to access these persons in representative numbers for interviewing. Due to time constraints, it was difficult to get access to them either through NGOs working with gender and sexual minorities.

A gap analysis of the Rapid Assessment Tool was conducted for sexual and reproductive health and HIV linkages to:

i) facilitate awareness of the limitations of the Rapid Assessment Tool before undertaking stakeholder interviews/consultations; and
ii) identify documentation required for as thorough as possible desk review on the policy and service delivery context on SRH and HIV in Grenada.

Key gaps identified in the tool were:

Foundational gaps

- The approach of the Rapid Assessment Tool is a risk rather than vulnerability model and therefore promotes a biomedical approach to the integration of SRH and HIV services. The definition of risk and vulnerability provided should note that vulnerability is the presence of a pre-existing condition that promotes an environment of risk for an individual or community of people, not merely a condition that is out of the control of an individual or community.

- Gender inequality is not mentioned as a pre-existing structural determinant of HIV and sexual and reproductive ill health, while poverty, un-equal access to services and other structural determinants are. As gender inequality is one of the causes of poverty and the consequent inequity in accessing services, and also determines the behavioural conditions under which men and key vulnerable populations do not access care, it bears mentioning.

- While a working definition of SRH programmes is provided, a working definition of SRH is not. Defining SRH is important as this directs the development and implementation of required services.

- Harm reduction is referenced but not defined. Considering the implications for service provision, it should be.

SRH services gaps

- There is a focus on services related to reproductive health and not enough on sexual health.
- Sexual health services addressed in the rapid assessment should include mental, physical and social health services related to the protection of bodily integrity and sexual safety, sexual health and gender, sexual health and sexual orientation, sexual health and emotional attachments/relationships, sexual health and reproduction and sexual health and eroticism.
- Following on the above points, psychosocial support should also be addressed in the context of services for the promotion of healthy sexuality development.
- A key population that must be considered in relations to SRH is persons with mental and physical disabilities and this should be specified in the tool.
- Services for in- and out-of-school youth should be addressed and in- and out-of-school youth should be specified as separate target groups.
- The tool does not target socio-economically marginalized populations.

I. Conceptual Framework

1. Key Terms and Definitions

TERMS	DEFINITIONS
Gender	Gender refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relationships between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities. Gender is part of the broader socio-cultural context. Other important criteria for socio-cultural analysis include class, race, poverty level, ethnic group and age. (UN Women, www.un.org/womenwatch/osagi/conceptsandefinitions.htm)
Gender Identity	Gender identity is understood to refer to a person's deeply felt internal and individual experience of gender (which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of personal appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms. (Yogyakarta Principles: the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity, www.yogyakartaprinciples.org/principles_en.pdf)
Gender, human rights and autonomy	The autonomy of women, men, girls and boys in both private and public life is an essential factor in ensuring the enjoyment of their human rights. The ability to generate their own incomes and to control assets and resources (economic autonomy), have control over their own bodies (physical autonomy) and fully participate in the decisions affecting their lives and their community (autonomy in decision-making) are the three pillars of gender equality and citizenship with parity. (Adapted from the Economic Commission for Latin America and the Caribbean (ECLAC)) Gender, human rights and autonomy.
A human rights-based approach (HRBA)	A human rights-based approach reflects the principles of respect for the dignity and worth of each person and the universality of human rights. In the area of health, this approach requires that human rights legislation and principles be fully integrated into the design and implementation of all health projects.
Gender analysis	The identification and examination of the differential needs and vulnerabilities of women, men, girls, boys and the relationships between and among them. In the context of this assessment, it looks at their access to and the constraints they face in terms of SRH and HIV services.

I. Conceptual Framework

1. Key Terms and Definitions

TERMS	DEFINITIONS
Comprehensive sexual and reproductive health care	The constellation of methods, techniques and services that promote the complete physical, mental and social wellbeing of individuals in all matters relating to the sexual and reproductive system and its functions and processes. (1994 Programme for Action, Cairo, www.iisd.ca/cairo.html)
Sexual orientation	Sexual orientation is understood to refer to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender. (Yogyakarta Principles)
Sexuality	Sexuality refers to a core dimension of being human that includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/ love and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles and relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors. While sexuality can include all of these aspects, not all of these dimensions need to be experienced or expressed. However, in sum, our sexuality is experienced and expressed in all that we are, what we feel, think and do. (PAHO and WHO 2000)
Heterosexual	Sexual orientation or preference for persons of the opposite sex.
Homosexual	Sexual orientation or preference for persons of the same sex.
Bisexual	Sexual orientation toward sexual relations with both sexes.
Transgender	The gender identity of transgender persons differs from that usually associated with their birth/biological sex. In other words, they prefer to express themselves in the other gender.
Transsexual	Transsexuals are transgender people who wish to live full time as members of the gender opposite to their birth sex. They usually seek changes in their physical body to match their gender identity through gender reassignment surgery and hormone treatment.
Sexual activity	Sexual activity is a behavioural expression of one's sexuality where the erotic component of sexuality is most evident. Sexual activity is characterized by behaviours that seek eroticism and synonymous to sexual behaviour. Sexual practice is a pattern of sexual activity that is exhibited by an individual or a community with enough consistency to be expected as a behaviour. (PAHO and WHO 2000)

I. Conceptual Framework

1. Key Terms and Definitions

TERMS	DEFINITIONS
Safer sex	Safer sex is a term used to specify sexual practices and sexual behaviours that reduce the risk of contracting and transmitting sexually transmitted infections, especially HIV. (Ibid.)
Responsible sexual behaviour	Responsible sexual behaviour is expressed at individual, interpersonal and community levels. It is characterized by autonomy, mutuality, honesty, respectfulness, consent, protection, pursuit of pleasure, and wellness. The person exhibiting responsible sexual behaviour does not intend to cause harm and refrains from exploitation, harassment, manipulation and discrimination. A community promotes responsible sexual behaviours by providing the knowledge, resources and rights individuals need to engage in these practices. (Ibid.)
Social determinants of health	The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. (World Health Organization (WHO), www.who.int/social_determinants/en/)
Health literacy	The ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course. (Rootman and Gordon-El-Bihbety, 2008)
HIV vulnerability	The existence of pre-existing conditions that increase the likelihood of HIV infection – for example, economic situation and gender roles and expectations.
HIV risk	Actions and behaviours such as having unprotected sex with multiple partners.
HIV seropositive	Having traces of HIV antibodies in blood (i.e., infected with HIV), but without symptoms.
Harm reduction	In public health "harm reduction" is used to describe a concept aiming to prevent or reduce negative health consequences associated with certain behaviours. In relation to drug injecting, "harm reduction" components of comprehensive interventions aim to prevent transmission of HIV and other infections that occurs through sharing of non-sterile injection equipment and drug preparations. (WHO definition)

2. The Need to Strengthen Primary Health Care Systems to Promote SRH

At the onset of this assessment, an HIV-positive man was interviewed at the Grenada National Infectious Disease Unit after receiving his treatment. The following is his testimony of some of his experiences.

"There are people who are doing HIV counselling and treatment and they tend to have a discriminative spirit within them against people living with HIV. They tend to look at people living with HIV as people being promiscuous, they think it is a curse from God ... if people educate themselves, because education is everywhere, I think that everything will be different. People's frame of mind will see HIV as a disease as everything else, like cancer etc. Not as a curse.

People tend to look at HIV and homosexuals in the same context .... they say that most women who get HIV get it from a bi-sexual man, or down low men. I think that this is where discrimination is built. When I first discovered that I was HIV-positive, being involved with homosexuals and committed homosexual acts, I always had it mind to get tested. A few years ago in 2007 I met someone and had sex and the condom was broken, and I heard on the street that they were HIV-positive. This was in Grenada with an Antiguan friend. The funny thing is I got tested early and it came out negative. In December last year I had another test and it was positive, but I am not sure at what time, or when or who.

A lot of HIV-positive persons who are on treatment will tell people they are diabetic. I have heard people say that if they acquire HIV they will transmit to others. Everybody has the responsibility to protect themselves and to protect others.

Sometimes the people you come across seem so innocent, you tend to feel this person is not promiscuous, you tend to feel safe and trust. Some people, sometimes, most people who are infected think it's ok, we don't bound to use condoms ... and there are others who feel they don't want to use condoms they just wanna have raw sex.

The nurse asked me if I had sex with men and I denied it, because I know where I live, that in my country people are quite homophobic. I just think they would have looked at me as a whole different person. They tell me to protect myself and use condoms.

I found out in December last year. I just got up one morning and I was mentally prepared for the results. Maybe because prior to this I went to HIV workshops and got educated. I went to the workshops maybe because I love getting education, I just went. Maybe God allowed me to go. He probably knows the future and he knew what would happen to me. He probably prepared me then for now."

How did you find out about these workshops?

> "After I was in Antigua and found out my friend was [HIV positive}, he used to go to them. When I got back to Grenada, I went to GrenCHAP meetings. I don't think that if staff at the clinic knew my sexual practices that they would discriminate against me. My mother knows. I told her actually spiritually before I got tested. I got tested last year November. My Mom told me that she had a dream that her preacher told her that I was very sick and needed a transplant. I told my pastors and she told me that I have support, and I believe in healing. I do pray that God will heal me so that I can minister to others. If he wants God will heal me, but I am not scared, I'm going through this thing and I am not scared.
>
> When my results came, the nurse and one of the counsellors drove up to find me to tell me the results. She told me she's gonna be there for me. The information is confidential, she told me. She told me I had a lot of support. She called me all the time.
>
> No one in my community suspects. I wouldn't tell them, trust me. I know my community, once they have that information they would do anything to bring me down. Trust me, my name would be in the news. I am not prepared for that.
>
> Since people being carnal minded, and where people don't educate themselves they just don't get it. The discrimination, it's just like leprosy in the Bible time, you an outcast. They send you into exile. I think that some of these people, if they had a chance, they would send HIV-positive persons into exile. Some people die in really sad ways when they are HIV-positive, when you do not have your loved ones by your side to help you through this. The worst is when you don't have your family by your side to go through this with you I heard stories about people in the hospital, weak, and the nurses won't touch them.
>
> I believe in the Bible and its word, then why am I having those feelings? I cry to God and ask those questions. It is a spiritual battle, whether it is right or wrong, and you wanna get out, and people are struggling with it."

This client expressed happiness at being able to give an account of his experience. He was very forthcoming with information and expressed a strong desire to help others in a similar situation. His story expresses some of the challenges and discrimination faced by people living with HIV/AIDS.

Over the years humanity's understanding of health has evolved to recognize that health achievement requires attention to the connection and positive balance between the mind, the body, the social environment, physical living circumstances and the natural environment. The World Health

[3] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948

Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[3] This definition of health has not changed since 1948 and is used to guide the development of health achievement policies, systems and services globally.

Health both individual and societal depends on the development and implementation of a human rights-based and health-centred approach to human development. Primary health care (PHC) advocates argue for health policies in all sectors, government and non-governmental. PHC systems incorporate the social determinants of health as a framework for developing policy, systems and services structures and as a way to respond to the needs of marginalized populations, such as the client above, with the ultimate goal of reducing their vulnerability. This ensures human rights-based approaches to health achievement, which in turn safeguard the sustainability and effectiveness of health policy and corresponding systems and services.

The overarching approach to health achievement in Grenada is response-based rather than preventative care, as facilitated within the limits of existing services. Prevention of sexual and reproductive ill health and morbidity and HIV centres around public education focused on risk behaviours and is targeted primarily at young people in the school system, pregnant women, mothers and persons who are already 'in care'. In other words, prevention education targets already captive audiences. Interview respondents confirmed that most prevention education addresses populations who are easily accessed, not necessarily the most marginalized and their particular vulnerabilities. Health promotion for behaviour change concentrates on identifying risk rather than diagnosing vulnerability to ill health. This almost certainly ensures that in health achievement, prevention efforts are always one step too late. Furthermore, the limited human and financial resources available in the public health system deprive clients of preventative health care and limit the capacity of existing health practitioners to spend more time with clients, expand hours of operation or target vulnerable and marginalized groups for more inclusive service delivery.

The recommendations put forward in this report promote the placement of HIV prevention, treatment, care and support as a component of an overall investment in sexual and reproductive health and rights (SRHR) in Grenada. It advocates for the strengthening of PHC with a focus on the development of a national strategic plan in this regard.

3. International Recognition of the Importance of SRHR

The Pan American Health Organization (PAHO) in collaboration with the World Association for Sexology (WAS) held a consultation on sexual health promotion and maintenance, and the role of the health sector in achieving this, which identified a number of key developments concerning sexual health in the past 25 years including:

- Advances in knowledge about different aspects of human sexuality through theoretical inquiry, biomedical, psychological, sociological and anthropological research, epidemiological surveillance and clinical work.

- The emergence of the HIV pandemic and increased awareness of the impact of other sexually transmitted infections (STIs), the effective control of which relies on successfully changing the behaviours and sexual practices of people. The ability to promote behavioural change is, therefore, highly dependent on an adequate understanding of human sexuality.
- Formation of a solid body of knowledge originating in the writings and views of feminist scholars. This knowledge indicates that societies are articulated and regulated by a complex and pervasive set of rules and assumptions that permeate their every aspect and the very construction of knowledge. The gender perspective has shown that any consideration of human sexuality cannot be complete if it ignores the cultural concepts of "masculinity" and "femininity" (Dixon, 1996)
- Definition and consolidation of the field of reproductive health. In particular, the priority consideration given to reproductive health, including sexual health, in the Programme of Action of the International Conference on Population and Development (ICPD) (United Nations, 1995).
- Recognition of violence, including sexual violence, especially against women, children and sexual minorities, as a serious public health issue.
- Recognition of sexual rights as human rights. Sexual rights have been explicitly recognized and stated by groups such as the International Planned Parenthood Federation (IPPF,1996) and the World Association for Sexology (WAS, 1999). However, sexual rights have often only been recognized in their reproductive dimension. A more comprehensive stance needs to be taken to achieve full recognition of sexual rights.
- Increased advocacy by social movements for recognition, respect and the protection of the rights of "minorities" (such as gay, lesbian and transgender individuals.)
- Development of effective and safe medications to modify and improve the sexual functioning of individuals. This has prompted renewed interest in the prevalence and consequences of sexual dysfunctions and compulsive sexual behaviour. (PAHO and WHO, 2000)

SRHR are included within the human rights that are already recognized in national laws and international human rights documents (PAHO 2010). They include the rights of all people, free from coercion, discrimination and violence, to:

- Reach the highest standards of sexual health including access to sexual and reproductive health care;
- Seek, receive and issue information related to sexuality;
- Receive education on sexuality;
- Have their physical integrity protected and respected;
- Elect freely their partners;
- Decide to be sexually active or not;
- Engage in consensual sexual relations;
- Establish marriage ties consensually;
- Make decisions concerning having children and when to do it; and

- Try to have satisfactory, safe and pleasant sexual activity. (PAHO, 2010)

Reproductive health is defined in the ICPD Programme of Action as:

> "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes." "It implies therefore that people are able to have a safe and satisfying sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. It also includes sexual health, the purpose of which is the enhancement of life and personal relations." "Reproductive rights embrace certain human rights already recognized in international laws and human rights documents. They rest on the recognition of all people to decide freely and responsibly the number, spacing and timing of their children, free of coercion, discrimination and violence."

The ICPD Programme of Action also:

- Calls for the integration of STIs and HIV/AIDS prevention into sexual and reproductive health services;
- Recommends that governments take action to prevent and reduce the spread of HIV/AIDS through awareness campaigns emphasizing behavioural change;
- Seeks to ensure that people living with HIV/AIDS receive adequate medical care and are not discriminated against;
- Recommends further actions for governments to prevent and treat HIV/AIDS specifying that sex, age and other factors need to be recognized in prevention and education programmes;
- Recommends that special attention be given to the prevention of sexual exploitation of young women and the reduction of mother-to-child transmission. (ECLAC and UNFPA, 2003)

International human rights instruments and guidelines that support SRH and the rights of persons living with HIV (PLHIV) include:

- Programme of Action of the 1994 International Conference on Population and Development (ICPD)
- Universal Declaration of Human Rights (UDHR)
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- International Covenant on Civil and Political Rights (ICCPR)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Covenant on the Rights of the Child (CRC)
- United Nations Convention of the Rights of Persons with Disabilities
- United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities

Furthermore, respect for SRHR is imperative to health achievement, while violations of these rights have severe implications for the health of individuals and communities. Some of SRH needs are highlighted in Table 1.

Table 1. SRH needs related to access to SRHR
BODILY INTEGRITY AND SEXUAL SAFETY • Health-promoting behaviours for early identification of sexual problems (e.g., regular check-ups and health screening, breast and testicular self-exam) • Freedom from all forms of sexual coercion such as sexual violence (including sexual abuse and harassment) • Freedom from body mutilations (i.e., female genital mutilation) • Freedom from contracting or transmitting sexually transmitted infections (including but not limited to HIV and AIDS) • Reduction of sexual consequences of physical or mental disabilities • Reduction of impact on sexual life of medical and surgical conditions or treatments
EROTICISM • Knowledge about the body, as related to sexual response and pleasure • Recognition of the value of sexual pleasure enjoyed throughout life in safe and responsible manners within a values framework respectful of the rights of others • Promotion of sexual relationships practice in safe and responsible manners • Fostering of the practice and enjoyment of consensual, non-exploitive, honest and mutually pleasurable sexual relationships
GENDER • Gender equity • Freedom from all forms of discrimination based on gender • Respect and acceptance of gender differences
SEXUAL ORIENTATION • Freedom from discrimination based on sexual orientation • Freedom to express sexual orientation in safe and responsible manners within a values framework respectful of the rights of others
EMOTIONAL ATTACHMENTS • Freedom from exploitative, coercive, violent or manipulative relationships • Information regarding choices of family options and lifestyles • Skills, such as decision-making, communication, assertiveness and negotiation, that enhance personal relationships • Respectful and responsible expression of love and intimacy • Prevention and appropriate care of couple maladjustment and distress • Appropriate management of separation and divorce

REPRODUCTION

- Make informed and responsible choices about reproduction
- Make responsible decisions and practices regarding reproductive behaviour regardless of age, gender and marital status
- Access to reproductive health care
- Access to safe motherhood
- Prevention and care for infertility

Adapted from PAHO and WHO, 2000.

II. Grenada Health System: National and Regional Structures and Influences

1. Political Profile of Grenada

"Grenada gained independence from Britain in 1974 and is an independent nation within the British Commonwealth. Her Majesty, Queen Elizabeth II is the Head of State and is represented locally by the Governor General, who is appointed on the advice of the Prime Minister. Grenada has a Westminster style Parliamentary form of Government. The Parliament which exercises legislative power consists of the House of Representatives and the Senate. Executive power lies with the Prime Minister and his Cabinet. General Elections are held every five (5) years."

"Approximately 108,132 (est. 2008) people inhabit Grenada, including the 6,521 inhabitants of Carriacou and Petit Martinique. The nation's citizens are primarily of African, East Indian and European descent, with the largest proportion of the population, approximately 75%, of African descent. Grenada is an English-speaking nation".[4]

2. Grenada Public Health System

Like the rest of the Caribbean, public health management in Grenada follows the World Health Organization (WHO) model for primary health care (PHC).

The fundamental goal of PHC is to the achievement of health equity or "health for all" through:

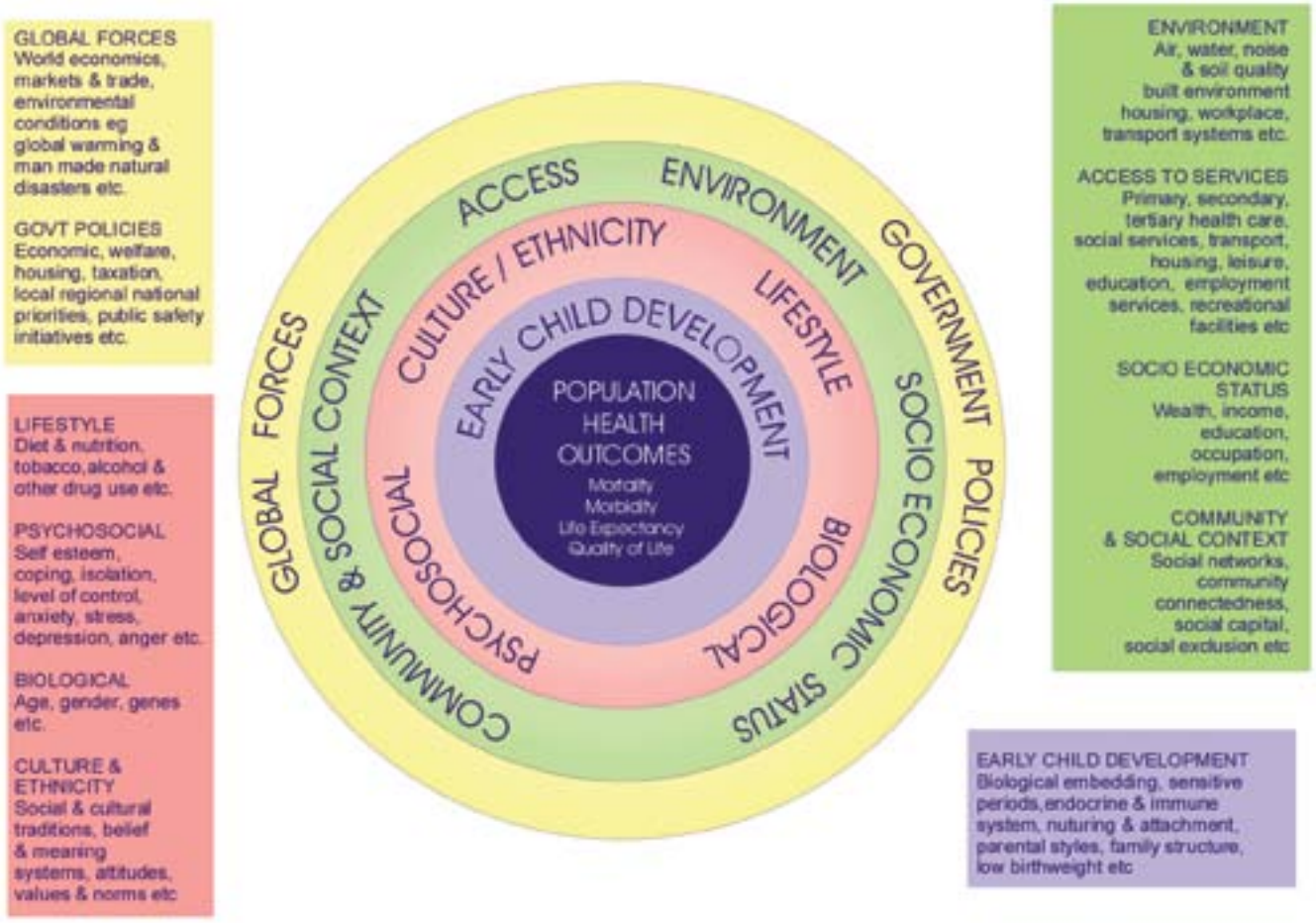
- Reducing exclusion and social disparities in health (universal coverage reforms);
- Organizing health services around people's needs and expectations (service delivery reforms);
- Integrating health into all sectors (public policy reforms);
- Pursuing collaborative models of policy dialogue (leadership reforms);

"The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health." *(CSDH 2008)*

WHO models for PHC incorporate attention to the social determinants of health for the achievement of health equity. This ensures that health is a central point of individual, community and national development. A comprehensive model of the social determinants of health is shown in Figure 1.

[4] Government of Grenada official website: http://www.gov.gd/about_grenada.html

Figure 1. Social determinants of health model



Source: Lloyd and others, 2004, p. 19.

In Grenada, most health service is provided through the public sector. There have been efforts to decentralize PHC, and services are delivered through 33 medical stations, 6 health centres and 2 maternity units. The majority of secondary health-care services are centralized at the General Hospital in the capital, St. George's.

Additionally, there are two other public sector hospitals: Princess Alice in the rural district of St. Andrew and Princess Royal on the island of Carriacou. There is one private hospital in St. Paul that offers in-patient services inclusive of maternity care. There are also one public and two private laboratories and a diagnostic facility. No NGOs currently provide in-patient care (NIDCU, 2010). Additionally, there is a psychiatric hospital, Mount Gay Hospital, and a psychiatric unit attached to the General Hospital, one rehabilitation centre and a home for the elderly (Government of Grenada, 2006).

The Grenada Ministry of Health Corporate Plan 2009 states its philosophy as "A Primary Health Care Approach using Health Promotion Strategies", and identifies the following key stakeholders:

- General public (well and sick, employed and unemployed, rich and poor)
- Physically challenged
- Mentally challenged
- All institutions of learning
- All local, private, public sector organizations
- Non-governmental organizations
- Other Ministries and Departments

While the Corporate Plan does identify important gaps to be filled in several areas – including strategic planning, health information systems, procurement and clinical services – there is no document outlining the implementation process and no report accessible on the progress made to date. Later on in this report it will become clear that while the plan is for 2009, many of the gaps identified are still relevant.

Furthermore, SRH does not feature in the Corporate Plan for 2009 while mental health, for example, does. Opportunities to address inequity and inequality in the health system are not explored comprehensively; for example, community services enhancement under the plan does not include capacity-building on service provision to socio-economically marginalized populations, that is, populations in the greatest need of health care.

The National Strategic Plan (NSP) for Health 2007–2011: "Health for Economic Growth and Human Development", while in draft form since December 2006, is seen to be the principle guidance for health service system policy and planning by the MoH.

The health issues, systems and services priorities outlined in the draft NSP are shown in Table 2.

Table 2

5.2 HEALTH ISSUES

5.2.1 - Non-communicable Diseases - Chronic (selected)
5.2.2 - Non-communicable Diseases - Acute (selected)
5.2.3 - Non-communicable Diseases - Cancer
5.2.4 - Non-communicable Diseases - Mental Health
5.2.5 - Communicable Diseases
5.2.6 - Reproductive and Child Health
5.2.7 - Health Care of the Elderly
5.2.8 - Accidents and Injuries
5.2.9 - Occupational Health

5.3 HEALTH SERVICE ISSUES

5.3.1 - Quality of Care
5.3.2 - Community Health Services
5.3.3 - Hospital Services
5.3.4 - Specialist Services

5.4 MANAGEMENT AND HEALTH SYSTEMS

5.4.1 - Health System Structure and Functions
5.4.2 - Management of Health System (Public Sector)
5.4.3 - Legislative Framework
5.4.4 - Health Planning
5.4.5 - Procurement and Inventory Management – Drugs, Medical Supplies and Other Supplies

Source: Government of Grenada, 2006.

The MoH's Policy and Planning Unit is primarily responsible for oversight of planning and quality assurance of health service delivery. Interview respondents indicated that the unit reviews proposed policies and makes recommendations for improvement and adoption. There is currently no monitoring and evaluation officer for the unit, which is staffed by the Chief Planner.

Table 3. Policy and Planning Unit: areas of responsibility (according to the provided organogram)
1) The National Infectious Disease Control Programme (NIDCP), which houses services for respiratory diseases, food-borne diseases, TB, leprosy and others, HIV/AIDS, STIs, vaccine-preventable diseases and vector-borne diseases
2) The National Non-communicable Disease Control Programme (NNDCP), which houses services for blindness; cancers; sickle cell; asthma; dental health; mental health; injuries and violence; drugs, alcohol and tobacco; nutrition, anaemia and obesity; diabetes, hypertension and cardiovascular diseases
3) All other health-related states and events
4) Target groups are linked to planning and services structures through the MoH Health Promotion Strategy, which includes intersectoral response through sub-programmes with the Royal Grenada Police Force (RGPF), district medical officer (DMO) services, other ministries, civil society programmes, nursing services, pharmacy services, dentistry, mental health, health education and health promotion, environmental health and St. George's University.
Sub-programmes include disaster mitigation, health systems and services and disease burdens from communicable and non-communicable diseases. Child sexual abuse, domestic violence, sexual abuse and post-natal care/care of the child are also dealt with under sub-programmes and are monitored by the unit. There are no programmes that address issues of sexual minorities such as homosexual populations and sex workers. MoH linkages with these populations are informally constructed through working with NGOs.

3. Primary Health Care Reform: Priorities for Grenada

Reform and revitalization of PHC is a priority for most Caribbean countries and Grenada is no exception. PHC frameworks are designed to promote health solidarity through social inclusion, people-centred care through service delivery reforms, health authorities that can be relied on through leadership reform, and communities where health is promoted and protected through public policy reforms. How PHC is viewed by the public and health providers is key to its success. In Grenada, as with many other countries in the Caribbean, doctors in the public health system also have private practices that compete with their public service provision. This has grave implications for the resultant quality of PHC. One client interview respondent stated *"Government service is slow as it is open to the public, [it is] for the poorer class. For people who don't have the funds for a private doctor. Old people and poor people."*

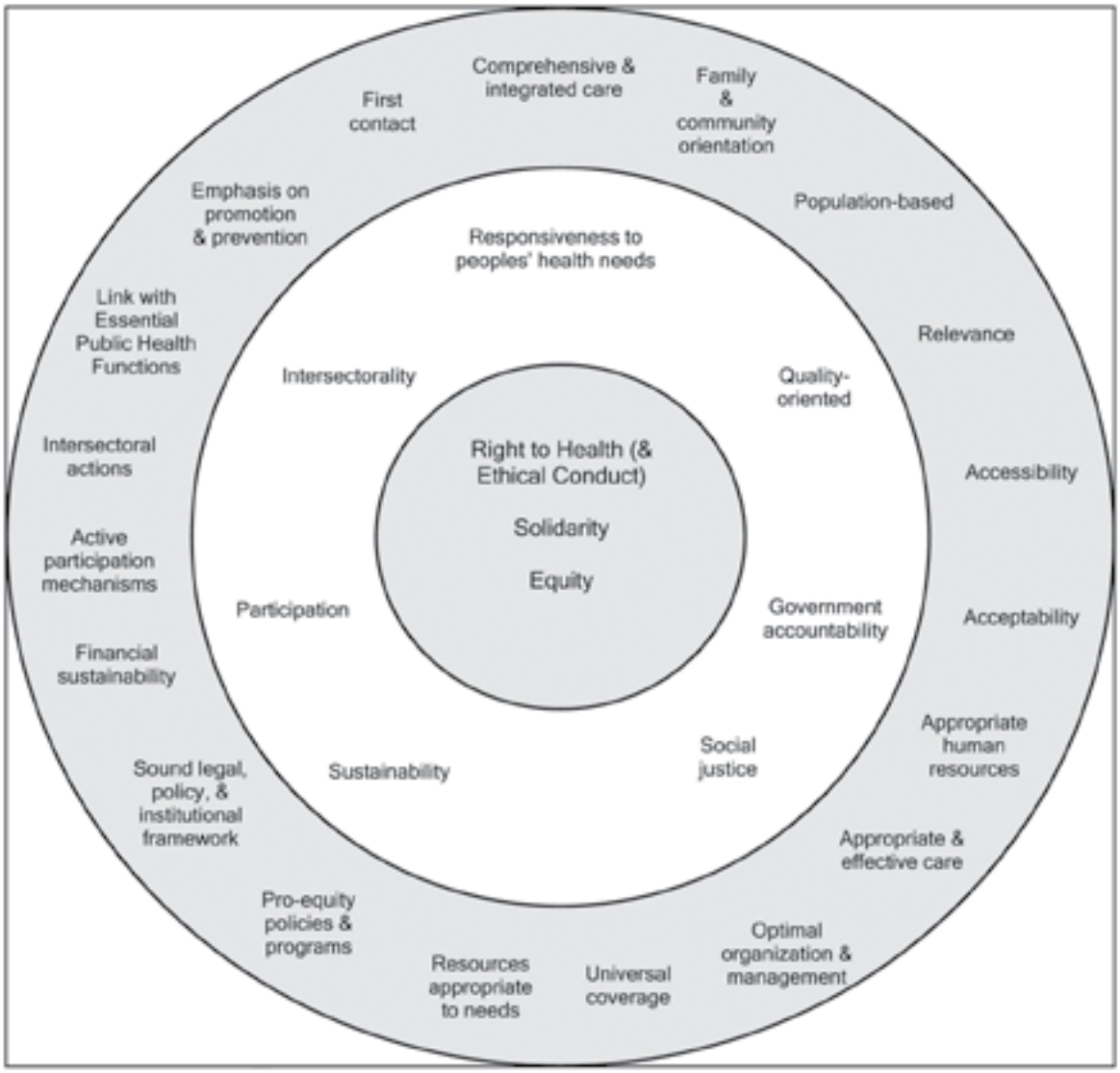
A PAHO position paper on PHC revitalization notes the following on decentralization of PHC as put forward at the Colombia National Consultation on Renewing Primary Health Care:

> "The best scenario for PHC is a decentralized approach whereby the community can demand its rights, the state and society respond to population needs, and the community actively participates in decision-making, regional entities exercise stewardship of health systems, there is sufficient political will to ensure resource redistribution, and there is adequate development of management capacity – all this is necessary for PHC to be effective." (PAHO, 2005)

It bears mentioning that at the heart of PHC values and principles as illustrated in Figure 2 are the right to health (and ethical conduct), solidarity and equity. In order to achieve this, health literacy is paramount for health service providers, health practitioners and the public at large. While the MoH Corporate Plan for 2009 and the NSP do address health promotion, health literacy is not mentioned. The NSP addresses health education in relation to health promotion among youth, cancer prevention and addressing stigma and discrimination against persons who are mentally differently-abled. The Corporate Plan states several objectives for health promotion including to empower target populations on health and health services; to develop, implement, monitor and evaluate media campaigns addressing priority health issues; and to develop and advocate for the National Health Promotion Policy. While there is some acknowledgment of the importance of an informed public, these are as yet short-sighted approaches to the achievement of health literacy.

Of note as pertains to SRH is the NSP policy objective to "provide, in collaboration with NGOs, accessible adolescent sexual and reproductive health services". The NSP does not indicate the extent of policy, systems and services reform needed for this objective to be realized. This will be explored in more detail later in this report.

Figure 2. Core values, principles and elements of PHC-based systems



Source: PAHO, 2005.

The Grenada MoH has recognized the need to strengthen PHC and has prioritized the development of a comprehensive revitalization plan. This process has already begun, but there was little documentation accessible at the time of this assessment on progress so far, aside from a document used in a planning session that outlined the following goals:

- Further decentralization of health services;
- Achieving buy-in by the wider public to the concept that one's health is one's responsibility;
- Achieving community participation in and support for chronic non-communicable disease prevention and control programmes;
- Creating empowering environments;
- Addressing social determinants of health.

The desired outcomes of the revitalization process include:

- Improved health outcomes of all Grenadians regardless of social standing;
- Reduction in the disparities among the population so that every Grenadian has equal access to health- care facilities regardless of income and/or location;
- Investment in prevention, early intervention and the health of future generations;
- Integration and multi-disciplinary care with an emphasis on provision of services in "one place";
- Better coordination between privately owned general practice services and community health services run by the Ministry;
- Improved access to health services for working families through access at schools;
- Health promotion;
- More effective management of public hospitals;
- Community and consumer participation.

An avenue being explored for scaling up community efforts for health promotion is the establishment of Primary Health Care Councils to facilitate bottom up information gathering and planning. The MoH would require that annual work plans be submitted for distribution of monthly subventions to councils. Both the Corporate Plan for 2009 and the NSP for 2007–2011 note the need to re-establish Primary Health Care Teams in each district. It was not clear whether this had been achieved at the time of this assessment.

Of greatest concern in the structure of PHC in Grenada is the lack of accessible and comprehensive service provision. Health centres and medical stations are operating within the limitations of a health system that appears severely lacking in both human and material resources. MoH health practitioners confirmed a standardized structure for service provision across the country that includes a weekly services schedule for health centres and medical stations. This requires that clients be aware of the schedule and be able to arrange to attend the clinical service on the appropriate day, and also makes it obvious what types of services clients are accessing.

Table 4. Gouyave Health Facility clinical service delivery schedule

Monday	Family Planning Clinic. This includes breast exams and pap smears
Tuesday	Antenatal Clinic. This includes parental classes where a representative from the MoH comes to facilitate
Wednesday	Chronic Disease Clinic. On this day the DMO comes in. High blood pressure checks are administered and diabetic patients attended to
Thursday	Child Health Clinic
Friday	General Clinic. The DMO is in attendance on this day also

Gouyave Health Facility had the weekly service delivery schedule shown in Table 4 posted in the waiting area on 27 October 2010. A common feature at all the facilities visited for this assessment was a client base of primarily elderly persons and women in post-natal care. It should be noted that when district medical officers (DMOs) are on site, they are not there for the entire day, some leaving as early as 12:30 p.m. at certain health facilities.

To further illustrate these constraints, the draft NSP for Health 2007–2011 identifies these primary challenges for the provision of community health services in Grenada:

- Inadequate range of community health services;
- Inadequate quality of service due to absence of personnel including doctors, and inadequate clinic opening times;
- Unclear focus on health promotion and its relationship with health education;
- Access to services;
- The effects of public knowledge, attitudes and beliefs including cultural taboos and religious beliefs on health-seeking behaviour and lifestyle issues;
- The need for an appropriate balance between hospital and community services. (Government of Grenada, 2006)

Most utilization of health service is limited to curative rather than preventive health care. Community health services data identify diabetes mellitus, hypertensive disease and upper respiratory infections as among the leading causes of morbidity for adults using these services (ibid.). It can be argued that these data directly correspond to the types of services offered, as attending to non-communicable diseases appears to comprise a large part of service provision at the community health clinics.

The draft NSP for Health 2007–2011 identifies the following six priority areas for social development:

- Human resource development
- Quality health care
- Poverty reduction and elimination
- Rural development
- Sustainable use of the physical environment
- Gender equality (ibid.)

Judging from the current nature of PHC service delivery and the general lack of developed policy and planning to support the above, it is unclear how the MoH plans to achieve these six priorities.

Table 5 shows the current MoH operated facilities in Grenada. Some foundation has been laid for the decentralization of PHC with the presence of health centres and medical stations throughout parishes. However, as previously mentioned and will be further illustrated, these facilities are highly constrained in their service provision.

Table 5. Grenada MoH health facilities by parish	
St. John Parish Gouyave Health Centre Grand Roy Medical Station Florida Medical Station	*St. David Parish* St. David's Health Centre Westerhall Medical Station Vincennes Medical Station Crochu Medical Station Perdmontemps Medical Station
St. Mark Parish Victoria Medical Station Union Medical Station	*St. Patrick Parish* Sauteurs Health Centre Tivoili Medical Station Hermitage Medical Station River Sallee Medical Station Mt. Rich Medical Station
St. Andrew Parish Princess Alice Hospital Grand Bras Health Centre Birchgrove Medical Station Paradise Medical Station Paraclete Medical Station Mt. Carmel Medical Station	*St. George Parish - South* Grand Anse Medical Station Woburn Medical Station Good Hope Medical Station Morne Jaloux Medical Station Calliste Medical Station St. Paul's Medical Station New Hampshire Medical Station
Carriacou Princess Royal Hospital Hillsborough Health Centre L'Esterre Medical Station	*St. George Parish - North* St. George's General Hospital St. George's Health Centre Snug Corner Medical Station Happy Hill Medical Station St. Moritz Medical Station

In reviewing current PHC systems in Grenada, it would appear that they are still in the early stages of decentralization. Table 6 illustrates the initial focus of PHC and suggests actions for reform. These are relevant for consideration by the MoH in its process of PHC revitalization.

Table 6. Concerns for PHC reform

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT CONCERNS OF PHC REFORMS
Extended access to a basic package of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
Concentration on mother and child health	Dealing with the health of everyone in the community
Focus on a small number of selected diseases, primarily infectious and acute	A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses
Improvement of hygiene, water, sanitation and health education at village level	Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards
Simple technology for volunteer, non-professional community health workers	Teams of health workers facilitating access to and appropriate use of technology and medicines
Participation as the mobilization of local resources and health-centre management through local health committees	Institutionalized participation of civil society in policy dialogue and accountability mechanisms
Government-funded and delivered services with a centralized top-down management	Pluralistic health systems operating in a globalized context
Management of growing scarcity and downsizing	Guiding the growth of resources for health towards universal coverage
Bilateral aid and technical assistance	Global solidarity and joint learning
Primary care as the antithesis of the hospital	Primary care as coordinator of a comprehensive response at all levels
PHC is cheap and requires only a modest investment	PHC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives

Source: WHO, 2008a.

4. Overview of Regional Health Systems: Policy, Planning and Regulation

Grenada's public health system is also affected by regional and international policy, planning and regulation. The trajectory of regional and national health systems development is largely influenced by international donor governments through several international development agencies, most significantly the United Nations.

Regional health bodies are primarily guided by the World Health Organization (WHO) and its regional office for the Americas, the Pan American Health Organization (PAHO), through the Caribbean Community (CARICOM). Currently CARICOM has five regional health institutes (RHIs) under its direction, two of which are PAHO-administered centres (Office of the Caribbean Programme

Coordination, 2010). Grenada is a recipient country of technical and other support provided through these health institutes. The five RHIs are:

- Caribbean Epidemiological Centre (CAREC)
- Caribbean Food and Nutrition Institute (CFNI)
- Caribbean Health Research Council (CHRC)
- Caribbean Environmental Health Institute (CEHI)
- Caribbean Regional Drug Testing Laboratory (CRDTL)

Some of the most influential regional health cooperation agreements are outlined below. If these were implemented in full, it would bring about a drastic improvement in regional/national health policy, systems and services.

Caribbean Charter for Health Promotion (CCHP)

The CCHP was signed in 1996 and identified the following health priority areas for the Caribbean:

- Health systems development
- Human resource development
- Family health, food and nutrition
- Chronic non-communicable diseases
- Communicable diseases
- Mental health
- Environmental health (CCH Secretariat, 1999)

The Caribbean Cooperation in Health Initiative (CCH)

The CCH was adopted by CARICOM Health Ministers in 1984 to promote collective action and collaboration in addressing critical health issues. It was approved in 1996 and Phase 1 launched. PAHO has been the primary international partner for the provision of technical and financial resources (CARICOM Secretariat, n.d.).

The strategic framework for CCH Phase 3 (CCH III) 2009–2015 has prioritized investing in the health of people in the region to ensure the:

- Highest attainable socio-economic development;
- Reduction of inequalities in health;
- Mobilization of traditional and non-traditional stakeholders in tackling health challenges and building sustainable health systems. (Ibid.)

In 2002, in line with CCH priorities, the CARICOM Secretariat undertook a review of the RHIs for more effective regional impact. After review and consideration, member governments agreed in 2007 to the development of the Public Health Agency for the Caribbean (CARPHA). CARPHA would integrate the RHIs into a single regional public health agency, with steering committee and project management team support provided by PAHO. CARICOM Heads of Government approved the plans for the implementation of CARPHA on 12 March 2010 with the goal of full implementation by the latter half of 2014 (CARICOM Secretariat, n.d.).

CARICOM has acknowledged the important role the education sector plays in securing the health of Caribbean children and has called on the health and education sectors in the region to work together, particularly for the prevention of chronic non-communicable diseases and of HIV and STIs, which are an increasing concern.

Regional education sector health goals include the development of a:

- School Health Promotion Policy – following WHO/PAHO guidance
- Caribbean Network of Health-Promoting Schools

The Port of Spain and Georgetown Declarations

The Port of Spain Declaration calls for taking gender into account in all programmes aimed at preventing and controlling non-communicable diseases (CARICOM, 2007), and the Georgetown Declaration of the 12th Special Meeting of the Council for Human and Social Development (COHSOD) on Children in March 2008 called for the implementation of Health and Family Life Education (HFLE) programmes for children in and out of school and for the consideration of children and their particular needs in the revision of the Caribbean Strategic Framework on HIV and AIDS (CARICOM, 2008).

Health and Education Ministerial Declaration on HIV Prevention

At the 1st Meeting of Ministers of Health and Education to Stop HIV in Latin America and the Caribbean, held in August 2008, a Ministerial Declaration was developed and signed that addressed HIV Prevention Through Education. It emphasized the need for comprehensive sexuality education, shared commitments between ministries of health and education, reduction of stigma, discrimination and homophobia, regional inter-ministerial work alliances and networks for strengthening HIV preventive response, and strategies to improve skills of teachers and health workers on HIV prevention. The main goals identified were:

- By 2015 to reduce by 75 per cent the number of schools under the jurisdiction of ministries of education that have failed to institutionalize comprehensive sex education;
- By 2015, to reduce by 50 per cent the number of adolescents and young people who are not covered by health services that address their sexual and reproductive health needs appropriately. (UNESCO, 2008)

Table 7. Key regional and international development partners
Key international agencies lending support to the development and implementation of SRH and HIV policy, systems and services management in Grenada include but are not limited to (in no particular order):
• Caribbean Community (CARICOM)
• Pan Caribbean Partnership Against HIV/AIDS (PANCAP)
• Organisation of Eastern Caribbean States (OECS) HIV and AIDS Programme Unit (HAPU)
• Pan American Health Organization (PAHO)/World Health Organization (WHO)
• United States Agency for International Development (USAID)
• World Bank
• United Nations Population Fund (UNFPA)
• Clinton Foundation
• PEPFAR (The US President's Emergency Plan for AIDS Relief)
• International Planned Parenthood Federation (IPPF)
• Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
• United Nations Joint Programme on HIV and AIDS (UNAIDS)
• United Nations Development Programme (UNDP)
• United Nations Children's Fund (UNICEF)
• Caribbean Development Bank (CDB)
• European Union (EU)

III. *Challenges to Grenada Health System Development: Implications for SRHR Policy & Planning*

1. Policy and Planning

> A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well known determinant of better health. *(WHO 2007)*

Health systems are vast and go well beyond the delivery of health-care services. According to the World Health Report 2000 (WHO, 2000), health systems are comprised of six main building blocks: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship).

In keeping with the social determinants model for the achievement of health equity, guidance is provided through international human rights protocols and approaches. The importance of policy and planning cannot be understated for the management of Grenada's health system. Written policies and planning documents ensure sustained protection of the right to health, support quality assurance in service delivery, support preparedness for contingencies and ultimately act as reference points for scaling up access to the best available standards of health care. In both its Corporate Plan for 2009 (no more current documentation was provided at the time of this assessment) and draft NSP for Health 2007–2011, the Grenada MoH has recognized the deficits in policy and planning. However, while reports on the progress made on implementation were not accessible, it is clear from the data acquired that far more resources and strategic use of existing supports must be employed.

In addressing the increasing demands on the health-care system due in part to the scaling up of existing primary health care (PHC) services, the MoH in its *Overall Health Policy* "invites additional collaboration between the public and private sectors to boost efficiency and productivity" in order to maximize taxed resources. The MoH acknowledges the need to develop systems that will address the legal, financial and administrative implications of such an intricate public-private sector collaboration. It also recognizes the need for implementing effective management systems and for infrastructure development. However, the MoH does not identify specific stakeholders in the private and non-governmental sector for strengthened collaboration in health service provision. So, while the gaps noted are an important part of strengthening existing health systems in Grenada, without specific guidance for cooperation and collaboration with key stakeholders these parties remain largely

invisible and linkages still intangible.

As noted previously, while the draft NSP for Health 2007–2011 and the Corporate Plan for 2009 note several key gaps to be addressed, it is not clear what the process is for monitoring and evaluating their implementation. Furthermore, capacity needs assessments have not been prioritized for determining what is achievable at present or what medium- and long-term planning should look like.

The draft NSP identifies the main challenges for the management of the public sector health system as: *"centralised management, the centralisation of addressing operational and policy issues, resistance to change and weak alliances with community and other potential stakeholders in health"* (Government of Grenada, 2006). Interview respondents for this rapid assessment echoed this, expressing the opinion that policy development appears to occur from the top down rather than in a fully integrative manner, i.e., incorporating perspectives from all spheres of the health sector including staff and client consultations.

Interview respondents from various areas of the health sector consistently reported a lack of support for policy and planning, noting that resources are spent only to have the developed documents unapproved or not utilized. Policy and planning documents remaining in draft form include the NSP for Health and the NSP for HIV and AIDS, both of which were funded by development partners to facilitate the provision of in-country technical support as far back as 2006.[5] Some interview respondents were of the opinion that there was resistance to implementing both new and old policy as a result of political resistance to either the new or old government administration. Lack of review and approval of strategic planning documents related to MoH departmental units was also a deficit commonly pointed out by respondents.

Additionally, interview respondents indicated that there is little written policy, and that unwritten policy to guide decision-making is ad hoc. They also noted the reliance on response-based problem solving in staff meetings as a substitute for planning for institutional and service delivery strengthening. These challenges were noted in the draft NSP for Health 2007–2011, which recommended the *"development and review of health policies through regular health needs assessments and monitoring and evaluation of service delivery"* and the development of a *"culture of participatory decision making"* (Government of Grenada, 2006).

Several interview respondents were unaware of what policies and planning documents were in existence related to their job portfolio, whether these documents were current and when they were developed. In the context of service delivery, respondents often claimed that they knew policies must exist – for example, as pertains to client confidentiality and records management – as they would have learned the processes in clinical training, but they could not produce examples of these or advise

[5] The NSP for Health was funded by the Caribbean Development Bank (CDB) and PAHO and a consultant provided from the Nuffield Centre for International Health and Development, University of Leeds. The development of the NSP for HIV and AIDS received funding support from the World Bank, the United Nations Development Fund for Women (UNIFEM) and other development partners for technical support.

where they could be obtained. Additionally, persons in key positions had been newly appointed with little orientation pertaining to written policy and procedures guidance.

Interview respondents noted the need for succession planning. This is echoed in the draft NSP for Health 2007–2011, which highlights human resource management and development challenges in Strategic objective 5.5.2 including *"poor succession planning, inadequate working conditions i.e. no job security, inadequate benefits and career planning, licensure and employee health"* (Government of Grenada, 2006).

Several respondents also reported a general lack of attention paid to SRH and HIV-related research with little priority placed on services and prevention programmes outside of the clinical setting. Furthermore, the report on the Government of Grenada HIV/AIDS Prevention and Control Project, funded by the World Bank, notes a lack of political commitment to the national HIV and AIDS response (World Bank, 2009).

Interview respondents also noted a lack of inter-ministry collaboration on implementation of line ministry HIV policies and plans. Reporting by line ministries on HIV-related data is also seen as weak. The draft NSP for Health 2007–2011 notes:

> "This plan is also considered to be a plan for Health, which requires an inter-sectoral approach to health. The systems for supporting the implementation of the plan (resource allocation) are however set in individual government Ministries. This is a challenge for planning for health at an inter-sectoral level as individual ministries and other stakeholders inevitably have other strategic priorities. It therefore remains the responsibility of the Ministry of Health to take the lead in advocating for Health at a national level. This is not an easy task when resources are focused at operational activities." *(Government of Grenada, 2006)*

2. Weak Collaboration Between Government and NGOs for Clinical and Non-clinical SRH and HIV Service Provision

MoH partnerships with non-governmental service providers are characterized by informal and ad hoc relationships. While these NGOs provide entry points for desperately needed prevention interventions, they have to be both advocate and service provider, often facing resistance from the Government and the broader civil society in supporting the human rights of women and youth as well as other vulnerable groups such as MSM and sex workers. Without an informed and human rights-led civil society discourse on SRHR, it is difficult to hold the Government accountable for health service provision and the realization of health equity among vulnerable groups. The Government has yet to make allies of and formalize partnerships with civil society organizations working towards health equity for SRHR achievement.

NGOs in Grenada provide a range of services from poverty alleviation to psychosocial support for survivors of domestic and sexual abuse and persons living with HIV and AIDS.

Persons working at NGOs spend large amounts of human resources and time searching for funding from regional and international development agencies. In response to this reality, interview respondents suggested that government ministries should pay them for service provision on a contractual basis as they are administering services that are government mandated but not part of government-operated services. For example, government health facilities do not offer services for the prevention of sexual and domestic violence, while the Grenada National Organisation of Women (GNOW) and the Legal Aid and Counselling Clinic (LACC), for example, do. NGOs working with vulnerable groups typically receive subventions either from the MoH or the MoSD, but some interview respondents from NGO service providers claimed receipt of subventions of only EC$2,000 (US$741) per annum.

In terms of advocacy, there is little support for, and no comprehensive national – that is government-led/supported – sexual and reproductive rights campaigning for the elimination of stigma and discrimination against marginalized gender and sexual minorities such as sex workers and homosexuals. In fact these vulnerable groups are associated with sexual activity that is criminalized in Grenada, which greatly impedes their access to health care. Youth SRHR are not advocated for either. Government-supported national campaigns related to SRH concentrate on raising awareness of domestic violence, condom promotion and HIV testing for HIV prevention.

NGOs in Grenada currently do not have the capacity to reach large numbers of vulnerable populations. Moreover, it is arguable that since some NGOs are known for the services they provide to 'certain populations', these marginalized groups are not accessing NGO support services in representative numbers due to the fear of stigma and discrimination. With increased national support for public campaigns, access to services would increase.

3. Key NGOs Offering SRH and HIV Services in Grenada

A fully representative account of all the research, projects, policies and protocols influenced, directed and produced by relevant NGOs in Grenada is beyond the scope of this rapid assessment; however, a brief review of the mandate and types of services offered are noted below.

Grenada Chapter of the Caribbean HIV/AIDS Partnership (GrenCHAP)

GrenCHAP Inc. is the local arm of CHAP (Caribbean HIV/AIDS Partnership), a network of groups in the OECS islands working with most-at-risk populations with a focus on HIV and human rights. Target groups include men who have sex with men (MSM), sex workers, people living with HIV/AIDS (PLWHA), drug users, prisoners and vulnerable youth. GrenCHAP offers voluntary counselling and testing services and psychosocial support and also serves as an advocate for the human rights of vulnerable and at risk groups. It engages in policy dialogue on HIV and human rights.[6]

[6] http://dir.groups.yahoo.com/group/GrenCHAP/?v=1&t=directory&ch=web&pub=groups&sec=dir&slk=3

The current President sits on the National AIDS Council and is participating in the review process of the draft NSP on HIV and AIDS. Projects being undertaken at present include work with sex worker populations. GrenCHAP collaborates to some extent with the MoH for the provision of training and also provides referrals to NIDCU.

The Grenada Community Development Agency (GRENCODA)[7]

GRENCODA is an indigenous non-profit, non-partisan, non-governmental development agency committed to the development of Grenada's rural communities.

The agency started in 1985 and was formally registered as a non-profit organization under the Grenada Companies Ordinance on 13 January 1986. It exists "to provide guidance and support to rural individuals, families and communities to improve their quality of life. It does this by encouraging people's participation in community based initiatives, which will build self-reliance particularly among small farmers, low-income workers, women and youth."

GRENCODA has five main programme areas:

- Community development, mobilization and services
- Education and training
- Institutional strengthening – human and financial
- Small business and entrepreneurial development
- Advocacy/research

GRENCODA's Strategic Priorities 2006–2010 included:

- Development of and support for economic project activity so as to improve livelihoods, particularly for women;
- Assistance to students from low-income households to obtain sound education and vocational training for poverty alleviation;
- Facilitating skills training and the acquisition of life skills for personal development to alleviate poverty;
- Advocacy on policy issues that have an impact on the situation of marginalized persons/groups;
- Improving the financial, human/physical resource base of the organization thus guaranteeing its sustainability;
- Stimulating/helping CBOs to become more self-reliant and organized;
- Focus on and increase of the level of communication with stakeholders in particular media and government.

Specific programmes include:

- Legal Aid and Counselling Centre (LACC) (see below)
- Student Assistance Programme
- Youth Development Programme

[7] Information garnered from a Briefing Paper on GRENCODA provided by GRENCODA Office in Grenada

- Skills Training for Rural Women
- Community Intervention Programme (with 14 communities)

Grenada Legal Aid and Counselling Clinic (LACC)

LACC has been in existence since 1987. The services offered by the clinic are:

- Legal advice and representation
- Counselling initiatives including
  - "Changes"
  - "Man-to-Man"
  - Other counselling services
  - Child maintenance programme
- Legal research and advocacy
- Public legal education

Man-to-Man is a court-based batterer intervention programme. It has seen some success in rehabilitating men who have been tried in the court system and found guilty of domestic violence.

Persons earning a maximum of EC$15,000 (US$5,600) per annum qualify for LACC services. In 2002, 1,309 persons benefited directly from the services, 69.5 per cent of them women. Among the issues dealt with were family conflict (12.2 per cent), civil administration matters (13.5 per cent), domestic violence (15 per cent), maintenance (17 per cent), property settlement, separation, rape, visitation rights and divorce and other social issues.

Grenada Planned Parenthood Association (GPPA)

The Grenada Planned Parenthood Association (GPPA) was founded in 1964 and runs two full-time clinics in Grenada, one in St. George and one in St. Andrew. It is an affiliate of the International Planned Parenthood Federation (IPPF) and provides basic SRH services including contraceptives, pap smears, pregnancy tests and STI treatment. GPPA also operates contraceptive retail sales outlets, mostly in rural areas, and collaborates with the MoH for the provision of contraceptives and capacity-building for nurses.

Grenada National Organisation of Women (GNOW)

Activities of GNOW include capacity-building and advocacy for women's rights with a focus on policy development and dialogue.

GNOW was instrumental in the development of the draft National Domestic Violence and Sexual Abuse Protocol for Grenada and the adoption of the Domestic Violence Bill 2010. GNOW has also drafted a Sexual Harassment Bill and has been advocating for its adoption. In addition, GNOW has reported on Grenada's adherence to the Convention on the Elimination of All Form of Discrimination against Women (CEDAW) and continues to advocate for the Government's accountability in this area.

Initiatives include:

- Training and capacity-building for members as well as government personnel on a number of issues including gender, sexuality and HIV;
- Direct intervention – e.g., creating a support network for women experiencing gender-based violence;
- Holding "Gender, Sexuality and HIV/AIDS" workshops for teachers, conferences for students and sensitization activities for the public.

Hope Pals Foundation – National Network of HIV Sero-positives

The main objectives of Hope Pals are:

1. Advocate and lobby for access to standardized and adequate care, treatment and support services for people living with and affected by HIV/AIDS in the tri-island State of Grenada, Carriacou and Petit Martinique;
2. Reduce stigma and discrimination and human rights violations against people living with and affected by HIV/AIDS;
3. Capacity-building;
4. Meaningful involvement of people living with and affected by HIV/AIDS in decision-making.

Activities employed /programmes:

- Community outreach
- Nutritional support
- Peer counselling
- Treatment adherence/compliance
- Education on HIV/STIs
- Law, ethics and human rights
- Women's empowerment
- Advocacy and lobbying
- Capacity-building
- Empowerment initiatives
- Decision-making processes
- Participation in national and regional workshops and conferences

4. Successful Partnerships: International NGOs of Note Working on SRHR

The following international organizations have a gender-responsive and human rights-based approach to development, which includes community-driven approaches to SRH achievement:

- International Planned Parenthood Federation (IPPF) (has affiliates in the Caribbean including the Grenada Planned Parenthood Association)

- Population Services International (PSI) (has conducted Caribbean-focused research in several islands on SRH)
- EngenderHealth
- Advocates for Youth
- Promundo (has supported programmes in the Caribbean with a focus on exploring masculinity and sexual health of boys and men)

They support youth SRHR, support the rights of women to choose whether or not to terminate a pregnancy, support persons living in poverty to exercise autonomy over their SRH choices, and make SRH commodities accessible. Additionally they support the promotion of sexual health among men and boys in recognition of the gender disparities in the realization of SRHR. They generally seek to prevent STIs including HIV through the promotion of healthy sexual behaviour.

Finally, these international NGOs operate under the premise that SRHR are the shared responsibility of individuals, communities and the state. The IPPF and PSI have been working in the Caribbean with notable success in providing support for access to SRH commodities and conducting important research on sexual activity and sexual health literacy among vulnerable groups.

5. At-a-Glance: Inter-ministry Efforts towards SRH Achievement in Grenada

As donor agencies seek collaboration and respond to requests from individual government ministries and NGOs, each vying for financial and material resources, comprehensive communication mechanisms and integrated approaches are difficult to create and sustain. International and regional policy, systems and services approaches to SRH achievement tend to focus on sector-specific responses rather than ensuring integrative mechanisms are foundationally in place. A social determinants model for health requires that each line ministry have a health policy that would directly correspond to the health policy and national strategic plan of the MoH. However, the MoH in Grenada is not strategically placed as a leader in directing health achievement in the country.

Key inter-sectoral planning and programming for SRH and HIV services integration should include systemic networks between the MoH and the following:

- Ministry of Social Development (MoSD) and in particular the:
- Probation Unit
- Domestic Violence Unit
- Social Services Department
- Ministry of Education (MoE)
- Ministry of Agriculture
- Ministry of Youth, Culture and Sports
- Child Welfare Authority
- Association of Professional Social Workers
- Royal Grenada Police Force (RGPF)

While linkages and collaborations do exist, they are not formally and strategically established beyond basic referral processes in existence between the ministries and agencies highlighted above. Furthermore, most inter-sectoral interaction and collaboration is response-based and not preventative, i.e., it does not adequately address the reduction of vulnerability to harm/ill health. These challenges can be linked back to the fragmented development process mentioned previously.

Attempts at preventative social programming are mainly informal and maintained according to the commitment of individuals rather than dictated by the parameters of job functions. An example of an informal collaboration is a parenting programme supported by the MoE and MoSD. In terms of formal inter-sectoral policy and planning linkages, the draft Corporate Plan for the MoE 2010 makes no mention of inter-ministry collaboration with the MoH or any other line ministry. Neither does the Corporate Plan for the MoSD 2007–2009.[8]

At the time of this rapid assessment it was not possible to interview persons from all relevant government sectors; however, there was an opportunity to speak with persons from the MoE and the MoSD. Reference was made to the fact that the NSP for Education 2006–2015 was being reviewed as well as to the renewal of the Corporate Plan for the MoSD, which expired at the end of 2009. Respondents at both ministries admitted to a lack of integrated policy and planning with the MoH and did not indicate any policy or planning goals toward bridging this gap in the near future. This has implications for the implementation of important protocols on, for example, sexual and domestic violence and child sexual abuse. The development of these was spearheaded by the MoSD and NGO partners – GNOW and LACC – but requires implementation commitments from several government sectors.

[8] The new corporate plan for the MoSD is currently being developed

IV. *Priority Challenges to Sexual and Reproductive Health and Rights Achievement in Grenada*

1. Sexual Health Not Prioritized in PHC

> "Sexuality is a fundamental dimension of the quality of life of individuals, families, and communities. It is profoundly influenced by social interaction, culture, and personal experiences. Thus, getting the issue on the public health agenda calls for a deep and clear understanding of the expressions and dynamic of sexuality in everyday life and throughout the life cycle—not only during the reproductive phase. Nor should sexuality be reduced simply to events associated with reproduction, because in a substantial proportion of human sexual activity the primary purpose and outcome are not procreation." (PAHO 2010)

The most recent country poverty assessment for Grenada, Carriacou and Petit Martinique 2007–2008 notes that while PHC has universal reach, certain social behaviours pose particularly serious challenges to public health (Kairi Consultants Limited, n.d.). The issues highlighted were abuse (primarily sexual abuse) of girls and teenage pregnancy, transactional unprotected sex, drug abuse and maiming among youth. It further notes that 40.3 per cent of females aged 15-49 reported having their first child between the ages 15-19; 57.8 per cent of females reporting as such were in the lowest economic quintiles; and 4 per cent of females in the lower quintiles reported having their first child before the age of 16 (the legal age of consent to sex).

Without recognition of sexual health as a distinct component of health and a human right in Grenada, important sexual health needs are left unmet. In addition to linkages to HIV, SRH is an element of many health concerns. Some of these are illustrated in Table 8.

Table 8: Key health concerns and the implications for SRH

Health issue	Sexual health implications for women	Sexual health implications for men
Diabetes	• Uncomfortable or painful sexual intercourse due to problems with vaginal lubrication • Decreased or no desire for sexual activity • Decreased or absent sexual response	• Difficulty with erections or ejaculation • Retrograde ejaculation

Table 8 (continued): Key health concerns and the implications for SRH		
Hypertensive diseases	• Decreased or no desire for sexual activity • Decreased or absent sexual response	• Difficulty with erections or ejaculation
Obesity	• Low self-esteem and tendency towards risky sexual behaviour	• Erectile dysfunction • Low self-esteem and tendency towards risky sexual behaviour
HIV	• Depression leading to lack of sexual desire • Early onset menopause from a decrease in production of progesterone and estrogen	• Decline in testosterone levels leading to erectile dysfunction and fatigue • Nerve damage leading to erectile dysfunction • Depression

SRH in Grenada is addressed at present primarily through family planning services with a focus on maternal and child health and STI prevention and treatment. Goals and priorities for clinical service provision have been influenced/guided by international organizations and agencies, most notably PAHO/WHO and the IPPF, which provides support to its national affiliate the Grenada Planned Parenthood Association (GPPA).

The draft NSP for Health 2007–2011 strategic priority on reproductive and child health identifies the key health issues and the corresponding objectives, strategies, services and indicators for addressing them. These are outlined in Table 9.

Table 9: Key reproductive and child health issues with objectives, strategies, services and indicators for addressing them

Health Issue

- Health of infants (including IMR [infant mortality rate])
- Immunisations
- Anaemia in mothers and infants
- Nutritional deficiencies in infants
- Obesity in mothers and children
- Maternal health and family planning
- Domestic violence
- Teenage pregnancies
- School health
- Accidents and injuries among children
- Respiratory infections

Table 9 continued: Key reproductive and child health issues with objectives, strategies, services and indicators for addressing them

Objectives

- Develop and implement mother and baby friendly policies
- Deliver appropriate and comprehensive health services
- Provide, in collaboration with NGOs, accessible adolescent sexual and reproductive health services
- Reduce neonatal, infant and child morbidity and mortality
- Prevent and manage consequences of malnutrition
- Ensure appropriate and accessible family planning services

Strategies

- Preventative and promotive strategies
- Develop standards and protocols for pre and post natal care in the community
- Provide consistent health education programmes and primary health care services in all health centres
- Promote breast feeding
- Intensify services to improve the nutritional status of pregnant women, infants and children
- Develop strategies in collaboration with other ministries (social services, the Prime Minister's Office etc.) to address teenage pregnancies and other social issues affecting the sexual health of women
- Enhance service for Planned Parenthood, screening (pap tests, breast examinations etc.) in collaboration with the Grenada Planned Parenthood Association (GPPA)
- Enhance school health programme linked to primary care services in the community
- Continue activities for the eradication and elimination of vaccine preventable diseases in conjunction with regional partners particularly PAHO
- Develop partnerships with other ministries and non-governmental organisations in providing health promotion programmes on youth issues (e.g., physical activity, diet, sexual health, drug use, accident prevention)

Curative strategies

- Deliver essential clinical care in the community utilising hospitals services through an established referral system
- Improve physical infrastructure of maternity units in districts, particularly in the north of Grenada, and promote utilisation of these maternity units
- Develop standards and protocols for paediatric services at general hospitals with appropriate links to district hospitals and community services
- Enhance child friendly facilities at all hospitals, including separate wards for children
- Ensure hospitals and maternity units become baby friendly

Table 9 continued: Key reproductive and child health issues with objectives, strategies, services and indicators for addressing them

Support Services

- In-service training of workers in pre and post natal care, including nutrition of mothers and infants
- Develop reporting system for incidents of violence against women and children in collaboration with the Ministry of Social Services
- Ensure adequate coverage of midwifery care in district maternity units
- Collaborate with other ministries (including Agriculture, Community Development, Marketing and National Importing Board) to ensure food security

Performance Indicators

- Reduced maternal morbidity
- Reduced hospitalisation in the prenatal period
- Reduced neonatal, infant and child morbidity and mortality
- Existence of appropriate and accessible family planning services
- Number of collaborative partners in activities to address reproductive and child health
- Existence of standards and protocols of reproductive and child health at all levels of care
- Number of working partners and health promotion programmes for youth
- Expanded child health programmes and child friendly services
- Improved physical infrastructure of maternity services with appropriate staffing
- Training sessions at the community level for enhanced community services and school health programme
- Number of health workers trained in pre and post natal care
- Reports on domestic violence
- Availability of midwives in the community
- Number of collaborative partners and health promotion programmes for ensuring food safety

Source: Government of Grenada, 2006.

There are important recommended objectives and strategies that have yet to be implemented by the MoH, which include:

- Provide, in collaboration with NGOs, accessible adolescent SRH services;
- Provide consistent health education programmes and PHC services in all health centres;
- Develop a reporting system for incidents of violence against women and children in collaboration with the Ministry of Social Services;
- Hold training sessions at the community level for enhanced community services and school health programme;
- Develop partnerships with other ministries and NGOs in providing health promotion programmes on youth issues

(e.g., physical activity, diet, sexual health, drug use, accident prevention).

Limitations of the strategy include:

- The focus on reproductive health exclusively, with no mention of sexual health;
- No mention of collaboration with male partners for the prevention of gender-based violence;
- No mention of SRH promotion for men;
- No psycho-social support specified for diagnosing vulnerability to domestic and sexual violence, child sexual abuse, HIV and other STIs;
- No account taken of gender and sexual minorities;
- No mention made of inter-ministry cooperation and collaboration for policy and planning on SRHR achievement.

2. Lack of Comprehensive Prevention Service Provision for Diagnosing Vulnerability to SRH Ill Health and Morbidity

> "I don't use condoms with my boyfriend. According to how you and a person interact will tell you if they have other sexual partners. But there is no guarantee. I have never asked him to use a condom." – Client exit interview respondent

Health practitioners reported no comprehensive sexual history taking, with individual sexual practices addressed primarily in the context of HIV-related counselling services.

The intake forms used are:

- Family planning service medical record
- Ante-natal record
- Personal immunization record
- Child health record

The family planning service medical record notes 'husband's name' under the primary client information and 'partner' as part of the social history section. The belief that a sexually active woman should also be married or in a relationship with someone of the opposite sex is still prevalent. There continues to be stigma associated with women who are sexually active or become pregnant out of wedlock, and they are seen as 'loose' or 'promiscuous'.

The social history section of this record asks the following: client education, religion, persons in house, head of the house, social conditions, drug abuse (incl. alcohol), other details, children, partner, occupation, type of union and attitude to family planning.

The intake form also takes minimal information on obstetric and gynaecological and family planning history. STIs, vaginal discharges and information about menstrual cycles and dysmenorrhoea are specified as well as basic breast and cervical exams administered to the client. This all focuses on reproductive health primarily.

Also noted is the lack of targeted psychosocial support for vulnerable groups. Interview respondents indicated that it is women who primarily access services as men are reluctant to discuss their emotional lives, and they highlighted that high levels of stigma and discrimination are still associated with mental health services.

A key challenge in providing targeted services for the most vulnerable groups noted by one interview respondent was the conflict between law, cultural beliefs and human rights. This respondent asked ***"How can we target vulnerable groups effectively, when their sexual practices have been criminalized?".***

Additionally, interview respondents note that post-exposure prophylaxis (PEP) kits are not easily accessed in clinical service delivery. There is also no consistent/comprehensive post-diagnosis psychosocial support for STIs with the exception of HIV.

School-based programmes, particularly Health and Family Life Education (HFLE), are seen as primary vehicles of health promotion; however, no data has been acquired on the effectiveness of these programmes in Grenada.

Table 10. Examples of programmes for prevention of sexual and reproductive ill health

- Nutrition education programmes including economical but healthy options for eating
- Emotional health literacy programmes and services
- Gender-responsive adolescent health programmes including psychosocial support for diagnosing sexual and domestic violence and addressing issues of sexuality, hormonal health management and SRH care
- SRH education and psychosocial support for vulnerable groups including safe sexual practices including masturbation/self-pleasure, safe practice of oral sex and anal sex
- Personal safety programmes and services for vulnerable groups including human rights-based information provision
- Health screening for chronic diseases such as clinical depression, which is a vulnerability factor influencing risky sexual behaviour
- Psychosocial support services for diagnosing vulnerability and the treatment of child and adult sexual abuse, domestic violence and discrimination based on sexuality and gender identity
- Sexual health literacy programmes and services
- STI prevention, treatment, care and support including gender-responsive guidance for men's health and sexual decision-making for women and men, and youth

3. Gender Inequity and Inequality

Gender and health service access

Community health services focus primarily on maternal and child health and are therefore more utilized by women. Family planning and cervical smear screening services are provided through district health services and through the GPPA. Postnatal services include screening for anaemia and at general clinics there is screening for blood sugar. High rates of obesity are a concern among women and pregnant women in particular (Government of Grenada, 2006).

Men are reported less likely to access health services due to illness than women (Kairi Consultants Limited, n.d.). Men access hospital services primarily for treatment of workplace injuries and road traffic accidents. Men also utilize most services related to drug and alcohol dependency. Regarding men's health-seeking behaviour, the draft NSP for Health reports that working men access community health services less than women as they prefer to see a private practitioner. It also notes that men's access to health services is limited as most community-based services are geared towards maternal and child care. Additionally, male partners of women receiving care are not targeted for service provision.

> "Women are afraid to get SRH/family planning information with their man partner, as men still have reluctance to have their women partner on contraceptives. Some men still believe that women smell when they use contraceptives." – *Interview respondent (health practitioner, MoH)*

Addressing men's SRH is critical as socio-cultural norms promote expressions of 'manhood' that associate profuse sexual activity with masculinity. There are no targeted interventions for men, although anecdotal evidence suggests that many Grenadian men are using unregulated products to enhance sexual performance.

Additionally, and most imperative, is the need for psychosocial support for addressing negative expressions of masculinity that promote domestic and sexual violence and child sexual abuse.

Gender-based discrimination and poverty

Grenada is a member state of the Caribbean Community (CARICOM) and Caribbean Single Market and Economy (CSME) and of the sub-regional Organisation of Eastern Caribbean States (OECS).

Economic security in Grenada has been severely compromised by the following according to the latest poverty assessment:

- Terrorist attacks in the United States on 11 September 2001
- Hurricane Ivan, 2004
- Hurricane Emily, 2005
- Escalation in prices of energy and essential foods in late 2007 and early 2008
- Global recession 2008, affecting the vital tourism sector and reducing remittance income from the Diaspora (Kairi Consultants Limited, n.d.)

Of the six parishes on the island of Grenada affected by Hurricane Ivan, St. George, St. David, St. Andrew and St. John were the most severely affected. These parishes contain 80 per cent of the island's population, and 90–96 per cent of the population in these parishes was affected. Moreover, 75 per cent of the nation's poor live in these parishes, and more than half of these (52 per cent) have female-headed households (USAID, n.d.).

Both women and men lost their means of securing livelihoods following the natural disaster. However, the gendered differentiation of skills existing in the labour force before the devastation of Ivan became more evident after the disaster and resulted in women's marginalization in newly constructed markets (ECLAC, UNIFEM and UNDP 2005).

> "In reality, by virtue of their social roles as compared to those of men, women in Grenada are particularly disadvantaged in a gender-blind development system." *(Government of Grenada and others, 2005)*

The following is a snapshot of the gender landscape from the Gender Core Welfare Indicators Questionnaire (CWIQ) for Grenada:

• Women make up 60–70 per cent of the informal employment sector. Additionally, women experience higher rates of unemployment than men.

• Rural women are over-represented among the poor and vulnerable due to their higher rates of unemployment, poor housing conditions, large number of children and the burden of providing care and support to their children and others.

• Access to higher education is elevating women out of low-paid jobs and redirecting them into higher-paying positions with decision-making authority. Education for women and their consequent availability for employment have led to their advancement and to the narrowing of income and professional placement gaps between women and men.

• Elderly men living alone, especially in rural areas, also constitute a vulnerable population. Many attained only primary education, worked in low-paid jobs and are without pensions. Though they may have fathered many children, they may not have built a stable family to which they can turn for support, care and companionship in their old age. Thus they live in material poverty and social (family) exclusion.

• Men are assigned specific gender roles, many of which have to do with what society sees as upholding masculinity (strength, control and power over women) while shying away from what is seen as feminine (nurturing, showing gentle and tender emotions). These socially ascribed roles have negative impacts on both men and women, on their households and on the island's development. (Government of Grenada and others, 2005)

Table 11. Employment status by sex 2007–2008

Employment Status	Male		Female		Total	
	Count	%	Count	%	Count	%
Employed	19,295	82.1	16,427	68.2	35,722	75.1
Unemployed	4,198	17.9	7,661	31.8	11,859	24.9
Total	24,493	100.0	24,088	100.0	47,581	100.0

Source: Kairi Consultants Limited, n.d.

Gender and sexual abuse

Interview respondents claim that there is very little sanction against perpetrators of sexual violence and child sexual abuse. It has also been noted that economical dependence of women on men allows for incestuous relationships between adult men and girls and, increasingly boys. There is anecdotal evidence of known perpetrators of rapes of girls 5–7 years of age who have not been charged and remain involved in community activities.

Relevant national research on the status of children in Grenada includes:

- Preliminary Consultations on the Status of Child Protection in Grenada, June 2001
- Audit Report on Child Protection Services in Grenada, August 2006
- National Action Plan on Child Abuse (Draft), August 2010

Key findings of these reports include:

- The Child Abuse Protocol is not being implemented as a result of a lack of proper systems for implementation;
- Data collection is weak and there is no centralized system for data collection;
- Institutional support should focus on strengthening human resources, development and implementation of adequate protocols, child-sensitive court processes and proceedings and social safety net programmes.

A study on child sexual abuse in Grenada (Jones and Jemmot, 2009) notes the effects of child sexual abuse on the level of the individual as including:

- Emotional problems: including aggression and difficulties with sexual boundaries;
- Psychological problems: including depression, self-harm, low self-esteem;
- Behavioural problems: including poor school performance, challenging behaviour, risky sexual behaviour, substance misuse and violence.

The impact of sexual abuse extends from the emotional and mental to the physical. Mental and physical trauma increase the likelihood of further risky sexual behaviour, and physical damage to the urethra, vagina and anus during the assault increase the potential for HIV transmission.

There is also reported to be widespread transactional sex primarily involving older men and girls but

also increasingly older men and boys.

> "[Transactional sex] was described as quite visible, i.e. an 'open secret' – and often happens with the full knowledge of parents, communities and officials. Such is the extent of the problem, that it was considered a firmly entrenched and established pattern of behaviour that did not need to be hidden since it was unlikely to attract penalty, and in some circumstances, would not even attract disapproval. Transactional sex was reported as being committed by men at all levels of society, including politicians and senior professionals." *(Ibid.)*

Gender-based discrimination – homophobia

Strong sanctions exist against same sex relationships in Grenada, as noted earlier, which is the case in the Caribbean region as a whole. A proportion of men who are having sex with men are also having sex with women and do not consider themselves to be homosexual. Negative masculinities encourage risky sexual behaviour in addition to secrecy about non-heterosexual relations.

> "In Grenada, as elsewhere, individuals who do not conform to conventions for the expression of gender report experiencing discrimination in employment, education and housing. Such discrimination has led biological males who do not conform to conventional gender expression into disproportionate involvement in sex work which, compounded by their economic marginalization, places them in a particularly vulnerable relationship to the state and to laws that stigmatise and criminalise consensual intimacy as against morality and nature. Such laws confer a stigma on their entire humanity as 'unnatural'." *(GrenCHAP and others, 2007)*

There are particular health concerns for MSM populations (whether gay identifying or not) that are not proactively addressed due to the climate of homophobia. These health concerns increase vulnerability and risk to HIV and also exacerbate the challenges of coping with HIV in positive persons. Some of these include (PAHO, 2009):

- *Mental health concerns as a result of stigma and discrimination, social isolation, emotional and physical violence,* e.g., High rates of episodic and chronic mental illness, long-term depression and anxiety and post traumatic stress;

- *Substance abuse:* Drug and alcohol abuse as coping strategies are common among MSM and increase the likelihood of risky sexual behaviours;

- *HPV/cancers:* MSM have a higher incidence of precursor lesions and anal cancer, in particular HIV-positive MSM;

- *STIs:* MSM populations continue to present with higher rates of STIs and are at greater risk for infections outside the genital tract, including diseases of the rectum and pharynx. STIs place individuals at risk of contracting other STIs including HIV.

4. Limited Access of Vulnerable Groups to Health Services

Cultural perspectives on sex and sexuality are hetero-normative and translate into the health sector approach to SRH. As noted earlier, SRH services are limited to reproductive care for women and support services for their children, corresponding to the conceptualization of sex as having primarily reproductive functions. Concepts of sexual health are therefore limited and service provision short-sighted. Targeted approaches and specialized services are not employed in the public clinical health service. The role of the health sector in assessing vulnerability to SRH ill health and morbidity is also severely overlooked. It follows that the needs of vulnerable and at-risk groups for sexual and reproductive ill health and HIV are not being addressed.

Vulnerable and at-risk groups in Grenada include women and girls, youth – especially boys in and out of school – and sexual/gender minorities such as:

- Sex workers
- Non-gay identifying MSM who may also have sex with women
- Self-identified gay, lesbian and bi-sexual persons
- Other sexual minorities including transgender males and females
- Prison populations, primarily male prisoners
- Differently-abled persons (persons with mental and physical disabilities)

FIGURE 3

TRADITIONAL PERSPECTIVE OF SEX

Sex for Reproduction

Sexual orientation therefore "should" be:

> "Given the overcrowding [in prisons], men who are weak and those perceived to either not be heterosexual or not conform to gender expectations are vulnerable in such a climate to both generalised violence and sexual violence, increasing the risk of HIV and STIs. Such violence appears both underreported and inadequately addressed by prison officials. While grievance procedures are in place, it is unrealistic, given the stigma associated with male on male rape and the inability to provide physical protection for inmates in the overcrowded conditions, that an inmate would bear the burden of reporting such incidents to the prison authorities." *(GrenCHAP and others, 2007)*

According to a shadow report to the United Nations Human Rights Committee, gay men in Grenada are disproportionately involved in sex work and are vulnerable to sexual violence in prison, which is underreported and inadequately investigated by authorities. It further notes that there is no condom provision in Grenada's prison facilities and health care professionals have reported that STIs are occasionally treated in the prison infirmary (ibid.).

Health service provision to migrant, illegal immigrant and other populations is not specifically addressed by the MoH although respondents recognise the "right to health services of all those in need in Grenada."

Differently-abled persons and health service access

It is estimated that 10 per cent of Grenadians have some form of disability. The Council for the Disabled, which gets support from the MoSD, is responsible for assessing needs and directing service provision for persons with disabilities.

There are several programmes that provide support for children with disabilities including the National Children's Home Action for Children in St. Mark Parish, the Dorothy Hopkins Home and Bel Air Home in St. George (PAHO, 2007).

Disabled youth are not targeted for specialized health services. Health centres and medical stations are rarely accessed by youth with disabilities. When asked about youth with disabilities and their SRHR, one interview respondent recounted,

> "I remember a nurse saying that a little Down's syndrome was asking his mother to find him a girlfriend. We just laughed, we think that they are mentally retarded, what they want with sex. I know a lot of these children, some parents put them in homes because they have been abused."

Youth and health service access

There is not as yet a strategy in place for the development of youth-friendly health services and so there is limited access to preventative health care for young people. Despite there being no legislated medical age of consent and a legal age of consent to sex of 16, most health practitioners stated that they would not provide contraceptive or any other SRH services to persons under 18. Interview respondents reported that health-care practitioners typically treat young people in accordance with their individual value system. One stated, *"There is a discrepancy in the age of medical consent. There is no protocol. Some use 18, some say if you still in uniform you have to come with a parent. "*

Minimal contact with youth was reported for the treatment of STIs, and one health practitioner reported administering contraceptives to a 15 year old who had come in with her mother.

An interesting point to note is the similarities in the limited clinical services available for youth and sexual minority groups. Administering of health services checklists at MoH facilities visited revealed no clinical services targeted at lesbian, gay, bi-sexual, transgender and transsexual persons (LGBTT), youth or youth with disabilities.

> "There is a very bad attitude towards gay people, the population has not accepted them ... even among health workers. I believe that people need a lot of education on that issues. Health workers need to understand the individual's right to care." – Interview respondent (health practitioner)

There was no service provision or collaboration sought with NGOs offering services to LGBTT populations. Most health practitioners did not know the names of any NGOs offering services to the

LGBTT community – for example, GrenCHAP. There were no pamphlets with information for LGBTT or youth in waiting rooms, though one health practitioner noted that sometimes information came from the MoE on HIV prevention among young people but they had run out. No information about SRHR of these populations was available for clients at health facilities visited, nor was any SRHR policy to guide service delivery to vulnerable groups made accessible for viewing.

Health practitioners interviewed at medical stations and health centres reported no staff visits to NGOs offering services to the LGBTT community and minimal to no contact with youth groups. In the event that health practitioners did outreach to youth groups, it was upon invitation. While school visits for in-school youth were part of health promotion, clinical service delivery targeted at youth was minimal to non-existent.

Additionally, while all health practitioners interviewed claimed that confidentiality of client records was maintained and that a confidentiality policy existed, no one interviewed could produce a copy of this policy. One health practitioner said that the confidentiality policy was covered in nursing school.

Box 1. Key elements of youth-friendly services

Service providers should:

- be specially trained;
- show respect for adolescents and young people;
- consider the best interests of the young person and take into account their evolving capacity;
- ensure privacy and confidentiality;
- allow adequate time for client-provider interaction.

Health facilities should:

- have separate, adequate space or special times set aside for consultations with adolescents and young people;
- be in an easy-to-reach location and be open at convenient times.

The programme should be designed:

- with involvement of adolescents and young people through design, service outreach, service delivery and feedback;
- so that drop-in clients are welcome and appointments are arranged rapidly;
- to welcome both boys and young men and girls and young women;
- to provide a wide range of services and referrals, including peer counselling.

Source: UNFPA, 2003.

All health practitioners interviewed claimed no contact with LGBTT populations in the delivery of services and minimal to no contact with differently-abled youth.

Specific vulnerabilities of youth

Data collected among Grenadian youth through the Global School-based Student Health Survey (GSHS) report forced sexual intercourse among both girls and boys. In some instances comparable and slightly higher rates were reported among boys, as was the case in Grenada's 2008 survey: 14.7 per cent boys and 14.1 per cent girls reported having been physically forced to have sexual intercourse when they did not want to. Furthermore, as reported in a baseline survey for an HFLE pilot study in 2005 (NIDCU, 2010), out of 525 secondary school students (approximately equal numbers of boys and girls):

- About a third of boys and 8 per cent of girls reported that they had had sex.
- Forced sex was reported by almost 1 in 5 of all sexually initiated students (16 per cent).
- Among those who reported having had sex, two-thirds did not use a condom all the time.
- Approximately one in ten students (12 per cent) reported being drunk at least once. Boys were approximately twice as likely as girls to report having been drunk.

Table 12 highlights some other important issues when addressing the sexual and reproductive ill health and vulnerability of Grenadian youth to HIV.

Table 12. GSHS Grenada fact sheet data 2008

Results for students aged 13-15 years	Total	Boys	Girls
Sexual Behaviours that contribute to HIV Infections, Other STIs, and Unintended Pregnancies			
Percentage of students who have ever had sexual intercourse	**26.5 ± 3.4**	**42.9 ± 6.4**	**14.8 ± 3.8**
Percentage of students who ever had sexual intercourse with two or more people during their life	**21.7 ± 2.8**	**34.9 ± 5.5**	**11.4 ± 2.4**
Among students who ever had sexual intercourse, the percentage who used a condom the last time they had sexual intercourse	**57.0 ± 6.3**	**57.0 ± 7.1**	*
Mental Health			
Percentage of students who felt lonely most of the time or always during the past 12 months	**14.2 ± 2.0**	**11.6 ± 3.0**	**16.2 ± 3.3**
Percentage of students who ever seriously considered attempting suicide during the past 12 months	**21.3 ± 2.9**	**17.9 ± 4.6**	**24.0 ± 4.1**
Percentage of students who have no close friends	**8.9 ± 2.0**	**9.4 ± 2.5**	**8.3 ± 2.9**
Unintentional Injuries and Violence			
Percentage of students who were physically attacked one or more times during the past 12 months	**41.0 ± 4.6**	**55.2 ± 4.6**	**30.0 ± 6.1**
Percentage of students who were in a physical fight one or more times during the past 12 months	**38.2 ± 3.4**	**52.7 ± 5.8**	**26.9 ± 4.5**
Percentage of students who were seriously injured one or more times during the past 12 months	**44.9 ± 4.1**	**52.4 ± 6.1**	**38.8 ± 5.5**
Percentage of students who were bullied on one or more days during the past 30 days	**27.2 ± 4.0**	**28.6 ± 6.1**	**26.1 ± 4.4**

Notes: 2009 data not yet released online; * indicates less than 100 students. *Source: WHO, 2008b.*

Drug and alcohol use and HIV among young people in Grenada

A semi-qualitative research study supported by the United Nations Office on Drugs and Crime (UNODC) Regional Office for Barbados was conducted in 2004 on the link between drug use and HIV/AIDS among young Grenadians. The key findings are worth including in their entirety:

> "Marijuana and alcohol are widely used among youth. Marijuana is the drug of choice among young persons with first use age as early as 10-13 years. Alcohol is used mainly at parties, fun occasions and in socializing, and its general social acceptance results in the minimization of its dangers by the society. The ready availability of alcohol at home and marijuana through local cultivation and cheap prices provided easy accessibility to these drugs. Cocaine and combining drugs were not popular practices among adolescents.
>
> "Young people used drugs for many reasons. The primary reason is for stress relief, to escape from problems – all focus groups identified marijuana as the main drug used for this purpose. Other significant factors include poor parent-child relationship, negative peer pressure (90 per cent), curiosity (60 per cent), fun (60 per cent), and to improve academic performance (60 per cent). Though not the main deciding factor, poor socio-economic status is influential in determining risky behaviour among youth.
>
> "The majority of young people seem to be sexually active. Factors influencing sexual behaviour among youth are peer pressure (90 per cent), experimentation (80 per cent), adult influences (70 per cent), hormones (70 per cent), money (60 per cent) and media influence (40 per cent). Half of ten focus groups and 75 per cent of all female groups report that love coupled with fear of loss are the main reasons for girls having sex for the first time.
>
> "100 per cent focus groups report multiple partnering as prevalent among youths as well as homosexual practices, particularly for monetary gain among young males with older men. There is also a trend of girls engaging in sexual activity with older men to facilitate easy access to money – poor young girls seem to be more involved in this activity, though girls of other strata were not immune to it.
>
> "Most young persons do not use condoms all of the time during sexual intercourse, and few use condoms at all, especially with their main boyfriend; 30 per cent practice coitus interruptus. The reasons for not using a condom during sex are love and trust (60 per cent) and 50 per cent believe that greater sexual satisfaction is achieved without a condom.
>
> "Young people are generally knowledgeable about how HIV/AIDS is contracted. Though unprotected sex was seen as a major risk factor, the majority of sexually active youth are reported to practice unprotected sex. Teenagers are generally believed to be more at risk for contracting the disease; further, some believe that girls are more vulnerable to SIDs [sic]. However, others believe HIV/AIDS is an adult disease.

"Most young people believe that marijuana and alcoholic beverages increase libido and sexual potency. Young people therefore do deliberately consume drugs for better sex. Alcohol (20 per cent) and Spanish fly (30 per cent) are substances used by boys to 'drug' girls mainly for their sexual pleasure.

"Further, youth are aware of the implications of using drugs – impaired judgment, short-term memory loss and potential sex without the use of condoms – increasing the risk of contracting HIV/AIDS. Young persons are then able to make the link between drug use and HIV/AIDS.

"Current prevention strategies, although somewhat influential, are generally perceived as ineffective by youth. They favour programmes that increased and encouraged parent involvement (60 per cent), improvement of socio-economic situations (50 per cent), were school-based (50 per cent), community-based (50 per cent) targeting youth on the block and the general public, and use of drug and HIV/AIDS victims (50 per cent) in these programmes. More youth participation through youth-to-youth interaction (40 per cent) and the use of entertainment and creative arts will help to increase the impact of prevention programmes on youth." *(UNODC, n.d.)*

5. Inadequate Protection of SRHR

The national legislative framework for Grenada is guided by the Constitution Order 1973. Chapter 1 notes that regardless of race, place of origin, political opinions, colour, creed or sex, every person in Grenada is entitled to the fundamental rights and freedoms of (a) life, liberty, security of person and the protection of law; (b) freedom of conscience, of expression and of assembly and association; (c) protection for the privacy of home and other property and from deprivation of property without compensation; and (d) the right to work. Grenada has also agreed to, signed or ratified a number of human rights conventions and other instruments (see Table 13).

Table 13. Relevant multilateral commitments, conventions and international human rights instruments

• International Covenant on Economic, Social and Cultural Rights
• International Covenant on Civil and Political Rights
• Convention on the Rights of the Child
• United Nations Convention Against Illicit Traffic in Narcotics Drugs and Psychotropic Substances
• Inter-American Convention on Mutual Assistance in Criminal Matters
• Charter of the Organization of American States
• Convention on the Political Rights for Women
• Convention on the Elimination of All Forms of Discrimination against Women
• The United Nations Convention on the Rights of Persons with Disabilities (Grenada signed on 12 July 2010. Has yet to ratify. Grenada has not yet signed the Optional Protocol)
• The ICPD Cairo Programme of Action
• The Declaration of Commitment on HIV/AIDS

At the Principals and Partners Meeting for Outlining the National HIV/AIDS Strategic Plan held in February 2008, there was recognition of the need to create an enabling environment for universal access to prevention, treatment, care and support services.

The human rights environment was seen as principle in this regard, and participants reconfirmed a number of recommendations put forward for constitutional reform in the National HIV/AIDS Assessment of the Law Ethics and Human Rights Project in Grenada, *Review of the Laws of Grenada, Carriacou and Petit Martinique for Implications of Discrimination and Breach of Human Rights, January 2008* (see Table 14).

Table 14. Recommended constitutional and legislative amendments from a 2008 review of Grenada's laws

Address discrimination on the ground of sexual orientation	Amendment to the law giving young persons the right to be tested at age 16 without the consent of a parent, equating this law with that of the age of sexual consent
Legislation recognizing male involvement in sex work	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
Legislation giving similar protection to young boys as to young girls	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	Amendment to the prison act, specifying who should have access to inmate 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

Table 14. continued - Recommended constitutional and legislative amendments from a 2008 review of Grenada's laws	
Amendment to the Immigration Act removing the possibility of a person being denied entry into Grenada because of that person's HIV status	Amendment to the Police Act to provide for treatment and care of police officers who contract HIV and also job security for those police officers who are living with HIV
Amendment to the Employment Act preventing mandatory HIV testing of employees and specifically providing that the health status of an employee cannot be used by an employer as a factor to dismiss an employee	Review of the Criminal Code as it related to unlawful connexion between consenting adults with a view to decriminalization, especially in light of the recommended Constitutional amendment
Review of the law of evidence as it relates to rape cases taking into consideration the corroboration requirement	Review of the law of evidence as it relates to rape cases especially making it mandatory that cases involving rape and indecent assault be tried 'in camera'
Recommendations for other policy, systems and services:	
Counselling for all people living with HIV (PLWHIV), their families and all persons affected by HIV/AIDS	Legal support for PLWHIV and their families
Job security for PLWHIV and their families	Female and male condom availability and promotion
Management of all STIs	Home-based care of PLWHIV
Post exposure prophylaxis as a general response to rape	Comprehensive HIV prevention and care programmes

Source: Friday, 2008.

Since the 2008 review of HIV and AIDS-related laws in Grenada, some efforts have been made toward addressing some of the deficits, particularly as related to treatment of child abuse and domestic and sexual violence. There are now a Child Abuse Protocol and a National Domestic Violence and Sexual Abuse Protocol for Grenada. However, implementation processes are unclear.

It should be noted that the Child Abuse Protocol is not fully enforced, particularly the mandatory reporting component, as there is not enough capacity to place large numbers of children-at-risk in protective care, especially boys (Government of Grenada, 2007).

The Organisation of Eastern Caribbean States (OECS) Family Law Reform and Domestic Violence project, in which Grenada is a participating country, provides technical assistance for legislative and judicial reform with the following five goals:

1. Revised OECS family law reform bills for passage in parliament;
2. A plan of action to address other identified areas for law reform;
3. A mapping of social services delivery gaps;
4. A plan of action for the institutional strengthening and capacity-building of relevant social service agencies;
5. A training and stakeholders outreach programme to guide effective implementation of the legislation.

The MoSD has been instrumental in supporting legal reform and has spearheaded the OECS law reform project. Through this, the Domestic Violence Bill 2010 was passed during a sitting of the House of Representatives on 29 October 2010. The Bill repeals the Domestic Violence Act. No. 15 of 2001, makes provision for the granting of protection orders and addresses economic vulnerability and the protection of the rights of children affected. At the same time, the Child Protection and Adoption Bill 2010 was also passed in Parliament. The MoSD continues to support the development and adoption of a National Gender Policy in conjunction with GNOW.

Current practice to be reformed upon implementation of the Domestic Violence Bill 2010 includes:

• Doctors and other health-care professionals are not required to report cases of domestic and sexual violence for adult survivors. Reports when completed vary in details. Doctors are typically not trained in responding to domestic violence.

• The police Community Relations Department (CRD) has domestic violence included in its mandate as a special area for attention. However, all police units respond to domestic violence and there is no designated unit for handling cases/incidents. Specialized training on domestic violence in police training school is limited and only provided by NGOs and the MoSD at intervals.

• The MoSD is the primary ministry providing advocacy and other support for addressing domestic violence, in collaboration with the MoE and the MoH. The MoSD Domestic Violence Unit has few human resources (one staff person) and is responsible for generating reports and providing some counselling services. It also has oversight of admission to a shelter.

• LACC provides legal counselling, research and advocacy support and implements the batterer intervention programme mentioned earlier, which is a court-based referral programme.

• The justice sector response to domestic violence has been clumsy, and access to justice by survivors is compromised by insensitive handling of cases and a lack of punitive action for offenders.

Grenada's abortion policy

Abortion in Grenada is governed by sections 234, 247 and 250 of the Criminal Code. The code provides that:

> "Whoever intentionally and unlawfully causes abortion or miscarriage shall be liable to imprisonment for ten years". Furthermore, "the offence of causing abortion or miscarriage of a woman can be committed either by that woman or by any other person; and that woman or any other person can be guilty of using means with intent to commit that offence, although the woman is not in fact pregnant. The offence of causing abortion can be committed by causing a woman to be prematurely delivered of a child, with intent unlawfully to cause or hasten the death of the child." It also provides that "Where any person does an act in good faith, for the purpose of medical or surgical treatment, an intent to cause death shall not be presumed from the fact that the act was or appeared likely to cause death" and that "Any act which is done, in good faith and without negligence, for the purpose of medical or surgical treatment of a pregnant woman is justifiable, although it causes or is intended to cause abortion or miscarriage, or premature delivery, or the death of the child."

Abortion is permitted in Grenada to save the life of the woman, to preserve physical health and/or to preserve mental health. It is not permitted on the grounds of rape or incest, foetal impairment, economic or social reasons or on request. The Government has expressed particular concern about morbidity and mortality resulting from induced abortion, complications of childbearing and childbirth.[9] Only the General Hospital in St. George's offers prevention of unsafe abortion in the form of counselling and family planning options with a view to deter women from having unplanned pregnancies, and post-abortion care and contraceptives for young people are not accessible.

According to a study undertaken at a private clinic in 1994, *"for every 400 live births to teenagers, there are approximately 200 abortions"* (Government of Grenada 2006).

Treatment of marital rape

Like many Caribbean countries, Grenada's treatment of marital rape is conditional and needs review. GNOW has been advocating for more stringent provisions.

[9] The Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Affairs of the United Nations Secretariat.

6. Lack of a Coordinated National Response on HIV and AIDS

Epidemiological overview

The Grenada UNGASS Country Progress Report for 2010 states a cumulative total of 403 HIV/AIDS cases confirmed in Grenada at the end of 2009. It further notes that *"while 13 persons out of a total of 5,963 tested in 2008 and 2009 were HIV positive, for the same period there were 56 newly diagnosed HIV positive cases"* (NIDCU, 2010).

As stated in the report there are few or no data on the most-at-risk populations; it references the findings of the preceding UNGASS country report, which stated that using quantitative data from various sources – including national surveillance data, the 2005 Behavioural Surveillance Surveys in six countries of the OECS, the UNICEF baseline survey for the HFLE curriculum study and information from key informants within MSM and sex worker-specific NGOs – the Grenada National AIDS Council had identified the following as being high-risk populations: MSM, sex workers, prisoners, youths, females and uniformed personnel (e.g. police and prison officers) (ibid.).

The report further notes:

- More males remain infected, with a cumulative male to female ratio of 1.8: 1;
- Among AIDS cases, 85 (or 70 per cent) of reported cases and 76 (or 82.6 per cent) of AIDS-related deaths were among persons aged 15–44 years;
- There is no known case of transmission through intravenous drug use and no record of transmission via blood transfusion;
- In 2009 the estimated prevalence rate of persons living with HIV/AIDS in Grenada was 0.57 per cent; it was about the same, 0.56 per cent, in 2008;
- Statistics provided by NIDCU reveal a total of 54 persons with advanced HIV disease on ART, 29 males and 25 females;
- Highly active antiretroviral treatment (HAART) was introduced in Grenada in October 2003. There followed years of fluctuating mortality figures (6 in 2004, 10 in 2005, 7 in 2006, 14 in 2007, 8 in 2008 and 7 in 2009) with no clear reduction;
- 137 male inmates (59 per cent of inmates on the survey days) of Her Majesty's Prison in Grenada were surveyed for their HIV serological status in August of 2005. Eight-three per cent of the survey participants were between the ages of 15 to 49 years. The seroprevalence rate for all inmates tested was 2.2 per cent and all HIV-positive inmates were age 15–49 years. (Ibid.)

Additionally, the report notes, *"Stigma is prevalent in Grenadian society which has the effect of the epidemic in the most-at-risk groups not being well captured by data and analysed. No new behaviour survey was conducted in the last two years."* (Ibid.)

Surveillance challenges: measuring prevalence and incidence of HIV and AIDS in Grenada

HIV and AIDS epidemics are typically defined by HIV prevalence rates in the population, i.e., the percentage of the population that is living with the disease. In a generalized epidemic HIV prevalence is 1 per cent or more in the general population; in a concentrated epidemic HIV prevalence is below

1 per cent in the general population but exceeds 5 per cent in particular groups or sup-populations. An epidemic is considered 'low level' if HIV prevalence is not recorded at any significant level in any population/population groups.

According to the Caribbean Epidemiological Centre (CAREC) *"Current HIV/AIDS/STI surveillance systems are heavily based on case reporting of AIDS and STI and a few HIV serosurveys initiated ... to determine HIV point prevalence among pregnant women".* (CAREC, 2002)

CAREC further notes the following data sources for HIV/AIDS/STI surveillance:

- clinician reporting
- laboratory reporting
- early detection/screening programmes
- behavioural surveys
- special studies, i.e., cross sectional surveys and aetiological studies
- registries and patient management information databases (ibid.)

As noted previously Grenada has limited – and no current – studies or behavioural surveys, limited screening programmes and inefficient patient management databases. Additionally, there is limited to no data collection among vulnerable populations, in particular sexual minority groups such as homosexuals and non-gay identifying MSM also having sex with women.

The UNGASS report for 2010 states:

> "It is also questionable whether the introduction of HAART (Highly Active Anti-retroviral Treatment) has had any effect on the numbers of persons getting testing. This is partially due to stigma (which remains deeply rooted in the society) as well as to the perception that HIV/AIDS is still seen by many as a death sentence. The majority of persons who tested positive for HIV did not come from VCT [voluntary counselling and testing] either." (NICDU 2010)

Judging from the above, it is difficult to truly know the nature of the HIV epidemic in Grenada.

Status of national response coordination

The national HIV and AIDS response was previously planned and implemented through the National AIDS Directorate (NAD), the National AIDS Commission (NAC) and the National Infectious Disease Control Unit (NIDCU). These were under the direction of the National AIDS Council and subsequently, with a restructuring of the national response, the NAD was disbanded in June of 2009. This has left the National Strategic Plan on HIV and AIDS in draft form and the national response fragmented. Interview respondents reported that recently UNAIDS has provided support for the establishment of an HIV Office.

UNAIDS, the World Bank and other international agencies also provided support to the development of a draft NSP on HIV. It was not possible to obtain a copy of the most recent draft for the purposes

of this assessment, although several requests were made to several different persons. A committee comprised of government representatives and the National AIDS Council has been put together to assist in the review of the draft NSP, but it is unclear what stage they have reached. Interview respondents claim that the MoH is currently seeking support from the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) for costing of the operational planning component of the document.

The report on the Government of Grenada HIV/AIDS Prevention and Control Project, funded by the World Bank, notes:

> "As it was, the Grenada project experienced great difficulties and significant delays partly because of the disconnect between the NAD and NIDCU. Putting the NAD in the OPM [Office of the Prime Minister] created an additional reporting relationship. It would have been better to keep both the NAD and the NIDCU under the MoH. This would have fostered better communication, improved working relationships and understanding of each other's role, and less rivalry." *(World Bank, 2009)*

The NAC is linked with the MoH through NIDCU and the Policy and Planning Unit. Its membership includes several faith-based organizations and NGOs working with the most vulnerable populations in Grenada, such as the Hope Pals Foundation, GRENCHAP, GRENCODA and GNOW.

Strategic planning priorities for the national HIV and AIDS response in Grenada

A national consultation was held on 18–20 February 2008 to develop the strategic outline for the NSP. This Principals and Partners Meeting for Outlining the National HIV/AIDS Strategic Plan put forward several recommendations including:

- Expand community-based programmes;
- Increase political and stakeholder buy in for policy development and implementation;
- Strengthen multi-sectoral approaches;
- Consider decentralization and/or replication of facilities and services to promote greater access;
- Invest more in public health programmes;
- Leaders in political, religious and traditional roles should confront taboos and stigma against HIV/AIDS (their own and those of their communities);
- Set up active surveillance systems;
- Invest in behaviour change programmes led by technical experts;
- Examine existing partnership arrangements and identify gaps in coordination systems;
- Engagement of the Ministry of Legal Affairs and Ministry of Community Development should be visible and active in the public sector response;
- Design a system that will be well monitored and evaluated;
- Propose a blueprint for sustainability of the various systems.

Currently, HIV and AIDS clinical services are mostly centralized with all positive cases being referred to NIDCU, which runs the National Infectious Disease Clinic devoted to HIV treatment and care. In

an assessment of MoH prevention of mother-to-child transmission (PMTCT) services it was noted that as a result of high levels of stigma and discrimination among health-care providers, results are passed on to the antiretroviral (ARV) clinic (located at NIDCU) and its clinical team contacts the client (MoH, 2007. The majority of public health-care facilities are limited to offering pre- and post-HIV test counselling (NIDCU, 2010).

In its 2010 draft Corporate Plan, the objectives of NIDCU are identified as:

1. To reduce the impact of infectious diseases on the individual, the family and society;
2. To control the spread of STIs including HIV;
3. To arrest the progress of the AIDS epidemic;
4. To facilitate the management of any emerging and re-emerging infectious diseases.

Contrary to planned advancements, rapid testing has not yet been introduced into public health facilities. Interview respondents noted that training was provided for the provision of rapid testing, but due to lack of adequate facilities this training was not put to use and is now no longer relevant. A new round of training is currently being undertaken. Sites have yet to be fully equipped to implement rapid testing, and only personnel at St. George's Health Centre out of the MoH facilities visited claimed to have a room identified for this. There was no equipment yet provided. As St. George is the most populated and most urban parish in Grenada, the lack of rapid testing is of even greater concern.

While the World Bank notes 36 public testing sites functioning as of 2009 (World Bank, 2009), consultant field visits and interviews for the undertaking of this assessment from August to November 2010 reveal that public heath centres/clinics and medical stations offer testing on 'blood-taking days' only. One interview respondent reported that a client coming for an HIV test on a day when blood was not being taken was asked to come back. Furthermore, on the days when tests are administered, persons must arrive before the ambulance is sent to retrieve blood from testing sites for delivery to the hospital laboratory in St. George's.

While decentralization of HIV services is being discussed, there are no current plans illustrating the 'how' of this process, which is expected to be spearheaded by the Policy and Planning Unit and NIDCU. Interview respondents argue that decentralization would require a vast increase in human and financial resources that are currently well beyond the means of the health sector, public and private. It was reported that there has been progress with decentralization of mental health services into community-based service provision at health centres. However, interview respondents indicate that these services are limited and offered at some medical stations only twice a month.

National HIV and AIDS response planning and implementation in Grenada is largely influenced by international and regional bodies. Key regional responses to HIV prevention, treatment, care and support are directed through the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) – based at CARICOM headquarters in Guyana; the Organisation of Eastern Caribbean States (OECS) HIV AIDS Programme Unit (HAPU); and the Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC).

Through PANCAP, the Caribbean Monitoring and Evaluation Technical Working Group coordinates regional agencies in the implementation of the Caribbean Regional Strategic Framework (CRSF) on HIV and AIDS, the most current of which covers the years 2008 through to 2012.

The six main priority areas of the CRSF 2008–2012 are:

1. Building an enabling environment that fosters universal access to HIV and AIDS prevention, treatment, care and support;
2. An expanded and coordinated inter-sectoral response;
3. Prevention of HIV transmission;
4. Treatment, care and support;
5. Capacity development for HIV/AIDS services;
6. Monitoring and evaluation and research.

Despite extensive regional dialogues, consultations and planning meetings for the development of the CRSF, it is unclear whether there is in fact monitoring and evaluation of a regional response to HIV. On a national level, certainly, there was no clear indication of consistent regional support for implementation of the CRSF, especially given that Grenada does not have a current NSP on HIV. It appears that regional and international planning goes beyond what the Grenada MoH is capable of at this time.

7. Limited Bi-Directional Integration of Existing SRH and HIV Clinical Services

Introduction

In addition to interviews with policy makers and planners, data collection was done through interviews with health practitioners at government, non-governmental and private medical facilities as well as clients utilizing government health facilities. As noted in the methodology, the Clinical Service Delivery and Client Exit Interview Questionnaires from the Rapid Assessment Tool were used to collect data on the quality of clinical service delivery of SRH and HIV services.

Health practitioners and clients were included in this rapid assessment from ten health service facilities, six of which were located in St. George, two in Carriacou, one in St. Patrick and one in St. Andrew. These included one private hospital, St. Augustine Medical Service, as well as the Grenada Planned Parenthood Association (GPPA), the only NGO in the country offering SRH services. Client exit interviews were conducted at MoH facilities only. A total of 15 clients ranging in age from 23–47 were interviewed as follows: four from facilities in St. George, four from facilities in St. Patrick, three from facilities in Carriacou, two from facilities in St. John and two from a facility in St. Andrew. Clients interviewed were primarily females receiving prenatal and maternal services, with one male who came for STI treatment.

As also noted in the methodology, health services checklists were administered at health service facilities (including medical stations) to determine the level of service delivery to LGBTT and youth,

including youth with disabilities. Ten health practitioners were interviewed: three in St. George, three in St. John, three in St. Patrick and one in Carriacou.

Defining elements of bi-directional integration of SRH and HIV clinical service provision
Tables 15 and 16 provide basic standards for identifying gaps in bi-directional integration of SRH and HIV clinical service provision.

Table 15. Recommended goals for integrated SRH and HIV service provision in Grenada

a. Sexual health counselling, treatment and supplies provided for the purposes of identifying/ diagnosing vulnerability and reducing exposure of vulnerable groups to risk-promoting environments and behaviour and reducing both SRH and HIV morbidity and mortality.	**b.** Sexual health education and psychosocial support for vulnerable groups including but not limited to sex workers, non-gay identifying MSM, gay, lesbian, bisexual, transgender and transsexual persons, women and girls, differently-abled persons and youth.
c. Youth-friendly and gender-responsive information, education and services accommodating the special sexual and reproductive health needs of young women and men, being sure to focus on detecting and treating child sexual abuse.	**d.** Services to prevent and respond to gender-based violence, including gender-responsive referrals to SRH and HIV services, legal services and psychosocial care.
e. Services targeted at persons with disabilities, including differently-abled female and male youth, inclusive of psychosocial support for protection from sexual and domestic violence.	**f.** Procurement, promotion and provision of condoms (male and female) as the only contraceptive method that provides dual protection against unintended pregnancy and STIs, including HIV.
g. Antenatal and perinatal care for all pregnant women, including delivery and postpartum care, as well as emergency obstetric care that considers HIV status.	**h.** PMTCT Plus, including initial provision of PMTCT interventions to pregnant and delivering women and their newborns; delivery and post-partum care; HIV treatment for women, infants and their families as appropriate; SRH services, including family planning and dual protection advice for women and their partners; and counselling and support with regard to infant feeding options.

Table 15. continued - Recommended goals for integrated SRH and HIV service provision in Grenada

k. Provision of comprehensive family planning services for all people of reproductive age, with non-coercive contraceptive advice tailored to HIV status and counselling and/or provision of safe abortion in circumstances in which it is legal.	**l.** Provision of contraceptive services for dual protection as a component of STI services and other services for vulnerable groups such as sex workers, injecting drug users and MSM.

Adapted from Safreed-Harmon and Daly, 2008.

Box 2. Imperative linkage mechanisms and systems

While there are a number of wider health systems considerations, in the context of SRH and HIV linkages the following systems should be assessed and strengthened:

Partnerships – for situation analysis, planning, budgeting, resource mobilization, advocacy, implementation, monitoring and evaluation by development partners including civil society (networks of people living with HIV, key populations, women's organizations, young people, etc.).

Coordination mechanisms – for SRH and HIV joint planning, management and administration of linked advocacy and policies, and integrated services.

Human resources and capacity-building – joint SRH and HIV capacity-building including in-service training, of health providers and teachers; increase knowledge, skills and understanding of how to eliminate stigma and discrimination and gender inequality.

Logistics and supplies systems – for ensuring SRH and HIV commodities security, preferably combined systems, including but not limited to condoms for dual protection, lubricants, full range of contraceptives, STI drugs, post-exposure prophylaxis kits, delivery kits, 'dignity' kits for humanitarian settings, HIV test kits, post-rape kits, antiretroviral drugs, drugs for opportunistic infections, anti-malarials, iron/folate, safe injecting equipment, methadone, etc.

Laboratories – for the combined needs of SRH and HIV including haemoglobin concentration, blood grouping and typing, STI diagnosis, (including RPR /VDRL for syphilis), HIV diagnosis (including rapid tests), CD4 count, HIV viral load, liver function tests, urinalysis, random blood sugar, pregnancy testing, diagnosis of cervical and other cancers etc.

Source: UNAIDS, 2010.

Current status of SRH and HIV clinical service provision and integration

Overview

> "In 1974, the Government began integrating family planning services into the national health programme. As of 1990, family planning services were available in all health-care clinics throughout the country. The Grenada Planned Parenthood Association provides family planning services through government health centres and a community-based distribution programme, with support from the Ministry of Health."[10]

At the time of this assessment, comprehensive bi-directional SRH and HIV services integration had not been a focus of MoH policies, systems and service delivery, and it is only in recent years becoming the focus of the international development agenda as the HIV and AIDS epidemics are increasingly recognized as socially determined.

The majority of health practitioners surveyed were at MoH operated facilities (80 per cent). As already noted, only one facility was private and one was an NGO. The NGO offers family planning and does not offer HIV services. MoH and private facilities offer prevention and management of STIs and maternal and newborn care. In addition, the MoH offers counselling and family planning options with a view to deter women from having unplanned pregnancies as well as post-abortion care. The private facility offers home-based care for HIV-positive persons along with condom provision, HIV testing and counselling and prophylaxis treatment.

Health practitioners noted the lack of a national framework for SRH in Grenada and that existing SRH services were limited and centred around the reproductive health of women, child care and HIV treatment and care.

> "We don't have a structured sexual and reproductive health clinic. It is only family planning. There is no sexual and reproductive health nurse. We have a list of contraceptive clients." Interview respondent *(health practitioner, MoH)*

Additional examples of limitations identified by interviewed health practitioners in SRH and HIV clinical service delivery include:

- Although syphilis is increasingly presenting in clients, there are no comprehensive prevention programmes to address this;
- There is uncertainty as to the most current practice for administering caesarian sections to HIV-positive mothers;
- There is minimal to no prevention service delivery for HIV-positive persons
- Gender-responsive service provision is lacking, and there is no service provision for prevention and management of gender-based violence;

[10] The Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Affairs of the United Nations Secretariat

- Clients accessing SRH services at MoH-operated facilities are referred to the NIDCU clinic for HIV treatment with the exception of testing and counselling;
- Access to HIV testing is limited, as testing is not done every day at MoH facilities – rural communities are particularly constrained in this regard;
- There is limited service provision targeted at groups that are marginalized on the basis of gender, expressions of sexuality or sexual practice including sex workers and MSM;
- Confidentiality and privacy are concerning for HIV-positive persons due to the small size of Grenada;
- There is currently no national campaign for immunization against human papillomavirus (HPV) and Hepatitis B;
- There is minimal to no HIV prevention information provided at health facilities for marginalized populations, i.e., MSM, sex workers and injecting drug users.

Bi-directional services integration within this limited context of SRH and HIV services is minimal, response rather than prevention-based, and concentrates on the prevention of mother-to-child transmission and condom promotion for protection from STIs, primarily HIV. While voluntary counselling and testing (VCT) is provided fairly consistently, provider initiated testing and counselling (PITC) is inconsistently done, as is counselling and information provision on family planning.

One client interview respondent, aged 24, stated,

> "This is my fourth pregnancy. I asked for information on contraceptives to avoid further pregnancies. Once you reach here is for the whole day. Some women have been sent to pregnancy workshops. There should be more pamphlets in the waiting room. Make more women aware of who they are, their rights, their value, sometimes they want to reach their full potential but it's buried inside. Sometimes they want a partner to dominate them. Have counselling sessions during antenatal care process, like a classroom session with a nurse, and hold these sessions while women wait for care, counselling on women's rights."

Overall, although they are not comprehensively integrated, St. George provides the largest variety of SRH and HIV services while the facilities visited in St. John, St. Patrick and Carriacou primarily offer HIV testing and counselling and male condom provision. St. George's facilities report combined SRH (family planning, prevention and management of STIs and maternal and newborn care) with HIV counselling, prophylaxis treatment, HIV prevention information, condom provisions and PMTCT. St. John's and St. Patrick's facilities offer family planning, prevention and management of STIs and maternal newborn care with HIV counselling and prophylaxis and treatment services. Of all the providers, only one in St. George offers post-abortion care.

Systemic constraints for HIV services integration into SRH services

It should be noted that HIV services integration into existing SRH services is limited as a result of still centralized HIV treatment and care services. This has implications for responding to sexual violence and the availability and administering of post-exposure prophylaxis (PEP). There were no protocols made available at the time of this assessment as pertains to stocking and administering of PEP kits

and post-rape kits, for example. Legislation and protocols recently developed on sexual and domestic violence are yet to be implemented; furthermore, there are limitations to the extent to which systems approaches to managing the procurement, distribution and administering of these SRH commodities have been defined.

Additionally, while the Rapid Assessment Tool did not specify female or male condom usage, condom provision at government health facilities is limited to male condom provision exclusively as the MoH does not procure female condoms. If female condoms are provided at government health facilities, it is usually on the impetus of a donor agency or an NGO. One client interview respondent who is also a nurse claimed that female condoms had been made available for a time in 2005 at her health facility but not since then.

HIV services integration into existing SRH services

As previously indicated, the main HIV services offered at the 10 facilities visited are VCT and STI management, inclusive of male condom provision, and PITC is not consistently practiced. Additionally, data indicates that condom provision is typically administered upon client request rather than as a result of promotion on the part of the service provider. Table 16 illustrates the topics raised by health service practitioner at the time of the client visit, where between two to four practitioners mentioned condoms and prevention of STI or HIV. Relationships and issues of sexuality were discussed by only one to three practitioners only.

Table 16. Topics the health practitioner discussed during the client visit

Topic	# (%) of health service practitioners addressing topics with clients
Family planning	5 (67)
Use of condoms to prevent pregnancy	3 (20)
Use of condoms to prevent HIV/STI	4 (27)
STI management	2 (13)
HIV prevention	4 (27)
Relationships	3 (20)
Sexuality	1 (7)
Other Breastfeeding practice	1 (7)

In the client interviews it was reported that the most mentioned topics during client visits were family planning (33 per cent), use of condoms to prevent HIV/STI (27 per cent), HIV prevention (27 per cent), condom use for prevention of pregnancy (20 per cent) and relationships (20 per cent), all low numbers. It should be noted that none of the health service practitioners raised issues of domestic/sexual violence or breast and cervical cancer prevention/screening. No health practitioner interviewed indicated comprehensive integration of HIV services with prevention and management of STI services at her/his facility.

A client presenting with a cough, explained to the interviewer how she got the cough, *"My sister and her children's father was in a little fight and I ran out of the house after two in the morning and I caught a draft. He buss she head – she get ten stitches."* Through further inquiry the same client revealed,

> "I have unprotected sex but I never really think about HIV. I have had the same partner for the last 2-3 years. He is a womaniser, I tell him already don't bring any sickness for me. But I don't put myself in a position to get HIV. I have two children in secondary school. I want to live to see them grow up. My oldest is 17 years and I don't plan on having any more. I tell him to use a condom, I think he uses a condom because he travels and has to take regular tests. When I ask him to use condoms he asks me why now. When I use condoms about a day after I find there is a smell. I stay with him because from times is he my children see growing up. He is the father of my last child."

The health practitioner providing service to treat the client's cough did not provide any information on HIV or take a sexual history as part of the client screening process.

Of the facilities offering family planning services, 75 per cent were reported as integrating HIV counselling and testing and 75 per cent reported male condom provision. Of these facilities, 67 per cent provide VCT and 33 per cent PITC (see Table 17). All the health practitioners except one reported there was no integration of HIV services with maternal and newborn care services. The health practitioner who reported this did not identify any of the essential HIV services.

Table 17. Health practitioner responses on HIV services included in family planning services

	Total	*SG	*SP	*SP	*C
HIV counselling and testing	6 (75)	3 (50)	1 (100)		2 (100)
VCT	4 (67)	2 (33)	(100)		1 (50)
Provider-initiated testing and counselling (PITC)	2 (33)	1 (16)			1 (50)
Prophylaxis and treatment for PLHIV (opportunistic infections and HIV)	1 (12.5)	1 (16)			
Home-based care	1 (12.5)	1 (16)	1 (100)	1 (100)	1 (50)
Condom provisions	6 (75)	3 (50)			

** Note: SG - St. George; SP - St. Patrick; SJ - St. John; C - Carriacou)*

Despite the fact the pregnant women accessing care are especially accessible due to the likelihood of repeat visits, PITC is still inconsistently provided. Table 18 shows four out of ten facilities reporting service provision in PITC for pregnant women. Additionally, there is no HIV prevention for women of childbearing age and their partners, and only one facility reporting service provision for prevention of unintended pregnancies in HIV- positive women. General prevention is not done, with one provider

Table 18. Health practitioner responses on HIV services included in maternal and newborn care services	
Service	*# (%) of facilities reported as providing the service*
HIV counselling and testing	7 (77.8)
VCT	4 (44.4)
PITC	4 (44.4)
HIV prevention information and services for general population	1 (11.1)
Condom provision	2 (22.2)
PMTCT	
Prevention of HIV among women of childbearing age and partners	0 (0)
Prevention of unintended pregnancies in HIV+ women	1 (11.1)
Prevention of HIV transmission from an HIV+ woman to her child	1 (11.1)
Care and support for the HIV+ mother and her family	0 (0)
No integration	8 (88.9)

reporting HIV prevention information and service provision for the general public and two reporting condom provision.

Regarding follow-up care only 40 per cent of the health practitioners interviewed indicate there is follow up with their clients, but the nature of this was not specified, while 50 per cent indicate that follow up is not carried out. Of these, 60 per cent indicated that it was not necessary and 20 per cent responded they were too busy. One health practitioner indicated a lack of staff to accommodate client follow up.

SRH services integration into existing HIV services

At the 10 facilities visited health practitioners offered the SRH services shown in Table 20. Of note is

Table 19. Health practitioner responses on SRH services offered at the 10 facilities visited				
SRH services offered	*Total*	*NGO*	*MOH*	*Private*
Family planning	8 (80)	1 (100)	6 (75)	1 (100)
Prevention and management of STIs	7 (70)		6 (75)	1 (100)
Maternal and newborn care	9 (90)		8 (100)	1 (100)
Prevention and management of gender-based violence	0 (0)			
Post-abortion care	1 (10)		1 (13)	

that no facilities visited were noted as offering services for the prevention of gender-based violence and only one indicated providing post-abortion care.

The majority of SRH services that are integrated into HIV services (Table 20) are family planning and prevention and management of STIs. The SRH services included with specific HIV services are HIV

Table 20. Summary of SRH services health practitioners reported as integrated into HIV services at the facilities visited

Services	*None*	*Family planning*	*Prevention & management of STIs*	*Maternal & newborn care*	*Management of post-abortion care*
1. SRH services integrated with HIV services	3 (30%)	6 (60%)	5 (50%)	0	0
2. SRH services included in HIV counselling and testing services (n=9)	2 (22.2)	6 (66.7)	6 (66.7)	6 (66.7)	0
3. Included in prophylaxis and treatment (opportunistic infections and HIV) services (n=1)		1 (100)			
4. Included in home-based care services (n=1)			1 (100)	0	0
5. Included in psychosocial support services (n=1)	0	0	1 (100)	0	0
6. Included in services for prevention for and by people living with HIV	0	0	1	0	0
7. Included in HIV prevention and information services for the general population		1 (100)	1 (100)	0	0
8. Included in condom provision services (n=6)	0	4 (66.7)	4 (66.7)	2 (33.3)	0
9. Included in PMTCT services (n=1)			1 (100)	1 (100)	0
10. Included in specific services for key populations (n=1)	0	1 (100)	0	0	0

counselling and testing. Sixty-six per cent of the facilities include family planning and prevention and management of STIs in their HIV counselling and testing services.

When asked how the services are offered, 66 per cent offered them at their location with the same provider and on the same day while the remainder referred to another facility. In terms of follow up to see whether clients acted on referrals, 20 per cent responded that this was done and 60 per cent that is was not; 50 per cent of the facilities that do not monitor follow-up care indicated it was not necessary

Table 21. Rating by health practitioners of how great a constraint it is to offer integrated SRH and HIV services

Constraint	*Not at all*	*Small*	*Medium*	*Large*	*Don't know*
1. Shortage of equipment for offering integrated services	2 (20%)	1 (10%)	3 (30%)	2 (20%)	1 (10%)
2. Shortage of space for offering private and confidential services	2 (20%)	4 (40%)	3 (30%)	0	0
3. Shortage of staff time	1 (10%)	1 (10%)	4 (40%)	3 (30%)	0
4. Shortage of staff training	1 (10%)	3 (30%)	3 (30%)	2 (20%)	0
5. Inappropriate/insufficient staff supervision	6 (60%)	3 (30%)	0	0	0
6. Low staff motivation	2 (20%)	4 (40%)	3 (30%)	0	0

Note: Other constraints included lack of communication and lack of trained counsellors

Health practitioner-perceived advantages and constraints to offering integrated SRH and HIV services

Primary constraints and disadvantages perceived by health practitioners interviewed are highlighted in Table 21. The greatest constraints identified were shortages of staff time, staff training and equipment for offering integrated services. However, these constraints were perceived by only 20–30 per cent of interview respondents.

It is worth mentioning here that perceived constraints/disadvantages on the part of health practitioners certainly correspond to some of the gaps in service delivery, but it is unclear what constraints are present systemically and what constraints are being created through health practitioners' delivery of the service. More strategic use of human resources on site is worth investigating for an increase in service provision to clients.

One client interview respondent accessing services for a pain in her groin area and a vaginal discharge stated: *"I don't use condoms with my boyfriend. According to how you and a person interact will tell you if they have other sexual partners. But there is no guarantee. I have never asked him to use a condom".* This client was not counselled on family planning, condom usage or HIV prevention.

The interview respondent at the NGO identified lack of space, limited staff training and limited staff time as large constraints to integration of SRH and HIV service. Staff motivation and staff supervision were seen as small to medium constraints. Additionally, that respondent perceived an increase in cost of services both for the facility and client, increased workload for providers, increased time spent per client, a need for space and privacy and equipment. However, the respondent also noted a potential increase in efficiency of service provision and a possible decrease in the stigmatization

Table 22. Health practitioner perceptions of linking SRH and HIV services

Constraint	*Decrease*	*No change*	*Increase*	*Don't know*	*Don't know*
1. Costs of services (facility)	4	1	4	0	1 (10%)
2. Cost of services (client)	4	1	4	0	0
3. Efficiency of services	0	0	8	0	0
4. Stigmatization of HIV clients	8	0	0	0	0
5. Stigmatization of SRH clients	8	0	0	0	0
6. Workload for providers	1	1	7	0	0
7. Time spent per client	0	0	9	0	
8. Space and privacy	0	6	3	0	
9. Need for equipment, supplies and drugs	0	0	8	0	

of HIV and SRH clients. The majority (>50 per cent) of the MoH and the private facility respondents indicated a perceived decrease in the cost of services for both the facility and client and a decrease in stigmatization for SRH and HIV clients, as illustrated in Table 22. The MoH and private facility respondents also perceive an increase in efficiency, workload for health practitioners, equipment and time spent per client.

The majority (70.4 per cent) of the clients interviewed had received obstetrical and gynaecological services, approximately 53 per cent of the clients required maternal and newborn care and 20 per cent had other gynaecological issues, including two clients who received treatment for ectopic pregnancies and one for fibroid cysts. Ninety-three per cent of the clients received all of the services they wanted and 46.7 per cent were referred to other services. One client did not receive the sought after services. Clients identified the following things that could improve service provision: economic assistance, maternal and newborn care, on sight ultrasound, and vitamin supplements to be provided

at medical dispensaries in public health facilities. One client also identified "a gift for the baby" when asked what would have made her visit better.

The main concern of clients in terms of receiving SRH and HIV services from the same facility at the same time were stigma and discrimination, noted by 33 per cent of interview respondents, and fear of loss of confidentiality (27%) (see Table 23).

Seventy-three per cent of clients indicated that they prefer the same facility and site for SRH and HIV service delivery. Reasons were primarily linked to convenience (73 per cent) and 18 per cent indicated privacy. Twenty per cent of the clients preferred the services at different facilities and sites, stating that privacy was their main concern. There was a perception among some clients that public health facilities afforded less privacy than privately operated ones.

Table 23. CClient-perceived disadvantages of receiving SRH and HIV services from the same facility at one time

Disadvantages	# (%) of clients out of 15
Fear of stigma and discrimination	5 (33)
Fear of breach of confidentiality	4 (27)
Other Privacy Crowded Lack of trained staff	3 (20) 1 (33) 1 (33) 1 (33)

"I do not usually access these services, I used to get regular check ups, not any more since I moved because of bus fare. Before when I got regular check ups I never got a pap smear – always got blood pressure and some blood tests. I can't remember what the blood tests were for." - Client interview respondent

The majority of client respondents indicated economic issues as the primary benefit of accessing services at the same facility (see Table 24). Specifically, 73 per cent referred to reduced transportation fees, 53 per cent to a reduced number of trips to the facility and 47 per cent to reduced service fees. It should be noted that most clients interviewed were pregnant or receiving post-natal care and said that HIV testing was accepted as part of pre-natal service provision. This could possibly be a reason for the lack of fear of stigma and discrimination and loss of confidentiality. HIV-positive persons would be referred to the National Infectious Disease Control Unit for care and so would not have to receive ARV treatment from the health facility that did the testing and counselling.

Advantages noted by both client and health practitioner respondents centre primarily around decreases in costs as a result of reduced transportation costs and service fees. Additionally, and in contrast to the above-stated disadvantages, interviewed health practitioners perceived an increase in efficiency of services provided if SRH and HIV services were linked as there would be an increase in the amount of time spent with clients.

Table 24. Client-perceived benefits of receiving all SRH and HIV services from the same facility at one time	
Benefits	# (%) of clients out of 15
Reduce number of trips to facility	8 (53)
Improve efficiency of services	2 (13)
Reduce transportation costs	11 (73)
Reduce fees	7 (47)
Reduce stigma for HIV	1 (7)
Other[1] Efficient All records in one place Time More comfort	3 (20) 1 (33) 1 (33) 1 (33) 1 (33)

Note: [1] – one person indicated two reasons

The Rapid Assessment Tool made a distinction between the receipt of services from the same facility and from the same provider. It was difficult to know how clients perceived the differences in the two, though most clients answered similarly for both. Generally, clients saw economic benefits to receiving care from the same provider, indicating a reduction in transportation fees, 60% per cent indicated a perceived reduction in service fees and 53 per cent indicated a perceived reduction in the number of trips to the facility. The main disadvantage of using the same provider (as opposed to the same facility) was fear of stigma and discrimination (27 per cent), fear of lack of confidentiality (20 per cent) and increased waiting time (20 per cent).

Overall, the majority of clients (87 per cent) were satisfied (mostly and very satisfied) with the services they received.

The following summarizes client responses on what can be done to improve service delivery at facilities visited:

- General improvement of services;
- Ceiling fans;
- Improve access to facilities, i.e., having a pharmacy on site, increase the variety of medication available through dispensaries;
- Better retention of nurses and more training on professional communication and a more disciplined approach;
- Reducing waiting time and increase the number of doctors on site;
- Increase information pamphlets in the waiting area;
- Increase staff;
- Provide programmes on sexual health including cervical cancer and STIs;
- Increase equipment on site to reduce referrals, e.g., ultrasound;
- Bigger space;
- More information provided by doctors (one client noted that she was given minimal information and that it was her first pregnancy).

The following summarizes client suggestions for SRH and HIV service integration at facilities visited:

- Better and increased access to testing at facility;
- Daily lectures on SRH and HIV so people will feel more comfortable talking about it;
- Counselling sessions during antenatal process – like classroom session with a nurse – that could be held while women wait for care;
- Counselling on women's rights;
- Keep some services private – ARVs should be taken to your house;
- Provide information on condom usage;
- STI information provided at pregnancy visits;
- Workshops twice monthly for young people;
- Replacement of the coding system, which was not viewed as private and confidential;[11]
- Prevention of pregnancy among people not in a position to help themselves and their children.

Main challenges to bi-directional SRH and HIV services integration

As noted, there is currently no comprehensive SRH service provision and by extension no comprehensive HIV service provision. In addition, of the services that do exist there is limited to no integration of SRH and HIV services. Table 25 identifies some of the key challenges to realizing SRH achievement in Grenada.

Table 25. Key health policy and systems challenges to achieving SRH in Grenada
Lack of national level technical support for process-driven responses that promote targeted and sustainable health system development
Poor understanding of public health management in a PHC context – i.e., the lack of a gender-responsive and human rights-based approach to national health achievement
Competing interests of limited medical personnel between public health service provision and private practice
Lack of implementation of developed policy and a general lack of written policy
Un-strategic and inefficient utilization of and investment in human resources
Lack of research and public inclusion in setting health promotion priorities for diagnosing vulnerability

[11] This refers to the HIV test coding system, where names are not used and a code is assigned to protect client identity on test results.

Table 25. continued - Key health policy and systems challenges to achieving SRH in Grenada
Lack of inter-ministry cooperation and collaboration
Lack of inter-sectoral cooperation and collaboration
Key challenges related to clinical service delivery
Sexual health is not comprehensively understood, addressed or incorporated in reproductive health and HIV policy, systems and services either by governmental or non-governmental service providers
HIV prevention is not addressed as a component of SRHR promotion
SRH and HIV policy, systems and services are primarily treated in parallel with minimal integration
Reproductive health services are not accessible to vulnerable and marginalized groups, but rather focused on maternal and child care, as a result of cultural and religious norms that promote hetero-normativity and heterosexism based on the notion that sex is for reproduction – this perpetuates stigma and discrimination and limits the quality of care to gender and sexual minorities and youth as well as marginalizing men's health needs
HIV services are centralized and focus on treatment and care
Health service delivery has been governed by response-based priorities set within the limitations of existing systems and services, rather than critical and strategic action, priority setting and decision-making
There is limited and inconsistent training for health practitioners, particularly front line personnel, on new SRH technologies
Policy and practice varies according to health practitioner and is often subject to their personal opinions and value systems as these pertain to SRH

Addressing SRH and HIV services integration in the context of PHC systems must include planning and service delivery approaches that are stakeholder-driven and client-centred based on:

- Identifying vulnerability;
- Using gender-responsive and human rights-based approaches;
- Engaging in health promotion and prevention and treatment of ill health that is inter-sectoral and integrative;
- Ensuring inclusion and participation of civil society.

Table 26 provides guidance on general policy, systems and services for SRH and HIV services integration.

Table 26. General policy, systems and services guidance for SRH and HIV services integration

1. Address structural determinants: Root causes of HIV and sexual and reproductive ill health need to be addressed. This includes action to reduce gender inequality and poverty, ensure equity of access to key health services and improve access to information and education opportunities.
2. Focus on human rights and gender: Sexual and reproductive and human rights of all people including women and men living with HIV need to be emphasized, as well as the rights of marginalized populations such as MSM, sex workers and injecting drug users. Gender-sensitive policies to establish gender equality and eliminate gender-based violence are additional requirements.
3. Promote a coordinated and coherent response: Promote attention to SRH priorities within a coordinated and coherent response to HIV that builds on the principles of one national HIV framework, one broad-based multi-sectoral HIV coordinating body, and one agreed country level monitoring and evaluation system (known as the "Three Ones").
4. Meaningfully involve people living with HIV: Women and men living with HIV need to be fully involved in designing, implementing and evaluating policies and programmes and research that affect their lives.
5. Foster community participation: Young people, key vulnerable populations and the community at large are essential partners for an adequate response to the described challenges and for meeting the needs of affected people and communities.

Table 26. continued - General policy, systems and services guidance for SRH and HIV services integration
6. Reduce stigma and discrimination: More vigorous legal and policy measures are urgently required to protect people living with HIV and vulnerable populations from discrimination.
7. Recognize the centrality of sexuality: Sexuality is an essential element in human life and in individual, family and community well-being.

8. Limited SRH Commodity Procurement and Distribution Systems

MoH procurement of SRH commodities is governed by the OECS Pharmaceutical Procurement Services (PPS), of which a technical advisory committee meets annually to review the 7th OECS Medicine Formulary. The committee discusses and determines what SRH commodities will be purchased for distribution in the OECS member countries.

The draft NSP for Health 2007-2011 notes that there is *"weak procurement, inventory management and distribution systems for medical consumables, drugs and other supplies," and with regard to donations recommends that the MoH "enforce [the] donations policy with respect to medical supplies and drugs"* (Government of Grenada, 2006). Currently, the Grenada MoH procures the following main SRH (contraceptive) commodities:

- Prevention of pregnancy only: Depo Provera, Noristerat, Microgynon
- Dual protection: male condoms

Interview respondents report resistance to procuring female condoms at the OECS level and no MoH intentions to do so. As noted above, NGOs are said to be the only service providers that distribute female condoms when they are made available to them (mostly through international donors). Interview respondents stated that donated condoms are not typically recorded nor is distribution tracked. The last donation of female condoms recalled by one respondent was post-Hurricane Ivan, and these were passed on to the NAD for distribution. NIDCU reports having had limited access to female condoms.

There is no in-country testing of the effects of contraceptive drugs on female clients, although respondents have indicated that there have been concerns with the effects of Depo Provera in particular. No SRH drug trials are conducted by the MoH. There is no in-country surveillance of SRH commodity usage and so the procurement and distribution of male condoms, for example, is not

governed by client demand but based on availability. Interview respondents indicate that there is no national procurement plan and no logistics plan for forecasting needs. This results in shortages of male condoms. As previously noted, female condoms are not procured by the MoH.

SRH commodity distribution to rural medical facilities is compromised by an unclear distribution policy and practice, and when health centres request commodities – condoms specifically – access is not guaranteed. Some respondents reported that such requests were simply made via telephone, but while 1,000 condoms might be requested the facility might only receive 500. Furthermore, the level of training on contraceptive technologies seems low and inconsistent.

9. No Comprehensive SRH Education for In- or Out-of-School Youth

The responsibility of the MoE for service provision to out-of-school youth is not clear. There are currently no comprehensive MoE programmes for youth not in school. Other ministry support is limited and does not adequately address issues of sexual and reproductive health. Typically youth who are out of school are seen as deviant. The 'boys on the block' label is pervasive and this group of youngsters, typically males, are seen as perpetuating crime and violence in communities.

Due to the limitations of time and documentation, this assessment focused on the MoE response to youth SRHR. The MoE houses an HIV and AIDS Response Coordinator (this position is meant to provide a link to the broader national HIV and AIDS response and is the only one of its kind in any line ministry), the Drug Control Programme and the Health and Family Life Education (HFLE) Programme.

Interview respondents referred to an intended shift in focus of the MoE to 'holistic education' that is based on *"more than academics"*. Further discussion on the intended changes to the current curriculum to achieve this revealed an emphasis on developing life-skills through 'values-based learning'. Respondents indicated that Christianity-based education models would be adapted from programmes deemed successful in the United States. However, human rights-based approaches are not mainstreamed into this renewed approach. One interview respondent expressed the view that academics must include spirituality, which was defined as Christian. This same respondent further stated that *"human rights-based approaches are 'theoretical'".*

While there are more resilience-focused initiatives, the lack of a human rights-based approach to education has serious implications for health achievement in Grenada. Indeed, what then are the implications of the current approach for existing and planned life-skills, behaviour change and parenting programmes being facilitated through the MoE? In the case of SRH education, cultural beliefs echoed in religious value systems and embedded in the education sector have the potential to impede the ability of the sector to effectively address issues such as child sexual abuse, transactional sex, incest and HIV.

A recent assessment of the gender responsiveness of the HFLE curriculum was undertaken with support from the United Nations Development Fund for Women (UNIFEM). The assessment was managed by the HIV and AIDS Response Coordinator with the support of the HFLE Curriculum Developer Officer. A consultant was hired and the report, yet unreleased, is being reviewed by ministry officials in both education and health.

Through Student Support Services, social issues are addressed and assistance programmes for students are provided in a number of areas. There is a counselling arm that comprises a chief counsellor and secondary school counsellors, and there is now training being undertaken for primary school counsellors; however, there will not be one per school. Additionally the Student Activities Coordinator, with responsibility for Girl Guides, Boy Scouts and other education sector-approved/initiated extra curricular activities, is expected to be supporting the development of a student council initiative. There is currently a draft Student Council Policy with the goal of finalization by the end of the year. Synergies between the Student Support Services, the HFLE Programme, the Drug Control Programme, Student Councils and the HIV and AIDS Response Coordinator should be explored, and joint planning with the MoH for gender-responsive and human rights-based programmes formalized.

Social programmes embedded in regular school functioning include a school feeding programme, a text book programme, a necessitous funds initiative and mentoring programmes. Reports on the effectiveness of these programmes were not easily accessed at the time of this rapid assessment.

Interview respondents indicated that the Education Policy for Grenada does address HIV and that there is sporadic training for teachers on HIV including the application of universal precautions in the case of accidents on school property involving blood/bodily fluids. A copy of the Education Policy was not easily accessed at the time of the interview but there is clear indication of the MoE's commitment to continuing HIV education as illustrated in the HFLE curriculum and HIV education initiatives undertaken under the HIV and AIDS Response Coordinator's portfolio, although there is no particular strategic plan for SRH and HIV nor specific budgetary allocations. The National Schools Policy on Drugs, developed by the Drug Avoidance Secretariat and adopted by Cabinet in February 2002, makes reference to HIV and AIDS Education as follows:

> "HIV/AIDS Education: Statistics from the Ministry of Health reveal that some children and young people have fallen victim to the HIV/AIDS virus. It is therefore necessary to educate students about this growing menace and its deadly consequences. There is a direct correlation between drug use and HIV/AIDS; both are lifestyle issues. The Ministry of Health plays a strategic role in HIV/AIDS education."

Box 3. Characteristics of successful health education programmes to prevent HIV

This list is based on reviews of school-based HIV prevention programmes in over 38 countries. Health education programmes provide basic, accurate information that is relevant to behaviour change, especially regarding the risks of unprotected intercourse and methods for avoiding unprotected intercourse.

Successful health education programmes have the following characteristics:

- They make use of social learning theories as the foundation for programme development.
- They are age-appropriate so they target students in different age groups and at different stages of development with suitable relevant messages and appropriate goals. For example, a programme for younger students who are not yet sexually active might have the goal of delaying initiation of intercourse; but a programme for older sexually active students might place emphasis on reducing the number of sexual partners and encouraging use of condoms.
- They are gender sensitive, and intended for both boys and girls.
- They use participatory activities such as games, role-playing and group discussions to personalize information, explore attitudes and values, and allow practice of skills.
- They include training for teachers and trainers, so that implementers master the basic information about HIV and AIDS, and opportunities for them to practise and become confident in life-skills training methods.
- They emphasize clear and appropriate values that strengthen individual values and group norms against unprotected sex.
- They offer modelling and practice in communication and negotiation skills, as well as other related life skills.
- They address social influences on sexual behaviour, including the important role of the media and peers.
- They support reproductive health and HIV/STI prevention programmes set up by school authorities, decision- makers and policy-makers, and the community at large.

Source: WHO, 2010.

10. Lack of Comprehensive Gender-Responsive and Human Rights-Based Training for Health Practitioners

"Anything pertaining to sexual and reproductive health is mainly handouts. There are no guidelines really." – Interview respondent (health practitioner, MoH)

Targeted training on gender and HIV vulnerability and mainstreaming gender into policy, systems and services are not consistent or far reaching, Such technical training is limited to availability of funding and technical support from the regional and international development sector. The differential needs of sex workers, homosexuals and other gender and sexual minorities are either ignored, not understood or not investigated. When asked how these people's needs are met, several respondents said *"We do not discriminate, we treat everyone the same".* However, one respondent revealed,

> "I cannot conceptualize homosexuality, I hear about it, but I cannot conceptualize it as a person. Unless the data is showing me that, I do not think we have a problem .... I cannot come to terms with male on male sex" – *Interview respondent (MoH)*

Capacity-building for health counsellors is not done consistently or uniformly. Training addressing SRH and differential needs of vulnerable groups is not prioritized or consistent in any sphere of the public health sector. There is limited formal human resource development planning undertaken and little critical strategic planning done in general.

Of important note is the lack of communication between donor/development agencies and among units at the MoH as pertains to research, policy and programme development and capacity-building initiatives being undertaken. Furthermore sustainability of these efforts is hardly ever planned or achieved.

In the course of the second in-country visit for data collection for this rapid assessment, at a visit to a health centre, it was discovered that research was being undertaken by the MoH in collaboration with PAHO on *Assessing Ante and Post Natal Care in Grenada.* The respondent indicated that other research was being undertaken within the MoH under the same study, but they were unsure as to the details. Key persons involved in coordinating said research had been previously interviewed on the first country visit but no mention had been made of the study or the intended response to outcomes. In addition, in 2006 an assessment was undertaken of HIV and AIDS service provision in Grenada (USAID and others, 2007). These examples highlight the potential for duplication of donor efforts as well as a lack of communication and comprehensive knowledge of relevant health research and other activities within the MoH itself among staff persons in their field of work.

Sustaining capacity-building initiatives is of special concern as otherwise efforts are essentially wasted in the context of improving service delivery system-wide For example, UNIFEM undertook capacity-building training on gender, sexuality and human rights in the health and education sectors, with support from the MoH and the MoE, in 2009 and 2010. Persons involved in the coordination of these two training workshops, with guidance counsellors and teachers in the education sector and nurses with a focus on VCT providers in the health sector, indicated that no additional funding was provided for more training to be delivered in-country and no plans for follow up were included in the planning and implementation of the initiative. During the course of this rapid assessment, several nurses who had attended the training were encountered and indicated that there had indeed been no follow up; however, they indicated in general that the training had positively affected their approach to service delivery.

MoE respondents for this rapid assessment stated that teachers exhibit considerable discomfort in teaching about sex and sexuality to young people. The primary reasons they noted were:

- Fear of negative implications of discussing sex with students as pertains to student-teacher relations;
- Religious and moral beliefs that do not approve of same sex relations;
- The belief that discussing sex inadvertently encourages sexual behaviour among young people.

Most public health programmes for young people are focused on education for behaviour change. In speaking about identifying vulnerability/targeting young people in school-based HIV and STI prevention programmes, one interview respondent replied:

> "Students considered to be troublemakers are spoken to about HIV and AIDS. They are considered troublemakers not necessarily because of sexual behaviour, but general behaviour that is seen to make them vulnerable e.g., attitudes to school work, attitudes about sex, staying out late at night, having problems with parents."

The primary challenges to the education sector treatment of SRH and HIV, according to interview respondents, lies in (1) the lack of financial and human resources to facilitate research for data collection, (2) the lack of gender-responsive programmes and (3) religious and cultural values and beliefs that are in opposition to comprehensive, gender-responsive and human rights-based education.

The United Nations Development Programme (UNDP) has been identified as a funding source for new HIV education texts, including the Heinemann Junior Africa Writers (JAWS) HIV/AIDS series. This would replace the currently used Choices textbook, which was also geared towards African audiences. The JAWS Teachers Guide, a copy of which was supplied for this review, addresses key issues of gender, sexuality and human rights that were not covered in the Choices text. The ten themes that the JAWS series addresses are:

- Feelings
- Life skills
- Death, loss and grief
- Stigma and discrimination
- Information about HIV/AIDS
- Gender, power and human rights
- Prevention
- Care and support
- Normalization and disclosure
- Orphans and vulnerable children

The implementation of this series, with adequate training provided to teachers, would mark a definite advance in the approach to HIV in the education sector.

11.Limited to No Linkages between Health Promotion and Health Literacy

There is a general lack of acknowledgement of health literacy as a building block of achieving health equity in Grenada. As noted previously, the current approaches suggested in the draft NSP for 2007–2011 and the Corporate Plan for 2009 centre around public education and include limited capacity-

building priorities for health practitioners.

The Commission on the Social Determinants of Health notes, *"These inequities in health, avoidable health inequalities, arise because of the circumstances in which people live, work, and age, and the systems put in place to deal with illness"* (CSDH, 2008). Grenada's Country Poverty Assessment 2007–2008 reports the leading health challenges as diabetes, hypertensive cancer, obesity and HIV, all of which are preventable and all of which have implications for individuals' SRH. Additionally, correlations were made between ill health and socio-economic status, which in turn affect access to care and health literacy (Kairi Consultants Limited, n.d.). The Community Health Department has invested in wellness programmes with a focus on behaviour change but have not garnered great success.

"Health literacy is not just about the individual's ability to read, understand, and act of health information, but also the ability of public and private sector actors to communicate health-related information in relevant and easy-to-understand ways. This requires improving awareness and knowledge of health literacy among health professionals. (Rootman and Fordon-El-Bihbety, 2008)

Public health promotion approaches to SRH

A behaviour change model for health promotion is currently employed by the MoH through the Health Promotion Department. Public education is the main strategy used and focuses on reducing risk behaviour for the prevention of STIs, including in particular HIV. Recently efforts have been expanded to include awareness-raising on child sexual abuse and domestic violence. These initiatives are concentrated in the education sector and there is some contact with vulnerable groups, who are targeted through the NGO community and therefore reached in small numbers. A more comprehensive approach incorporating the three main aspects of health promotion – including education, prevention and protection (Tannahill, 1985) – needs to be employed. Furthermore, a larger investment has to be made in promoting health literacy to compliment and reinforce other health promotion initiatives.

Grenada is a signatory to the Caribbean Charter for Health Promotion (1994), which advocates:

- Formulating public health policy
- Reorienting health services
- Empowering communities to achieving well being
- Creating supportive environments
- Developing/increasing personal health skills
- Building alliances with special emphasis on the media (Government of Grenada, 2006)

For prevention efforts to be successful they must be rooted in strategies to reduce vulnerabilities that expose people to risk-taking behaviour and environments. Health promotion should address prevention at all levels; it should not be confined to public education but must be linked with health literacy approaches that integrate health promotion efforts into health policy, systems and services development. The three stages of prevention based on the reduction of vulnerability and risk are defined in Box 4.

Box 4. Three stages of prevention

Primary prevention
All action taken to prevent a health problem from occurring in a particular population, suppressing insofar as possible the emergence of cases of an undesirable event (disease, injuries, deaths), falls within the concept. The tasks involved in primary prevention are the reduction or elimination of exposure to harmful agents or determinants (i.e., risk reduction) and the removal of obstacles that limit the control that populations should have over their health, their environment, and their lives (i.e., reduction of vulnerabilities through protective action, individual and community empowerment, and appropriate programs).

Secondary prevention
Secondary prevention consists of efforts to ensure that even though there has been exposure to a harmful agent, the harm that it may cause can be contained (e.g., early detection of HIV infection so that treatment can be initiated to prevent replication of the virus and the progression of the disease, treatment of pregnant women who test positive for syphilis to prevent cases of congenital syphilis).

Tertiary prevention
Tertiary prevention is designed to prevent the damage caused by harmful agents from resulting in incapacitating injuries and disorders or causes of illness, suffering, or threats to life (e.g., detection of unapparent infections of the female genital tract that can lead to chronic inflammation and tubal injury with secondary infertility).

Source: PAHO, 2010.

The following recommendations were put forward by interview respondents for the improvement of SRH promotion:

- Develop relevant policies
- Have gender-responsive approaches, especially in addressing negative expressions of masculinities and femininities that put individuals at risk;
- Scale up education interventions through innovative approaches including adjusting the language used, making it specific to the target group;
- Increase personal contact with vulnerable populations;
- Increase interventions to support people who cannot support themselves – i.e., great improvements needed in diagnosing vulnerability and making referrals as pertains to survivors of sexual and domestic violence, supporting women and their children who are exposed to such violence.

Box 5. Characteristics of a sexually healthy society

Political commitment: The state recognizes that sexual health is a fundamental human right and takes responsibility for promoting sexual health.

Explicit policies: Social institutions, including governmental agencies, formulate, develop and implement public policies involving clear and precise directions for protecting and promoting sexual health as a fundamental human right.

Legislation: Laws to protect sexual rights are necessary to promote sexual health. Specifically, legislation is needed that protects the vulnerable from exploitation (e.g., child prostitution), recognizes the rights of all persons to integrity of the body (e.g., protection from genital mutilation), protects the rights of sexual minorities to such fundamental human rights as education, health, and employment (e.g. anti-discrimination legislation) and promotes equity across sexual dimensions (e.g., equal opportunity legislation).

Good education/SRH literacy: A necessary component of a sexually healthy society is universal access to age-appropriate, comprehensive sexuality education across the lifespan.

Sufficient infrastructure: To ensure people have access to services, an infrastructure of professionals and paraprofessionals specializing in sexual concerns and problems is necessary. This includes the provision of training programmes for professionals to specialize in sexual health.

Research: A society committed to the sexual health of its members will support adequate and sound research to address the sexual health-related clinical, educational and public health concerns. This includes both research on emerging concerns (e.g., new infections) and behavioural surveillance to monitor preventive health concerns (e.g., rates of unsafe sex in high-risk sub-populations, rates of sexual violence, prevalence of sexual dysfunctions, etc.).

Adequate surveillance, monitoring and evaluation: Surveillance is necessary to monitor biomedical and behavioural markers of sexual health concerns and problems. Effective programmes will integrate monitoring and evaluation mechanisms as part of the development of sustainable, adaptable and transformative approaches.

Culture: A culture of openness to, and prioritization of, sexual health is necessary. Such indicators as the quality of media reporting on sexual health concerns and the degree to which public health messages regarding serious threats to sexual health can be openly promoted can measure the culture.

Source: Adapted from: PAHO 2000.

V. *Global Examples of Successful SRHR Interventions for Programmes with Limited Resources and Relevant to the Grenade Context.*

The examples in this section are taken from *Developing Sexual Health Programmes - A Framework for Action* (WHO, 2010). [12]

1. Integrating HIV Services with Local Family Planning in Zimbabwe

The Zimbabwe National Family Planning Council and Ministry of Health created a community-based distribution (CBD) programme in 1967 to bring family planning (FP) services to the doorsteps of hard-to-reach rural populations. However, data showed that fewer people were assessing contraception through the programme over time. There was a simultaneous growth in HIV prevalence rates, which presented a critical public health challenge in the country. A national assessment conducted in 2002 revealed that family planning clients were approaching community-based distributors for information about HIV-prevention, treatment and care services. The existing community-based programme was at that point inadequately equipped to provide both family planning and HIV services.

As a result, the community-based programme was developed to provide these integrated services. This involved training community-based distributors and a new cadre of community-based health workers (called "depot holders") to integrate HIV prevention strategies and voluntary counselling and testing (VCT) into the existing family planning programme. Using a "satellite approach", depot holders served as stationary resupply agents with commodities in their homes, and as mobile agents who distributed door-to-door in communities. They also supported home-based care activities, for example by visiting the homes of people living with HIV to keep them supplied with contraceptives, by providing counselling on healthy behaviours, and by referring sick clients to health and VCT centres. Family planning services were also provided at community sites (e.g. churches and markets), which was often preferred by men and young people.

A series of meetings between community-based health workers and clinical providers identified ways to maintain a continuum of care between clinic and home. It also encouraged a range of service providers to sustain communications with one another. This community dialogue also created opportunities for information sharing, and to normalize the use of services as women, men, and young people grew accustomed to hearing about family planning and HIV services and taking action to receive care.

[12] Spelling, etc. as in the original.

As a result of this project:

- Integrated HIV, AIDS and family planning services were successfully introduced in 16 health districts in rural and urban areas.
- 174 CBD agents and 708 depot holders were trained in STI, HIV and AIDS prevention and counselling. Their additional knowledge and skills have resulted in increased referral to both HIV and family planning services.
- Large increases were seen in the distribution of male and female contraceptives.
- There was a significant rise in people's awareness of HIV risk factors and in uptake of HIV testing.
- There were many new family planning clients, including men, young people, and people living with HIV. (USAID, 2007)

2. TASO - The AIDS Support Organization in Uganda

TASO provides sexuality counselling and promotes discussion on sexual pleasure, masturbation, family planning, and other sexual issues with HIV-positive individuals, and in couples in which one person is infected. TASO's services are linked to the National Public Health services, but are not fully integrated. By its nature, TASO plays a pivotal and strategic role in the region, by building capacity and scaling up HIV- and AIDS-related intervention. Between 2005 and 2008, 687 HIV/AIDS practitioners from across sub-Saharan Africa were trained in best practices in service provision. (TASO, 2008)

3. Health Services for Men Who Have Sex with Men in Lebanon

The International HIV/AIDS Alliance and the National AIDS Programme of Lebanon have been collaborating with local NGOs to address the medical and psychological needs of men who have sex with men in Lebanon. Findings from participatory community assessments carried out in 2005 and 2006 revealed that these men often had low levels of awareness regarding sexual health and were engaged in high levels of risky behaviour. Fewer than 55% of the men who were surveyed, for example, reported using condoms. Only 34% had discussed their sexuality during visits to health professionals, despite 37% reporting that they needed urgent medical attention for STIs. This problem was felt to be exacerbated by discriminatory attitudes among health workers towards men who have sex with men.

These results demonstrated the urgent need for the implementation of a referral system appropriate for these men that would link to prevention and treatment services for HIV and other sexually transmitted infections, as well as psychological and legal support services.

In response, the Alliance and the National AIDS Programme of Lebanon have been working with two organizations, known as Soins Infirmiers et Développement Communautaire (SIDC) and Helem, to initiate a referral system among 15 NGOs and medical and social services in Beirut. This system comprises legal, healthcare and social services, psychological support and free HIV counselling and testing.

To ensure the services were promoted, the project had to strengthen partnerships through meetings with officials, NGOs, medical and social facilities, and pharmacies, and work to sensitize political and religious authorities and the public about the importance of implementing services for men who have sex with men. This led to the creation of a partnership with owners of bars and movie theatres and the establishment of a group of peer educators (via street work, an advice service and a hotline) to promote the services.

They developed promotional materials including a referral protocol, guide and card. The project team also developed and distributed "health boxes" containing preventative materials, cards to promote the referral system, a brochure about men who have sex with men, and a brochure for the families of these men. (International HIV/AIDS Alliance, 2007)

4. Sexual and Reproductive Health Services in the Army in Nicaragua

The Military Medical Corps of the National Army of Nicaragua provides healthcare services to army members and their dependents. A UNFPA-supported project was initiated not only to strengthen the quality of healthcare in the army, but also to provide primary healthcare, information, education and communication (IEC) and reproductive healthcare to communities surrounding military units with little access to public health services.

The project had two components: (i) training and education for military personnel in reproductive health and family planning, and (ii) service delivery. It promoted the concept of sexual and reproductive health as a human right. Doctors, nurses, and nurse auxiliaries were trained to integrate reproductive health and family planning services into the primary and secondary healthcare offered by military health units. Some 1000 soldiers and officers were trained to carry out information and sensitization (awareness-raising) activities on reproductive health and sexual rights. Educational materials produced by the Nicaraguan Community Movement organization were adapted for use in reproductive health and IEC activities. The Military Medical Corps developed a working relationship with several government and nongovernment reproductive health projects. For instance, the Centro de Información y Servicios de Asesoría en Salud (Centre of Information, Services and Counselling on Health) and the Nicaraguan Community Movement worked with the Medical Corps to train health leaders in reproductive health and family planning.

As a result of the project:

- Army commanders, officers, and soldiers became far more aware about issues related to sexuality, particularly prevention of STIs and gender-based violence.
- Military personnel, men, and women, were sensitized about reproductive health, family planning and gender equality.

After the country was struck by Hurricane Mitch, military health teams working in disaster zones provided reproductive health and family planning information, and distributed oral contraceptives and condoms.

Two lessons learnt from this:

- First, the Military Medical Corps and army are effective mechanisms for reaching large numbers of men, including male adolescents.
- Second, the army can become a provider of quality services to rural populations. (Reproductive Health Outlook, 2006)

5. Encouraging Male Adolescents to Think Critically about Gender Norms in Nigeria

The Nigerian Conscientizing Male Adolescents (CMA) programme was established in 1995, with funding from the international Women's Health Coalition. The programme aims to teach and encourage Nigerian male adolescents, aged 14-20 years, to develop a critical awareness of their prejudices and practices in an effort to help abandon them. Taking cultural norms into consideration, the programme focuses on topics such as Nigerian society, women's roles and family structures, sexuality, reproductive health and rights, and violence against women.

The programme started with 25 participants who met weekly for 9 months to discuss, debate, question, and analyse issues such as reproductive health, violence, gender equality, and human rights. The dialogue was led by adult facilitators, who encouraged the participating adolescents to explore their attitudes, beliefs and values. As a result, the participants became better equipped to think independently and analytically. After evaluating the one-year programme, a second year was added, in which monthly meetings were held to reinforce what had been learnt. In 1999, the two year programme had 100 participants. Since then, it has been expanded even further, with a peer education component, an outreach element, and development of a training manual.

Several other initiatives are planned. One aims to establish discussion groups in several post-primary and secondary schools in the state and in a neighbouring state. The CMA also plans to disseminate a newsletter more broadly, so that it reaches more schools. Ultimately, the CMA hopes to replicate its programme in other locations, to have a greater effect on Nigerian society. (International Women's Health Coalition, 2000; Population Council, 2003)

6. Providing Youth-friendly Sexual Health Services in Lesotho

In 2003, the Lesotho Planned Parenthood Federation set up a youth resource centre with a clinic and sexual and reproductive health information integrated with recreational services, a library and an internet café. Young people were encouraged to take ownership of the project, and saw the centre as a safe space for discussing topics such as sexuality, contraception and STIs. As well as working with schools, the centre staff provided

outreach work to target vulnerable groups such as young people with disabilities, teenage parents, young people in correctional institutions, and herd boys (a tradition in which young boys aged as young as 5 years are sent to tend livestock alone in the remote highlands for months at a time). The project also made use of radio, television, music, drama and puppetry to address sexual and reproductive health issues.

Between 2003 and 2007:

- 16 289 girls and 10 595 boys received sexual and reproductive health information.
- 3550 visits were made to the youth centre.
- 103 peer-educators were trained to provide sexual and reproductive health information and support. (UNFPA, 2009)

7. Sensitizing Parents in Ghana

Discussion with children about matters related to sexual and reproductive health is regarded by many parents in Ghana as taboo. However, there is a high incidence of abortion, teenage pregnancy, STIs and HIV infection among young people, which had highlighted the need to improve the role of parents in communicating about sexual and reproductive health.

World Education Ghana, through the Strategizing HIV Prevention Efforts (SHAPE Project) is collaborating with civil society organizations to sensitize parent-teacher association meetings.

During one of these meetings, a group of parents were presented with the data from a baseline study on students' sexual behaviour. They were asked whether their own children were aware of STIs, HIV and reproductive health issues. While some parents responded in the affirmative, others considered that these issues were not important. Two students who had been trained at a newly established sexual and reproductive health club were invited to facilitate one of the sessions. The parents listened with keen interest and asked the students several questions, expressing surprise at the students' wealth of information and the assertiveness skills they had acquired. They asked for training in communication skills (for themselves), to enable them to talk to their children about sexual matters. (Wood and Aggleton, 2004)

8. Providing Advice and Support on Sexual Health Issues for Young People in Kenya

The Kenya Adolescent Reproductive Health Projects (KARHP) was implemented by the Program for Appropriate Technology in Health (PATH) and the Population Council/FRONTIERS (Frontiers in Reproductive Health project) from 1999 to 2003 in two rural districts in Western Kenya. Focusing on sexual health issues for in-school and out-of-school youths aged 10-19 years, the project included peer education, guidance and counselling in schools, and the introduction of youth-friendly services in participating health facilities.

A group of peer educators were trained to provide information to young people and to make referrals to health centres for more information and services. The peer educators reached young people through group

discussions, drama presentations, outreach meetings, demonstrations of condom use, condom distribution, one-to-one counselling, video shows, and distribution of other information, education, and communication materials. Eighty religious leaders were also trained as counsellors to young people in their congregations and allowed the peer educators to use their facilities for outreach activities. Health service providers were also trained to deliver youth-friendly reproductive and sexual health services in special "youth friendly" rooms within the health centres.

The success of the programme is such that it has been expanded to cover six additional districts in western Kenya, and to two further provinces since 2003. (Humphres and others, 2008)

9. A Community-based Programme for Sexual Minorities in Indonesia

Consider the following scenario. Around midnight, Dede pulls his motorcycle up beside a large, dark field at the end of the main street of his town. Before he gets his helmet off, two young men holding each other's hands approach him and ask him for condoms. Dede is a street outreach worker working in the "gay community" on behalf of Lentera, a programme of the Indonesia Planned Parenthood Association.

Lentera was founded in 1993 by a group of young people concerned about sexual health. One of its first initiatives was a programme for young homosexual men, who at that time were becoming increasingly concerned about what they heard about AIDS from other countries. Lentera's strategy is to provide them with the information, support, and services that help them choose to lead healthy lives. The programme first reaches young men in the "cruising" areas, where they congregate at night and meet sexual partners. Street outreach workers are in the area several nights a week to talk, provide condoms, and refer people for relevant services. The programme has developed a series of pamphlets using "gay" slang to discuss issues such as the correct way to use condoms, relationships, and STIs. Outreach workers also help organize events in the community, such as monthly meetings of support groups and weekend retreats for the youth, and the Planned Parenthood Association clinic provides them with STI services one evening a week.

The following lessons were learnt from the programme:

- Involving young homosexual men in the programme built trust between Lentera and the gay community. The programme has had at least one homosexual member of staff since it was founded and encourages others to get involved as volunteers- both for gay community and for the other programmes Lentera provides. Support-group meetings and weekend retreats are fully planned and organized by homosexual youths.

- Careful selection, training, and supervision of outreach workers are key to the programme's success. Outreach workers receive three days of training, and accompany a senior outreach worker for a month before being assigned to their own field location. They must commit to carry

out outreach work at least two nights a week for at least six months, and are required to write a short report each time. A strong code of ethics, developed and reviewed periodically by the street outreach team, guides their work in the field. They are supervised by a part-time staff member who meets with the gay community monthly to get feedback about the team's performance.

After the first year of outreach, Lentera had built up enough trust within the gay community to conduct almost 200 interviews with young homosexual men about their relationships and sexual behaviour. The programme was then able to identify key risks and target them more effectively. For instance, it was found that these men often used condoms the first few times they had sex with a particular partner, but abandoned them once they felt that the relationship was stable. Information, education, and communication messages were adjusted accordingly. Lentera also found that the most common reason for not using a condom was not having one; this prompted them to develop an innovative condom distribution scheme through the small food stands frequented by gay youths at night.

While supporting safe sexual behaviour, the programme also pays attention to the broader spectrum of young people's needs, namely issues relating to sexual identity, telling friends and family about being gay, depression, the religious implications of being homosexual, problems with relationships, drinking and drug abuse, and coping with life after marriage. These are dealt with in various ways through the programme.

Reaching young homosexual men through a programme that works with young people in general has several benefits. First, many of them are not open about their sexual orientation and so feel more comfortable with an organization that is not identified as having an exclusive focus on homosexuality. Second, the work has resulted in a broader understanding and acceptance of the gay community by non-homosexual young people. (Reproductive Health Outlook, 2006)

VI. *Goal and Strategies for SRHR Achievement in Grenada.*

Based on the limitations inherent in existing policy, systems and clinical and non-clinical SRH and HIV service delivery, the development of a National Strategic Plan (NSP) for achieving sexual and reproductive health and rights (SRHR) is pivotal.

The following five main goals and accompanying strategies are recommended for SRHR achievement. A rationale is provided to support goals and strategies based on interviews and documents garnered on the SRH and HIV policy, systems and service delivery context in Grenada.

Goal 1: Promote sexual health; including the elimination of barriers to sexual and reproductive health and rights

Goal 2: Provide comprehensive sexuality education to the public at large

Goal 3: Provide education, training and support to professionals working in sexual health-related fields

Goal 4: Develop and provide access to comprehensive sexual health care services to the population

Goal 5: Promote and sponsor research and evaluation in sexuality and sexual health and the dissemination of the knowledge derived from it to health practitioners, the public at large and vulnerable groups

These five goals are based on the World Health Organization (WHO), recommendations on SRH achievement for governmental and non-governmental agencies and institutions in the health sector in the region of the Americas (PAHO/WHO 2000). Complementary strategies have been modified for country-specific relevance in the Grenada context.

Goal 1: Promote sexual health, including the elimination of barriers to sexual and reproductive health and rights

Strategy 1.1: Integrate SRH into public health programmes
Strategy 1.2: Promote gender equality and equity and eliminate gender-based discrimination
Strategy 1.3: Promote responsible sexual behaviour and involve the media in efforts to deliver and promote comprehensive sexuality education.
Strategy 1.4: Eliminate fear, prejudice, discrimination and hatred related to sexuality and sexual minority groups
Strategy 1.5: Eliminate sexual and domestic violence and protect SRHR
Strategy 1.6: Recognize the SRHR of youth and address youth vulnerability to SRH ill health

Specific actions recommended for this strategy include:

- Develop an NSP for SRHRA;
- Incorporate national HIV prevention, treatment, care and support objectives into the NSP for SRHRA;
- Synergize the NSP for HIV and AIDS and NSP for SRHRA;
- Promote legislation that ensures the feasibility of the NSP for SRHRA;
- Integrate a SRHR approach into existing health programmes;
- Develop indicators of SRHR to be used in policy and programme development and evaluation;
- Promote consensus in the definition and classification of sexual problems;
- Develop best practice guidelines for addressing sexual problems.

Goal 2: Provide sexual health literacy and comprehensive sexuality education to the population at large

Recommended strategies include:

Strategy 2.1: Develop a national policy and plan for health literacy achievement including sexual health literacy

Strategy 2.2: Integrate sexuality education into the general curriculum of educational institutions as appropriate.

Strategy 2.3: Provide comprehensive sexuality education to persons with mental and physical disabilities, out-of-school youth, prisoners, illegal immigrants, the institutionalized and the homeless.

Strategy 2.4: Provide comprehensive and consistent gender-responsive and human rights-based capacity-building for health practitioners on SRHR service provision for the general public and the treatment of vulnerable populations

Strategy 2.5: Develop an SRHR media partnership policy for national campaigning on SRHR

Goal 3: Provide education, training and support to professionals working in sexual health-related fields

Recommended strategies include:

Strategy 3.1: Provide education and training in sexual health for health and allied health professionals

Strategy 3.2: Provide education and training in sexual health for school teachers

Strategy 3.3: Provide education and training on the social determinants of sexual and reproductive ill health and morbidity for media group allies

Sexual health education for health professionals should be promoted at four different levels at least:

1. Basic sexual health education for all health professionals included both in their basic

training and in continued educational programmes. Health professionals include medicine, nursing clinical psychology, social work and health practitioners and promoters;

2. Sexual health education for health professionals specializing in reproductive health programmes;
3. Sexual health education for professionals specializing in STIs and HIV/AIDS prevention and control programmes;
4. Sexual health education and training for professionals specializing in sexology, including education for sexuality, clinical sexology (sexual medicine, sexual surgery, sexual counselling and sexual psychotherapy) and basic research sexology.

Strategy 3.4: Promote sexology as a profession/discipline

More specifically, there is a need to:

- Establish training standards for sexual educators and sexuality specialists;
- Promote sexology as a discipline/profession;
- Advocate to governments for sexuality training programmes for professionals.

Goal 4: Develop and provide access to comprehensive sexual health care services to the population.

Recommended strategies include:

Strategy 4.1: Integrate sexual health issues into existing public health programmes

Strategy 4.2: Provide access to comprehensive sexual health services to the general population

Strategy 4.3: Provide access to comprehensive sexual health services to persons with mental and physical disabilities

Strategy 4.4: Provide access to comprehensive sexual health services to special populations (e.g., prisoners, illegal immigrants, the institutionalized and the homeless)

Components of this strategy include the following:

- Integrate a sexual health approach into existing health programmes related directly or indirectly to sexual health, i.e., cardiovascular health promotion programmes, anti-smoking programmes (benefits of not smoking on erectile performance), cancer prevention (early detection of breast and cervical cancer through screening programmes) and health education programmes (link between preventive health and sexual performance);

- As part of general health assessments, address sexual issues when clients come into contact with public health programmes. This can be advanced by review and, where necessary, reform of existing protocols to ensure adequate addressing of sexual health concerns. For example, general practitioners, family physicians and physicians in public health clinics should incorporate sexual health screening/ history taking into general health assessments.

Goal 5: Promote and sponsor research and evaluation in sexuality and sexual health and the dissemination of the knowledge derived from it to health practitioners, the public at large and vulnerable groups

Recommended strategies include:

5.1: Development of a Policy and Plan for SRH Research for Programmes and Services Development including guidance for conducting community-based SRH needs assessments and developing corresponding community-led interventions

VII. Recommended Next Steps

1. The development of a National Strategic Plan on Sexual and Reproductive Health and Rights Achievement (NSP on SRHRA);

2. The formation of a Health Policy Committee for the development of a health policy among line ministries and partner NGOs/civil society groups. These policies will outline systems and services collaboration and surveillance reporting frameworks;

3. The sourcing of funding for the appointment of a technical advisor to the MoH Planning and Policy Unit for the development of the NSP on SRHRA, including for oversight of research prioritization and the undertaking of capacity needs assessment for change management;

4. The development of a communications strategy for the MoH to guide the NSP on SRHRA campaign development and implementation;

5. Development of a civil society and government service partnership policy and plan for implementation.

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Appendices

Appendix 1. List of Interview Respondents	
Person	*Position / Agency*
Mr. Arthur Pierre	Focal Point – National HIV Policy and HIV/AIDS Response Coordinator, Ministry of Education
Mr. Dave Duncan	Chief Planner, Ministry of Health
Ms Ellen Gabriel	Chief Pharmacist, Ministry of Health
Dr. Henry	Director, National Infectious Disease Control Unit (NIDCU)
Ms. Cornice Marquez	Nurse, NIDCU
Mr. Marichaud	HIV Counsellor
Ms Hilary Gabriel	Chief Programme Officer, Council for the Disabled
Hon. Ann Peters	Minister of Health
Mr. Terron Gilchrist	Political Advisor to the Minister of Health
Ms Jackie Sealey-Burke	Director, Legal Aid and Counselling Clinic (LACC)
Ms Thomas	Permanent Secretary, Ministry of Social Affairs
Ms Judy Benoit	Health Promotion Officer
Nurse Lydia Francis	Chief Community Health Nurse
Mr. Dave Alexander	Director, National Drug Avoidance Programme
Ms Rachel Charles	Executive Director, Hope Pals Foundation
Ms Lorice Pascal and Ms Bernadette Bartholomew	Grenada National Organisation of Women (GNOW)
Mr. Winston Duncan	Grenada Planned Parenthood Association (GPPA)
Mr. Terry Charles	Chair, National AIDS Council
Mr. Nigel Mathlin	President, Grenada/Caribbean HIV/AIDS Partnership (GrenCHAP)
Ms Kriss Davies	Project Officer, Child Welfare
Ms June Salab	Director, Lab Services, General Hospital
Ms Karen Samuel	Senior Legal Council, Ministry of Legal Affairs
Ms Judy Williams	Director, Grenada Community Development Agency (GRENCODA)
Ms Meryl Mc. Queen	Nurse, St. George's Health Centre, North St. George
Ms Marva St. Paul	Public Health Nurse, St. George's Health Centre (South Clinic, assists in the North)
Ms Tessa St. Bernard	Nurses' Assistant, Good Hope Medical Station, St. George
Ms Suezelle Nedd	Grand Roy Medical Station, Gouyave, St. John
Ms Diana Stanislaus	Public Health Nurse, Gouyave Health Facility, St. John
Ms Sharon Tannis	Nurse, St. Patrick's Health Facility
Ms Dannette St. Bernard	Public Health Nurse, Hillsborough Health Centre, Carriacou

Appendix 1. (continued) List of Interview Respondents	
Person	*Position / Agency*
Mr. Emmanuel Bain	Social worker with responsibilities for mental health service provision at health facilities in St. John, St. Mark and Carriacou (based at Mount Gay Hospital)
Ms Fleary	Nurse, St. George's Health Centre, North St. George
Dr. Prabhu Bhupathiraju	District Medical Officer (DMO), River Sallee Medical Station, St. Patrick
Ms Jennie Lyons	District Nurse, St. Patrick
Dr. Lambert	District Medical Officer, St. George's Health Centre
Dr, Charles	Gouyave Health Facility, St. John
Dr. Friday	DMO, St. Patrick's Health Centre
Dr. Davis	DMO, Carriacou
Dr. Amichi	St. Augustine Hospital (private hospital)

Appendix 2. Health Services Checklists for LGBTT Communities and Youth	
Health Services Checklist for LGBTT Communities	
Instructions: This brief Health Services Checklist is designed to assess the access and quality of care at your organization/agency for lesbian, gay, bisexual, transgender and transsexual (LGBTT) individuals and non-gay identifying men who have sex with men (MSM). The checklist covers five different areas for health setting accessibility to LGBTT. The purpose of the overall score is to help agencies (clinics, NGOs, etc.) determine their progress and identify areas to improve their sensitivity and quality of care for these populations.	
In Part A for each question please respond 1 for Yes and 0 for No. Stop after completing Part A.	Yes/No
Part A	
OUTREACH	
1. Does your agency have promotional materials that state that services are provided without discrimination based on sexual orientation and gender identity?	
2. Does your agency make it clear to patients that their privacy and confidentiality is respected?	
3. Have staff members from your agency gone out to LGBTT organizations or special meetings to promote your services?	
OFFICE SPACE	
4. Does your agency display a sign that states "We do not discriminate on the basis of age, race, sex, sexual orientation, gender identity, religion, language or disability?"	

Appendix 2. (continued) Health Services Checklists for LGBTT Communities and Youth	
Health Services Checklist for LGBTT Communities	
5. Do your waiting room materials and/or presentations cover issues of interest to the LGBTT community and not include any negative language regarding the LGBTT community?	
6. Are friends and partners of LBGTT patients given the respect and privileges usually given to a spouse or relative?	
INTAKE FORMS AND INTERVIEW	
7. Does your intake interview/form include gender-neutral options such as "Living with domestic partner" along with standard options such as married or single? Does it use gender-neutral terms such as 'partner' in addition to 'husband/wife?'	
8. Do providers in your agency seek out colleagues who have experience in LGBTT health care for advice and referrals?	
9. Do providers in your agency take complete sexual histories in a non-judgmental manner?	
CONFIDENTIALITY POLICIES	
10. Does your agency have a policy for maintaining confidentiality of client records?	
STAFF TRAINING	
11. Have reception and medical staff in your agency received in-depth training on homophobia and/or LGBTT health concerns?	
12. Do staff members treat information about HIV status as highly sensitive information?	
13. Do staff members treat information about sexual behaviour as highly confidential?	
Sum up your score to see how LGBTT-friendly your agency/organization is.	Total Score
The framework provided in this audit will be especially beneficial as your organization/ agency begins to identify the steps to improve the sensitivity and quality of care for LGBTT persons.	0-3
Your organization/agency has already adopted some key principles that are necessary for establishing an LGBTT-friendly setting. This checklist can help you identify areas that need further development.	4-7
Your organization/agency is well on its way to navigating the barriers faced by LGBTT persons seeking health care. Effort has been made in a number of areas to provide sensitive and high quality service. A few more actions should significantly enhance the environment in your organization/agency. The areas that received a negative score on this survey were likely to be overlooked or have proved to be particularly entrenched and difficult to change.	8-10

Appendix 2. (continued) Health Services Checklists for LGBTT Communities and Youth	
Health Services Checklist for LGBTT Communities	
Your organization/agency has successfully navigated the main barriers that LGBTT persons often encounter when accessing health-care services. Your staff members have created a workplace where the rights and needs of LGBTT and non-gay identifying MSM patients are acknowledged and respected. This affirming attitude likely extends to the care given to all categories of patients, and so all patients will feel comfortable, safe and respected. Keep up the good work.	11-13
PART B List the main action(s) necessary for change in relation to each component of care and identify the person/position most suited to take the lead on implementing this change.	
Action:	Lead person
Outreach:	
Office space:	
Intake forms and interview:	
Confidentiality policies:	
Staff training:	

Health Services Checklist: Youth
Instructions: This brief Health Services Checklist is designed to assess girl and boy youth access and quality of care at your agency. The checklist covers five different areas for health setting accessibility to youth. The purpose of the overall score is to help agencies (clinics, NGOs, etc.) determine their progress and identify areas to improve their sensitivity and quality of care for these populations. Youth-friendly services must be gender responsive to be effective.

Health Services Checklist: Youth

Instructions: This brief Health Services Checklist is designed to assess girl and boy youth access and quality of care at your agency. The checklist covers five different areas for health setting accessibility to youth. The purpose of the overall score is to help agencies (clinics, NGOs, etc.) determine their progress and identify areas to improve their sensitivity and quality of care for these populations. Youth-friendly services must be gender responsive to be effective.

In Part A for each question please respond 1 for Yes and 0 for No. Stop after completing Part A.	Yes/No
Part A	
OUTREACH	
1. Does your agency have promotional materials stating that services are provided without discrimination based on sexual orientation and gender identity targeted at youth?	
2. Does your agency address youth vulnerability through gender-responsive information, education and communication (IEC) campaigns? *That is, does the IEC campaign address gender-specific behaviours and promote positive behaviour transformation of boys, girls, women and men?*	
3. Does your agency have displayed promotional materials stating that services are provided to youth without discrimination based on disability?	
4. Does your agency make it clear to youth accessing services that their sexual and reproductive rights are respected?	
5. Have staff members from your agency gone out to youth organizations or special meetings to promote your services?	
6. Have staff members from your agency gone out to organizations representing disabled youth?	
OFFICE SPACE	
7. Does your agency display a sign that states "We do not discriminate on the basis of age, race, sex, sexual orientation, gender identity, religion, language or disability?"	
8. Do your waiting room materials and/or presentations cover issues of interest to youth (girls and boys) and not include any negative language regarding the sexual and reproductive rights of youth?	
9. Are friends and partners of youth accessing services given respect and treated as a relative would be?	
INTAKE FORMS AND INTERVIEW	
10. Does your intake interview/form include options for service provision that are gender responsive and specific to the needs of youth – for example, if a pregnant youth is accessing care is there encouragement of her partner as sharing responsibility for ante- and post-natal care?	
11. Do providers in your agency seek out colleagues who have experience in gender-responsive youth-friendly health care for advice and referrals?	
12. Do providers in your agency take complete sexual histories in a non-judgmental manner?	

Health Services Checklist: Youth	
13. Do providers in your agency take complete sexual histories of youth with disabilities in a non-judgemental manner?	
CONFIDENTIALITY POLICIES	
14. Does your agency have a policy for maintaining confidentiality of client records?	
STAFF TRAINING	
15. Have reception and medical staff in your agency received in-depth training on gender, human rights and youth sexuality development?	
16. Have reception and medical staff in your agency received in-depth training on SHR and rights of disabled youth?	
17. Do staff members treat information about HIV status as highly sensitive information?	
18. Do staff members treat information about sexual behaviour as highly confidential?	
Sum up your score to see how youth-friendly your agency/organization is. Total Score	
The framework provided in this audit will be especially beneficial as your organization/ agency begins to identify the steps to improve the sensitivity and quality of care for youth.	0-5
Your organization/agency has already adopted some key principles that are necessary for establishing a youth-friendly setting. This checklist can help you identify areas that need further development.	6-10
Your organization/agency is well on its way to navigating the barriers faced by youth when seeking health care. Effort has been made in a number of areas to provide gender-responsive, sensitive and high quality service. A few more actions should significantly enhance the environment in your organization/agency. The areas that received a negative score on this survey were likely to be overlooked or have proved to be particularly entrenched and difficult to change.	11-14
Your organization/agency has successfully navigated the main barriers that youth often encounter when accessing health-care services. Your staff members have created a workplace where the rights and needs of youth are acknowledged and respected. This affirming attitude likely extends to the care given to all categories of patients, and so all patients will feel comfortable, safe and respected. Keep up the good work.	15-17

PART B
List the main action(s) necessary for change in relation to each component of care and identify the person/position most suited to take the lead on implementing this change.

Action:	Lead person
Outreach:	4-7
Office space:	8-10

Health Services Checklist: Youth	
Intake forms and interview:	
Confidentiality policies:	
Staff training:	

Appendix 3. National Documents Collected In-country for Desk Review

National Governance

- Grenada Constitution Order 1973
- Drug Abuse (Prevention and Control) Act No. 7 of 1992
- Child Protection Act No. 17 of 1998

National Reports and Assessments

Human rights and HIV and AIDS

- National HIV/AIDS Assessment, Law, Ethics and Human Rights Project, Grenada – Review of the Laws of Grenada, Carriacou and Petit Martinique for Implications of Discrimination and Breach of Human Rights, January 2008 (by Keith H.W. Friday)

Clinical services

- Grenada PMTCT Assessment: Preliminary Findings (PowerPoint presentation)
- Draft Evaluation – Grenada Ministry of Health's Prevention of Mother to Child Transmission of HIV (PMTCT) and Congenital Syphilis (CS) Programmes, July 2007 (Ministry of Health, Grenada in Collaboration with Caribbean Epidemiology Centre/Pan American Health Organization)

Youth programme

- Grenada Skills for Inclusive Growth Project - Status Report #1, November 2009

Drug Control

- Sociological Analysis of Alcohol and Marijuana Use and Abuse Among Young People in Grenada, 2006 (by Claude Douglas)
- Focus Group Study: The Link Between Drug Use and HIV/AIDS Among Young People in Grenada – A semi-qualitative research study supported by the United Nations Office on Drugs and Crime, Regional Office, Barbados

- Grenada Drug Information Network (GRENDIN) Statistical Report Indicators, 1 January 1998 – 31 December 2009

Ministry of Health

Planning documents

- Grenada National Strategic Plan for Health (2007–2011): Health for Economic Growth and Human Development, December 2006 (Draft)
- National Infectious Disease Control Unit (NIDCU) Corporate Plan 2010
- Excerpts from Planning Document: Plan for Primary Health Care Revitalisation in Grenada
- Ministry of Health Corporate Plan 2009
- Ministry of Health Corporate Plan 2010 – Principles and Values Section

National Infectious Disease Control Unit (NIDCU)

Clinical guidelines and other documents related to clinical service delivery

- Clinical Guidelines for Management of Persons with HIV Infection, NIDCU, Ministry of Health, Social Security, the Environment and Ecclesiastical Relations of Grenada, March 2007
- Guidelines for the Prevention of Mother to Child Transmission of HIV, NIDCU, Ministry of Health, Social Security, the Environment and Ecclesiastical Relations of Grenada, March 2007
- Guidelines for the Prevention and Management of Accidental Exposure to Blood and Bodily Fluids – NIDCU, Ministry of Health, Social Security, the Environment and Ecclesiastical Relations of Grenada, March 2007
- HIV Testing and Counselling and Partner Notification, NIDCU, Ministry of Health, Social Security, the Environment and Ecclesiastical Relations of Grenada, March 2007
- Regional Model Code Of Practice for Psycho-social Practitioners in HIV and AIDS Care, Pan Caribbean Partnership Against HIV/AIDS (PANCAP) Law, Ethics and Human Rights Project

Ministry of Education

- Draft Corporate Plan 2010 (the draft plan is currently being reviewed)
- Strategic Plan for Educational Enhancement and Development 2006–2015. Volume 1: The Strategic Framework, Ministry of Education and Labour 2006 (currently under review)

Health and Family Life Education (HFLE) Programme

Provided by the HIV and AIDS Response Coordinator:

- CHOICES - A Guide for Young People (by Gill Gordon) - currently being used, but funds have been requested from UNDP to support its replacement with 'Your Life, Your Dreams'. It is unclear exactly when the transition will occur
- J.A.W.S - HIV/AIDS Readers Teacher's Guide (by Sally Howes and Glynis Clanchert), funds have been requested from UNDP for implementation in the 2011 academic year)

Ministry of Social Development

- Corporate Plan 2007–2009 (new plan being developed/reviewed)

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