Caribbean Regional Operational Plan

ROP 2015

Strategic Direction Summary

August 24th, 2015

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Goal Statement

The goal of the PEPFAR Caribbean Regional HIV and AIDS Program (CRP) is to reduce HIV transmission in the Caribbean region and increase the proportion of people living with HIV who are virally suppressed. Most of the program's financial and technical support will go towards reaching key populations (KPs) – men who have sex with men (MSM), sex workers (SW), and trangenders (TG) – in Jamaica, Suriname, and Trinidad and Tobago (Tier I: ~80% of PLHIV). A smaller amount will go to Barbados and the Bahamas (Tier II: ~15% of PLHIV). Military programs will receive quality improvement technical assistance and monitoring and evaluation to support sustainable HIV programs. The programmatic focus will be to strengthen core activities along the HIV continuum of care where gaps have been identified. This includes identifying HIV positive MSM, SW, and TG earlier and improving rates of linkage to and retention in care. This will be done by providing technical assistance, rather than direct service delivery, to MOHs and civil society to develop sustainable and effective National HIV and AIDS programs and impactful community interventions. By implementing activities at high volume, high yield facilities and community "hot spots" where transmission occurs, it is anticipated that the Caribbean program will have a significant impact on the epidemic within five years. It will bring the Caribbean closer to reaching the UNAIDS 90-90-90 targets by 2020. Sustainability and expenditure/cost analyses will be carried out to identify the most cost-effective interventions for a region with a relatively high per capita income. Activities will be evidence-based and tailored to each host country context. They will address stigma and discrimination (S&D) and protection of human rights. The United States (US) government agencies under PEFPAR will collaborate with the Joint United Nations Program on HIV/AIDS (UNAIDS), the Pan American Health Organization (PAHO), the World Health Organization (WHO) and the Global Fund (GF) to ensure complementary rather than duplicate activities.

1.0Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

HIV prevalence in the Caribbean Region is estimated to be 1.0% (UNAIDS, 2012). Of the 5.9 million[1] people in the 11 PEFPAR supported countries, approximately 63,000 are thought to be HIV positive. Eighty percent of these come from 5 countries: Jamaica, Trinidad and Tobago, Suriname, The Bahamas and Barbados. HIV prevalence ranges from <1% in the Organization of Eastern Caribbean States (OECS) to 2.8% in the Bahamas. In Jamaica, the highest burden country, 30,313 people were estimated to be HIV positive in 2013 (GARPR, 2014). In Trinidad and Tobago, the second highest burden country, 13,000 people were estimated to be HIV positive in 2012 (MOH, HACU Report, 2012). Spectrum estimates for the OECS are unavailable, but the burden is low. Some countries have reported fewer than 1,000 cumulative cases since the beginning of the epidemic. Across the region, HIV disproportionately affects men who have sex

[1] Refers to population in the 11 countries covered by the PEPFAR Caribbean program

with men and female sex workers. Available data have shown MSM HIV prevalence to be 32.8% in Jamaica (in 2012, GARPR 2014), 20.4% amongst MSM in Trinidad and Tobago (Lee *et al* 2004) and 6.7% in Suriname (MOH, 2013). Available data have shown FSW HIV prevalence to be 4.1% in Jamaica (GARPR 2014) and 5.8% in Suriname (2012, MOH). FSW HIV prevalence is unavailable for Trinidad and Tobago.

Sexual intercourse is the predominant mode of transmission in the region. Mother to child transmission rates have steadily declined and are considered low. Perinatal transmission currently accounts for a minority of cases (e.g. <2% of total annual reported cases in countries with highes burden). There is no evidence to support injecting drug use is a major contributor to the epidemic in the region.

Data in the region suggest a male dominated epidemic – higher numbers and proportions of men test positive for HIV – although coverage of testing is higher amongst females. Late diagnosis of HIV infection continues to be a problem in the region. Approximately 40% of PLHIV receive a concurrent HIV and AIDS diagnosis (PAHO, 2013). Higher proportions are eligible for ART initiation at diagnosis.

The total number of TB cases is low in all countries in the region; however, approximately 30 - 50% of reported TB cases are also HIV infected. Amongst the 5 countries with the highest HIV burden --, Suriname and Barbados had the highest and lowest numbers of reported TB cases, respectively. In 2013, there were 146 total reported cases of TB in Suriname. Of these 56 (38%) were HIV positive (WHO, 2013). In Barbados, there were 4 reported cases of TB, half of which were HIV positive (WHO, 2013). The low rates of HIV testing amongst TB patients make it difficult to reliably estimate the HIV burden amongst TB patients (PAHO, 2013).

There has been a decline in new infections in the region from 22,000 in 2001 to an estimated 13,000 in 2011 (UNAIDS, 2012). The numbers of newly infected individuals are estimated to be ~1,400 Jamaica, <1000 in Trinidad & Tobago, <500 in the Bahamas, <200 in Suriname, and <100 in Barbados (UNAIDS, 2013). AIDS related deaths have also declined in the region. This has coincided with the provision of antiretroviral therapy (ART) through national care and treatment programs. Strengthened health systems, including improved laboratory capacity to ensure timely diagnosis and clinical staging of patients, has contributed to the governments' ability to offer comprehensive care and treatment for PLHIV.

Regional ART coverage amongst eligible patients was 71% in 2012. This varies by country with 66, 69, 72, 73 and 95% in Suriname, Jamaica, Trinidad & Tobago, the Bahamas and Barbados, respectively (PAHO, 2013). ART coverage rates based on total PLHIV are estimated to be 30 - 50%. These gaps in coverage are partly explained by eligibility criteria; national guidelines recommend ART initiation at CD4 350 for all countries except Suriname. Suriname proposes to transition from CD4 200 to CD4 350 by June 2015. Earlier ART initiation is being explored across the region. Potential barriers include the costs of patient care, especially where local governments fully fund

their treatment programs. Based on 2013 reports, Jamaica and the OECS (with exception of St. Lucia) rely on external funding to cover 75 – 100% of ARV costs (PAHO, 2013).

Full clinical cascade data for Suriname, the Bahamas and Trinidad and Tobago are not available. Regional estimates indicate that 70% of PLHIV in the Caribbean know their status (UNAIDS, 2013). The Bahamas has indicated that trends for recently diagnosed PLHIV suggest the need to strengthen early linkage to and retention in care. The observed levels of viral suppression indicate a need to strengthen monitoring and improvement of medication adherence amongst ART patients. The proportion of PLHIV diagnosed is estimated to be 60% in Suriname (MOH, 2014), 83% in Jamaica (MOH, 2013) and 91% (MOH, 2012) in Barbados. Data from 2012 indicate that Barbados has reached the first of the "90-90-90 targets". In all countries, there are significant gaps in linkage to and retention of patients in care. Attrition at these stages contributes to the low levels of ART coverage. Retention amongst ART patients is shown to decline after 12 months (PAHO 2013; GARPR 2014 reports). Viral suppression amongst all PLHIV is 38% in Barbados and 12% in Jamaica. For patients on ART 43% and 83% are virally suppressed in Jamaica and Barbados, respectively. In Jamaica, viral suppression rates of patients on ART vary by site from 38 – 71%. A possible contributing factor to low viral suppression may be low levels of adherence amongst ART patients and HIV drug resistance. Drug resistance surveillance needs to be scaled up and adherence needs to be better understood and addressed in order to improve clinical outcomes of these patients.

Key population continuum of care data are not available for the region. Program monitoring data suggest low rates of prevention intervention coverage for KP (~20%). Low positivity rates from key population testing events, and low coverage rates suggest the need for revised strategies to reach and diagnose MSM and FSW. Although recognized as a priority by national governments, key population programs have historically been implemented by community based organizations with funding from external sources.

The economic profile of the 11 PEPFAR countries varies considerably. According to the World Bank, Jamaica and Suriname are considered upper middle income with GNIs between USD $ 4,126 and $12,745. Barbados, Trinidad and Tobago and the Bahamas are considered high income, with GNIs above USD $12,746. OECS countries fall within both upper middle and high income categories. These differences affect the countries' borrowing power and eligibility for donor funding. The differences in economic profiles and available finances can also be seen in the levels of domestic and external funding for national HIV responses.

Table 1.1.1 Key National Demographic and Epidemiological Data Jamaica											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	2,717,991		320,822		331,492		1,051,661		1,014,016		STATIN 2013
Prevalence (%)		1.8		NA		NA				NA	Spectrum estimates 2013
AIDS Deaths (per year)	298										MOH Spectrum Estimates (2013)
PLHIV (2013)	30,313		554				10715		19045		MOH Spectrum Estimates (2013)
Incidence Rate (Yr)											
New Infections (2013)	1,427										MOH Spectrum Estimates (2013)
Annual births	NA										
% >= 1 ANC visit	NA	NA						0.94			MOH (2013)
Pregnant women needing ARVs	466										GARPR 2014 MOH Spectrum Estimates (2013)
TB cases (Yr, 2013)	96										Tuberculosis Country Profile, 2013
TB/HIV Co-infection (2013)	16	22%									Tuberculosis Country Profile, 2013
Key Populations	51,696										
Total MSM*	33,000	4.5%									MOH estimates
MSM HIV Prevalence		32.8%									GARPR 2014
Total FSW	18,696	2.5%									
FSW HIV Prevalence		4.1%									GARPR 2014
Priority Population (military)	5000						250		4750		Ministry of Defense
**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*											

Table 1.1.1 Key National Demographic and Epidemiological Data Trinidad & Tobago											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population (2011)	**1,328,019**	**100.00**	**134,263**	**10.11**	**139,179**	**10.48**	**527,478**	**39.72**	**527,125**	***39.69***	MOH, Census, 2012
Prevalence (%) (2010)		**1.7**		NA		NA		NA		NA	MOH, HACU Report, 2012
AIDS Deaths (2011)	**42**		NA		NA		NA		NA		MOH, HACU Report, 2012
PLHIV (2011)	**13,000**		NA		NA		NA		NA		MOH, HACU Report, 2012
Incidence Rate (Yr)		NA		NA		NA		NA		NA	
New Infections (2011)	**1,284**										MOH, National HIV and AIDS Strategic Plan
Annual births (2011)	**19,888**										MOH, Census, 2012
% >= 1 ANC visit	**NA**										
Pregnant women needing ARVs	NA										
TB cases (2013)	**90**										WHO, TB Profile, 2013
TB/HIV Co-infection (2013)	**56**										WHO, TB Profile, 2013
Key Populations	**28,528**										PEPFAR Estimate**
Total MSM*	**8,271**										PEPFAR Estimate**
MSM HIV Prevalence	**20.4**										Lee, Poon-King,

											Legall, Samiel, & Trotman, 2005
Total FSW	**13,536**										PEPFAR Estimate**
Priority Population (military)	5300						225		4275		
** PEPFAR Key population estimates assume that 2% of the adult male population is MSM and 3.8% of the female population is FSW											

Table 1.1.1 Key National Demographic and Epidemiological Data Suriname											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	539,276			27							World Bank, 2013
Prevalence (%) 15-49 age group - 2012		0.9									UNAIDS, 2012 Suriname HIV Epidemiological Profile, 2013
AIDS Deaths (2012)	101		NA		NA		38		63		Suriname HIV Epidemiological Profile, 2013
PLHIV (2012)	4,000		NA		NA		NA		NA		UNAIDS -GAP, 2013
Incidence Rate (Yr)		NA		NA		NA		NA		NA	Not available
New Infections (2013)	500										Suriname HIV Epidemiological Profile, 2013
Annual births	2.29										WHO, 2012
% >= 1 ANC visit		88.6					93.2				WHO,2006 and 2010
Pregnant women needing ARVs	111										UNAIDS, 2012
TB cases (2013)	146										WHO,2013
TB/HIV Co-infection (2013)	56	NA	NA	NA	NA	NA	NA	NA	NA	NA	WHO,2013
Key Populations											
Total MSM (2010)*	5,000 (2,813 - 7,500)										NSP, 2014
MSM HIV Prevalence (2005)		6.7									Suriname HIV Epidemiological Profile, 2013
Total FSW	2228										NSP,2014
FSW HIV Prevalence (2012)		5.8									Suriname HIV Epidemiological Profile, 2013
Priority Populations (military)	3000						750		2250		Ministry of Defense, 2014
**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*											

Table 1.1.1 Key National Demographic and Epidemiological Data The Bahamas											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	367000	NA	NA		NA		NA		NA		Bahamas Statistics Department, 2014
Prevalence (%)		3									GARPR, 2014
AIDS Deaths (per year)	<1000		<1000		<1000		<1000		<1000		UNAIDS,2013
PLHIV -2013	7,552			103			3,568		3,984		GARPR, 2014
Incidence Rate (Yr -2013)		0.20		NA		NA		NA		NA	
New Infections (Yr - 2013)	<500										GARPR, 2014
New Infections (Yr - 2013)	293										GARPR, 2014 – newly reported cases
Annual births-2013	5,000										GARPR, 2014
% >= 1 ANC visit	NA	NA	NA	NA			NA	NA			
Pregnant women needing ARVs-2013	68	NA									GARPR, 2014
TB cases (2013)	33										WHO, 2013
TB/HIV Co-infection (2013)	10		NA	NA	NA	NA	NA	NA	NA	NA	WHO, 2013
Key Populations	8,715										
Total MSM*	4,000										MOH data
MSM HIV Prevalence	IQ										GARPR, 2014 – proxy from MSM HTC data -14%
Total FSW	4,715										PEFPAR Estimate
FSW HIV Prevalence	NA										
Total PWID	N/A										
PWID HIV Prevalence	N/A										
**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*											
N/A- not applicable ND- no data NA= Data not available											

Table 1.1.1 Key National Demographic and Epidemiological Data Barbados											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	287,733		26,990		26,989		121,537		112,217		GARP Report 2014
Prevalence (%) (15-49)-estimate		1.2									GARP Report 2014
AIDS Deaths (per year-2012)	30										GARP Report 2014
PLHIV – (2012)	2,200										GARP Report 2014
Incidence Rate (Yr)											
New Infections (Yr-2012)	138										GARP Report 2014
Annual births	NA	NA									
% >= 1 ANC visit	NA	NA									
Pregnant women needing ARVs -	21										Barbados HIV Surveillance Bulletin 2011
TB cases (Yr-2013)	4										WHO, 2013
TB/HIV Co-infection (2013)	2	50%									WHO, 2013
Key Populations	8,428										+PEPFAR Estimate
Total MSM*	2,784										PEPFAR Estimate
MSM HIV Prevalence											
Total FSW	5,644										+PEPFAR Estimate
FSW HIV Prevalence	NA										

**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*

+PEPFAR Key population estimates assume that 2% of the adult male population is MSM and 3.8% of the adult female population is FSW

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months) Jamaica										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	2,717,991	1.8	30,313	9,747	8,689	8,689	3,701	48,883	22,842	*12,657*
Population less than 15 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Pregnant Women	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

The estimated MSM population in Jamaica is 33,000 with an HIV prevalence rate of 32.8%. The estimated FSW population is 18,696 with a 4.1% HIV prevalence rate.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months) Trinidad & Tobago										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population (2011)	**1,328,019**	**1.7**	**13,000**	**+7,183**	**+5,019**	NA	NA	**52,393**	NA	NA
Population less than 15 years (2011)	**273,415**	**0.9**	NA	**64**	**60**	NA	NA	NA	NA	NA
Pregnant Women (2012)	NA	NA	NA	NA	NA	NA	NA	**13,340**	**223****	NA

The estimated MSM population in Trinidad and Tobago is 8,271 with an HIV prevalence rate of 20.4%. The estimated FSW population is 15,356 and the PWID estimate is 4,901. Both FSW and PWID HIV prevalence rates are unknown.

+ Partial data – data from all treatment sites is not available

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months) Suriname										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)** (CD4 at least once in 6 months)	**On ART (#)** (CD4 < 200 cells/ml)	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months (<1000 copies)**	**Tested for HIV (#) 2000 -2011**	**Diagnosed HIV Positive (#) 2000 -2011**	**Initiated on ART (#)**
Total population	**539,276**	**1**	**4000**	**+ 2874**	**+748**	**+1343**	**+389**	**188,217**	**7058**	***NA***
Population less than 15 years	NA	NA	NA	NA	71 (2013)	NA	NA	NA	NA	NA
Pregnant Women	NA	NA	NA	NA	112(2013)	NA	NA	NA	116	112/116

The estimated MSM population in Suriname is 5,000 with an HIV prevalence rate of 6.7%. The estimated FSW population is 2,228 with a 5.8% HIV prevalence rate. According to the GARPR, PWID is not relevant for Suriname.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months) The Bahamas										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population - 2013	NA	3	7,552	NA	2,255	NA	NA	*8095	137	*NA*
Population less than 15 years-2013	NA	NA	103	NA	49	NA	NA	NA	NA	NA
Pregnant Women-2013	NA	NA	NA	NA	62	NA	NA	NA	68	62
* PEPFAR HTC program data has been presented NA = Data not available										

The estimated MSM and FSW populations in the Bahamas are unknown.

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months) Barbados										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population (2012)	287,733	1.2	2,200	11,200	1004	NA	831	* 2044 (PEPFAR)	23 (PEPFAR)	*NA*
Population less than 15 years	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Pregnant Women	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
** The HTC data presented a PEPFAR FY14 APR data based on PEPFAR's support to rapid testing in Barbados.*										

The estimated MSM population in Barbados is 2,784 and the estimated FSW population is 5,644. HIV prevalence rates for both populations are unknown.

1.2 Investment Profile

Many countries within the Caribbean region are characterized by high debt to gross-domestic-product ratios and tight fiscal budgets. Across the region, the global economic crisis has resulted in strong growth contraction of member countries' economies, which for the HIV/AIDS response has led to increased dependence on donor and other foreign financing initiatives. Even where countries continue to finance the majority of their HIV/AIDS programs, the weak global economy has increased their fiscal vulnerability. Jamaica's most pressing challenge is the country's debt, currently estimated at 141.6% of GDP (World Bank March 2014) Total Health Expenditure (THE)[2] per capita across the Caribbean is estimated to be approximately USD $551 with the highest expenditures recorded by the Bahamas at USD $ 1,647, Trinidad and Tobago at USD $972 and Barbados at USD $1,291. The Caribbean average of THE as a percentage of Gross Domestic Product is 6.1 percent with Barbados being 8.7 percent, Bahamas 7.5 percent and Trinidad and Tobago 5.4 percent. Studies have shown that governments and households are the two biggest spenders on health in the Caribbean. Government health spending (GHE) as a percentage of the THE average is 61% in the Caribbean with the Bahamas' percentage at 46.1, Trinidad and Tobago's at 50.4% and Barbados' at 55.5%. Corresponding percentages for out-of-pocket spending for these three countries is USD $29, USD $42 and USD $38 respectively as compared to a Caribbean average of USD $32.

The majority of HIV/AIDS programs across the PEPFAR Caribbean regional program coverage area are funded at levels greater than 50 percent by national governments, with the exception of Suriname. In the Caribbean regional Tier 1 countries for example, the Government of Jamaica (GOJ) funds 70 percent of its annual HIV/AIDS expenditure of USD $20,392,492, while the Government of Trinidad and Tobago (GOTT) funds 74 percent of its USD $3,790,535 annual HIV/AIDS expenditure. For Trinidad and Tobago, the remaining 26 percent of HIV/AIDS annual expenditures are supported by PEPFAR. The Government of Suriname (GOS), which is also a PEPFAR Tier 1 country, funds only 49 percent of its USD $4,593,000 HIV/AIDS annual expenditure with Global Fund supporting 22 percent, other donors supporting 29 percent and historically, minimal PEPFAR support. In PEPFAR Tier 2 countries, the Government of Bahamas (GOBAH) funds 91 percent of its HIV/AIDS response and PEPFAR makes up the vast majority of additional donor support at 8.7 percent, while the Government of Barbados (GOB) funds 81 percent of its national HIV/AIDS response, PEPFAR 7% and other donors 12%.

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[2] "Health expenditure indicators are estimates sourced from: WHO Global Health Observatory http://www.who.int/research/en/ (accessed March 27, 2015) and World Bank DataBank http://databank.worldbank.org/data/home.aspx (accessed November 2014)."

More detailed financial data is limited in the region; however, where PEPFAR has supported National Health Accounts (NHA), such as in Jamaica and Barbados, additional analysis is possible. Jamaica's fiscal data shows that of its total expenditure of approximately USD $20.4 million per year, almost 30 percent is invested in clinical care, treatment and support including vertical transmission. Only about USD $2 million or 1 percent is invested in specific key population programming despite the fact that one out of every three gay men and other men who have sex with men are HIV positive according to the 2014 UNAIDS Gap Report.

The financial data available indicates that PEPFAR investments in HIV/AIDS programming across the Caribbean region represent a relatively small proportion of overall expenditures. Given the significant pivot of the PEPFAR Caribbean regional program initiated in July 2014, PEPFAR's investments in Tier 1 and Tier 2 countries will increase as resources are shifted away from HIV/AIDS programming in the OECS. However, even with this re-alignment, PEPFAR's overall contributions to the national responses in the Caribbean will remain a relatively small percentage of overall investments versus those of the partner governments. This underscores the critical importance of strong partnerships with national governments and with other donors which will determine PEPFAR's ability to influence national programming to direct more resources towards high quality and widely accessible key population services for epidemic control and ultimately the achievement of an HIV-free Caribbean.

Table 1.2.1 Investment Profile by Program Area[3]
Jamaica

Program Area	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
Clinical care, treatment and support	5,865,810				
Community-based care					
PMTCT	241,634				
HTC/VCT inc HTC for PMTCT, KP	287,523				
VMMC	0				
Priority population prevention	1,427,128				
Key population prevention /MARPS	2,140,423				
OVC	284,640				
Laboratory	904,697				
SI, Surveys and Surveillance	420,295				
HSS					
Total	20,392,492			70	

Table 1.2.1 Investment Profile by Program Area[4]
Barbados

Program Area	Total Expenditure	% PEPFAR	% GF	% GOB	% Other
Clinical care, treatment and support	**6,060,000**	**5.6**	0	**94**	**0.4**
Community-based care	NA	NA	0	NA	0
PMTCT	NA	NA	0	NA	0
HTC	**435,000**	**68**	0	**32**	0
VMMC	0	0	0	0	0
Priority population prevention	**1,805,000**	**27**	0	**73**	0
Key population prevention	NA	NA	0	NA	0
OVC	NA	NA	0	NA	0
Laboratory	NA	NA	0	NA	0
SI, Surveys and Surveillance	**100,000**	**100**	0	NA	0
HSS	**1,900,000**	NA	0	NA	0
Medical Goods Purchased Outside Of Health Facility	**225,000**	NA	0	0	0
Total	**10,525,000**				
% By Funding Source		**7**		**81**	**12**

Spending Assessment - Jamaica, UNAIDS 2014, 2012/2013 Results, all amounts in 2012 USD
[1]Barbados 2012 – 13 Health Accounts Report, all amounts in USD

Table 1.2.1 Investment Profile by Program Area[5]
Trinidad & Tobago, Suriname, and the Bahamas

Program Area	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
Clinical care, treatment and support	NA				
Community-based care	NA				
PMTCT	NA				
HTC	NA				
VMMC	NA				
Priority population prevention	NA				
Key population prevention	NA				
OVC	NA				
Laboratory	NA				
SI, Surveys and Surveillance	NA				
HSS	NA				
Total - Allocated Trinidad and Tobago	3,790,535	26%		74%	
Total – Allocated Suriname	4,593,000	-	22%	49%	29%
Total – Allocated The Bahamas	15,715,172.26	8.7%			

Program area allocations are not available for Trinidad and Tobago, Suriname and the Bahamas. Totals allocated are reflected.

Table 1.2.2 Procurement Profile for Key Commodities
Jamaica

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
ARVs	3,305,111				
Rapid test kits	1,702,811				
Other drugs	10,222				
Lab reagents	660,511				
Condoms	1,845,957				
VMMC kits					
Other commodities					
Total					

*Information from NASA Report 2012-2013

Table 1.2.2 Procurement Profile for Key Commodities
Barbados

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GOB	% Other
ARVs	**925,000**	NA	0	**100**	
Rapid test kits	NA	NA	0	NA	NA
Other drugs	NA	NA	0	NA	NA
Lab reagents	NA	NA	0	NA	NA
Condoms	**50,000**	NA	0	**40**	**60**
VMMC kits	0	0	0	0	0
Other commodities	**2,020,000**	NA	0	**100**	
Total	**2,995,000**	NA			
% By Funding Source				**82**	**18**

[5] (GRP, National AIDS Spending Assessment, 2012), all amounts in 2012 USD

Procurement profiles for key commodities allocations are not available for Trinidad and Tobago, Suriname and the Bahamas.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives Barbados

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH					
USAID TB					
USAID Malaria					
Family Planning					
NIH					
CDC NCD					
Peace Corps					
DOD Ebola					
MCC					
Private Sector					
PEPFAR Central Initiatives	**2,100,000**				LCI – To build the capacity of a regional organization and local CSOs that specifically focus on key populations to become more sustainable.
Total					

Non-PEPFAR funded investments and integration and PEPFAR central initiatives allocations are unavailable for Jamaica, Trinidad and Tobago, Suriname and the Bahamas.

1.3 National Sustainability Profile

The Sustainability Index for Jamaica (Appendix C)identified the following domains that need additional investment: Financial/Expenditure Data, Access and Demand, Human Resources for Health, Commodity Security and Supply Chain, and DRM Resource Commitment. Epidemiological and Health Data, Quality Management, DRM Resource Generation, Allocative Efficiency, Public Access to Information, Oversight and Stewardship, and Policies, Laws and Regulations were approaching sustainability and require little or no investment. Performance Data, Technical Efficiency and Planning and Coordination require no investment.

The issue of retaining qualified professionals in Jamaica is well documented. Because the health system is unable to retain multiple levels of qualified health care providers there is a continuous need for in-service training. The sustainability analysis addresses this problem but the challenges associated with task shifting and the high burden this places on the health sector remains.

While Jamaica is approaching sustainability in the policies, laws and regulations domain; this does not reflect the reality for key populations. In general, there is not a comprehensive HIV and

AIDS law, a general anti-discrimination law or a human rights commission, or any legal enforceable laws or policies that protect people against HIV-related discrimination (Legal Reforms, Social Change HIV/AIDS, 2013-Annex 9). Furthermore, the Offences against the Person Act criminalizes consenting same-sex relations. Another legal challenge is the age of consent for access to sexual and reproductive health services. Currently, healthcare workers cannot provide services to any person under the age of 18 without a parent's consent, even though the age of sexual consent is 16.

Finally, Jamaica's dependency on the Global Fund for ARVs is not sustainable. The risk of stock-outs and potential supply chain crises would impede the ability of the Government to reach epidemic control.

1.4 Alignment of PEPFAR investments geographically to disease burden

In ROP 14, the CRP underwent a program shift to better match resources to the geographic distribution of the epidemic. Three tiers emerged after examining the HIV burden in the region. Tier 1: Jamaica, Trinidad and Tobago, and Suriname (83% of new infections and 80% of PLHIV); Tier 2: Barbados and the Bahamas (12% of new infections); and Tier 3: the six OECS countries (5% of new infections). In ROP15, Caribbean Regional Program resources will only include core and near core activities. Non-core activities will be discontinued. In addition, resources will be invested almost entirely in Tier 1 and Tier 2 countries. This shift will better position the region to reach epidemic control.

During PEPFAR II, the Caribbean Regional Program's investments were spread over 11 Caribbean countries. In 2014, 76% of PEFPAR's investment in the region was for activities at the above-site level. Health systems strengthening and program management accounted for 37% and 25%, respectively, of the investment. The program focused on the national level rather than the site or service delivery level. Expenditure analysis shows that 17% of the total expenditure went to Facility Based Care and Treatment Sites (FBCTS) with only 3% going towards Community Based Care and Treatment Sites (CBCTS). KP programming accounted for 27% of the budget while GP programming accounted for 17%. HTC only accounted for 5% of the overall PEPFAR spend in 2014.

Table 1.4.1 shows the PEPFAR Caribbean Regional Program (CRP) FY2014 expenditure and estimated number of PLHIV by country. Table 1.4.2 shows the percentage of PLHIV by country and expenditure per PLHIV in FY2014. These tables show that the PEPFAR Caribbean Regional program invested a total of approximately USD 15,467,295 across the 11 countries. The individual country expenditures, however, do not correspond to the number or percentage of PLHIV. For example, Barbados, Antigua and Barbuda, Dominica, Grenada, St. Lucia, St. Kitts Nevis and St. Vincent and the Grenadines all show a high spend compared to the number of PLHIV. Jamaica, Trinidad & Tobago, Bahamas and Suriname have a low spend relative to the PLHIV numbers.

PEPFAR III is focused on sustainable control of the HIV/AIDS epidemic. UNAIDS has announced 90-90-90 global treatment targets; 90 percent of people living with HIV diagnosed, 90 percent

diagnosed on ART, and 90 percent of people on ART virally suppressed by 2020. To support these goals, the PEPFAR Caribbean Regional Program has shifted its strategic focus. The Caribbean Regional Program will focus on using data to target geographic areas and populations with the highest HIV burden. The program will focus on resources where we can achieve the greatest impact towards epidemic control. The expenditure will align with gaps along the HIV continuum of care in the high volume sites that have been identified within the highest burden geographic locations.

Figure 1.4.1

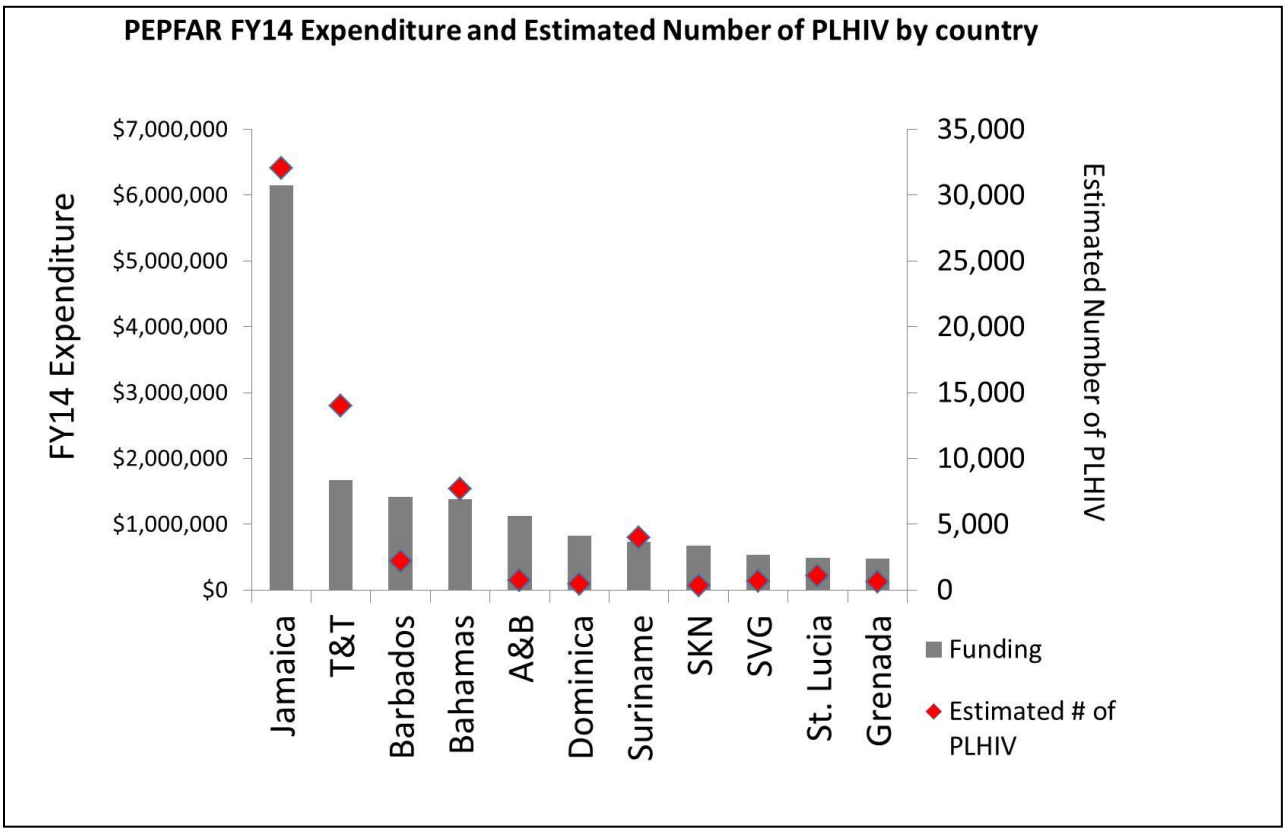
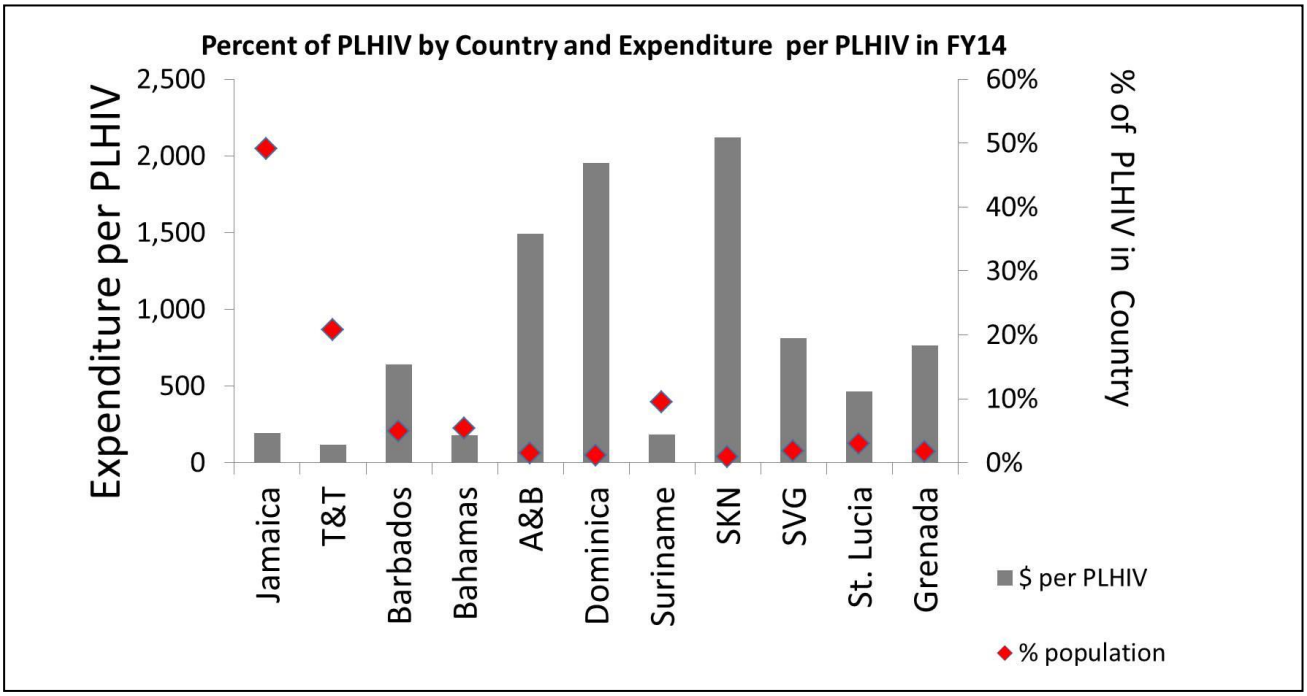


Figure 1.4.2



2.0 Core, Near-Core and Non-Core Activities

For ROP 15, the CRP identified activities necessary to contribute to a sustainable response to the concentrated HIV epidemic in Tier 1 and Tier 2 countries. These activities varied in their ability to make direct, measurable impact on the continuum of prevention, care, and treatment (CoPCT) and resulted in preliminary core, near-core, and non-core categorization. Tier 3 countries will continue to benefit from PEPFAR CRP technical assistance provided through regional platforms.

The PEPFAR CRP will provide support to Tier 1 and Tier 2 countries through two methods: 1) targeted implementation and evaluation of innovative service delivery models in high volume settings; and 2) targeted technical assistance at appropriate national and SNU levels based upon gaps/bottlenecks and service delivery targets. Given the need to scale combination prevention activities, activities previously supported in low yield sites will be redirected toward higher yield sites and activities not sufficiently targeted to priority populations will now be redirected toward priority populations. Technical assistance not currently allocated at the most appropriate level (e.g. national vs. SNU) will be adjusted accordingly in this ROP submission. Technical assistance not targeted to priority populations or not addressing gaps/bottlenecks within the continuum of care response is classified as non-core and will end in 2016.

Core and near-core activities were further refined for each country by assessing CoPCT data and the current national response and investment portfolio. Country consultations informed the

finalization of core and near-core program activities in ROP 15. See *Appendix A* for full list of core, near-core, and non-core activities.

Laboratory (Lab), Strategic Information (SI) and Health Systems Strengthening (HSS) support are foundational to addressing gaps across the CoPCT, as is the ability to collect, analyze and use priority epidemiological and program data. As such, the primary objective of HRH activities, as a component of the PEPFAR HSS support, will be to ensure adequate supply and quality of human resources for health (HRH) to expand HIV/AIDS services in PEPFAR-supported high-volume sites and within the stipulated geographic prioritization. HRH will focus on improving site level performance through clinical training and mentoring and QI/QA initiatives. HSS cross cutting focus addresses PEPFAR's sustainability action agenda by building on HRH programs and continuing the support for in-service training of locally employed staff at high volume sites as well as building the capacity of countries to collect and analyze health expenditure data. The cross cutting focus also aligns with the PEPFAR Human Rights agenda by addressing S&D to increase access to non-discriminatory prevention, care and treatment services. Core activities for HSS were determined using the PEPFAR 3.0 Blueprint and the new HRH Strategy as guiding documents.

Efforts will be made to ensure strengthened cross-cutting laboratory services to meet PEPFAR goals for scaling up HIV prevention, treatment, and care interventions. Core laboratory activities will include: 1) improving access and quality of HIV rapid testing at the facility and community sites; 2) ensuring strategic placement of point of care CD4 machines to match patient care needs; 3) improving access and coverage for viral load and HIV drug resistance testing; and 4) targeted support for quality improvement and accreditation of laboratories directly associated with PEPFAR supported HIV prevention, care and treatment sites.

In an effort to support CoPCT monitoring, as well as enabling site level assessments of progress towards epidemic control, core strategic information (SI) activities will include: 1) building MOH capacity in M&E and surveillance to improve collection, analysis and interpretation of site level and national data in Tier 1 & 2 countries; 2) targeted training in priority facilities in Tier 1 and 2 countries to address data quality and reporting gaps; 3) special ongoing studies (i.e., ongoing BBS studies, the proposed FSW study in Suriname, treatment outcome analyses, and ART costing studies; 4) regional capacity building to assist countries with analysis and use of site level prevention, care and treatment continuum data. These data will inform the scale-up of targeted interventions that contribute to epidemic control. System and site level core and near activities have been selected based on country needs, PEPFAR's role within the region, and the comparative advantage of PEPFAR supported IMs and planned support through other partners in the region. In addition to working closely with host governments, PEPFAR works collaboratively with UNAIDS, PAHO and the Caribbean Regional Public Health Agency (CARPHA) to implement the strategic information agenda.

Section 3: Geographic and Population Prioritization

National and subnational data show variation in prevalence and burden within and between countries. A tiered approach is needed in order to align PEPFAR's support with the epidemic in the Caribbean.

Countries were prioritized based on their total HIV burden. Jamaica, Trinidad and Suriname, with 80% of PLHIV, are Tier I countries The Bahamas and Barbados, where 15% of PLHIV live, are Tier II countries. The six OECS countries (Tier III) account for an estimated 5% of the ~ 63,000 PLHIV.

The regional prevalence of HIV is 1.0%; national prevalence is estimated to be <1% in the OECS and as high as 2.8% in the Bahamas. Where estimates are available, HIV prevalence amongst female sex workers (FSW) and men who have sex with men (MSM) is disproportionately high (e.g. 32.8% amongst MSM in Jamaica and 5.8% amongst FSW in Suriname). These data, in addition to estimates of HIV testing and prevention intervention coverage were used to prioritize MSM, including the sub-population who identifies as transgender, and FSW as groups of focus for "reach and test" interventions. Parish level prevalence data for MSM and FSW were not available – however, program data was used to identify KP hotspots and estimate the proportion of KP in the target geographic locations. National ANC data indicate high levels of HIV testing and PMTCT successes. As such, these are not areas of focus for PEPFAR. The geographic locations identified for military TA support in Tier I countries align with selected KP locations.

Continuum of care data, incidence and mortality data were reviewed to assess national progress with reaching epidemic control. An estimated 60% to 93% of PLHIV were diagnosed in supported countries using the most recent available data. Although not addressed by the 90-90-90 targets, the biggest gaps in the continuum are linkage to care and retention in care. ARV coverage amongst all PLHIV ranges from 29 – 45% (2012 (Jamaica), 2012 Barbados). These gaps in ARV coverage are partly explained by national eligibility criteria. Viral suppression is estimated to range from 11 % to 35% of all PLHIV in Jamaica and Barbados respectively. Less than 50% of PLHIV on ARVs in Jamaica are virally suppressed compared to 83% of PLHIV on ARVs in Barbados.

The PEPFAR team assessed available surveillance, C&T and key population data to identify the geographic regions and facilities within the 5 priority countries with the highest burden. For example, in Jamaica, data on the number of patients in care, ART patients and historical HIV diagnoses identified Kingston & St. Andrew, St. James, St. Catherine and St. Ann as parishes with the highest prevalence, burden and proportion of PLHIV. Using total numbers of patients served regardless of geographic location - health facilities within St. Andrew, St. James, St. Ann and St. Catherine account for 80% of the PLHIV. Although national ART coverage in is Jamaica 25% of all PLHIV and 50% of PLHIV in care, ART coverage amongst patients in care in the priority facilities ranges from 35 to 62% . These facility level continuum of care data were used to identify site level activities that would contribute to reaching 80% coverage by 2017.

This approach was used for priority setting in Trinidad and Tobago, Suriname, Barbados and the Bahamas. Where site level data were not available, proxy data were used to determine priority sites. Some locations (e.g. Sipalawani in Suriname) were excluded due to relative size, dearth of infrastructure/facilities and the potential difficulty in reaching target populations. All of the proposed sites were validated or revised through country consultations. Additional analyses were completed in collaboration with the MOHs to further refine selected sites, some analyses are still pending. Because some analyses are still pending, all sites are not finalized.

Key population interventions will support scale up in national results; however 80% coverage within selected districts is not feasible (see further detail in 4.0). Current projections are that PEPFAR will reach over 9,000 key populations in Jamaica, Trinidad, Suriname and the Bahamas. Uptake of HIV testing amongst KP will be at least 50% and approximately 300 KPLHIV will be diagnosed. Linkage and retention activities will support 70 – 80% of new patients being linked to care.

Since activities at the C&T sites target 80% of the PLHIV in care, the CRP anticipates that focused interventions to improve ARV coverage, retention and viral suppression at these sites will impact national outcomes. PEPFAR's technical assistance to the MOH is expected to contribute to increased ART coverage from an average of 31% to 36%, in priority districts in Jamaica. This will be a step towards closing the "ART gap" for PLHIV eligible for treatment according to national deadlines (55% estimated to be eligible at CD350 in 2013). This includes initiation of 448 patients on ART in Kingston & St. Andrew alone and an increase from an estimated 36% to 43% ARV coverage in this parish. Targeted assistance in non-priority districts (Clarendon, Westmoreland) is proposed based on the total number of patients in these facilities. Similarly, retention, return to care and facility level CQI activities will support an increase in ART coverage from 45% (2013) to 64% (2016) in Barbados.

Clinical testing coverage rates are anticipated to be at least 80% in facilities participating in CQI activities and receiving support for clinical testing through laboratory strengthening activities. Viral suppression rates are anticipated to increase by FY17 when patient retention and adherence issues are addressed through pilot interventions. The current projections are to increase viral suppression rates in target facilities in Jamaica to a mean of 60% of ART patients, higher than the baseline mean of 43% for patients at these facilities. Relatively high levels of viral suppression are observed for Barbados (83% of ART patients). Therefore, PEPFAR will provide targeted assistance to assist Barbados with achieving 90% viral suppression rates and increase ART coverage to decrease the community viral load. Targets for Suriname, Trinidad & Tobago and the Bahamas will be further refined during ongoing discussions. PEPFAR's contributions for C&T in these countries will focus on above site initiatives to strengthen linkage to care (including medication adherence) within care and treatment facilities.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

APR14 key population program results were used to determine the feasibility of 80% coverage by FY17. The Caribbean program considered 60% coverage by FY16 an ideal milestone towards reaching 80% coverage. However, 60% national coverage by FY16 was determined to not be feasible based on past results, population dynamics and planned investments (considering both PEPFAR and other partners). Consequently, targets are based on scale up of KP interventions in priority districts, investments and expected results of new strategies. Planned KP coverage ranges from 6 to 23% of key populations within in the selected locations (Table 4.1.4).

Targets for the Bahamas, Suriname and Trinidad represent a scale up in PEPFAR's key population coverage in these countries. Investments in prevention in Barbados are "above site" and do not directly contribute to MER site level targets. Additionally, 2013 continuum of care data show that Barbados has diagnosed 93% of PLHIV, resulting in minimal PEPFAR investments in "reach and test interventions." In Jamaica, targets are similar to APR14 data and FY15 targets but take into consideration that past data included duplicate contacts. During FY14, it was estimated that 13% of MSM were reached through PEPFAR (26% nationally) this figure includes duplicate individuals. Unique contacts will be enumerated during FY16, as such PEPFAR's target for MSM coverage for ROP15 is 10%; it is assumed that national coverage will be 20% (double PEPFAR's contribution) in Jamaica. In Trinidad and Tobago, the MOH has requested further data analysis in order to complete site selection. Since this is ongoing, estimates for key population coverage are based on the premise that the final selected SNUs will be where 80% of MSM and FSW can be reached with interventions. It is assumed that PEPFAR will focus on select intervention points within priority SNUs where 20% of KP can be reached with small scale pilot interventions. Based on these assumptions, modest targets have been proposed assuming a 3 to 6 month implementation period after site finalization. A total of 400 KP will be reached during this time and 300 tested. Earlier implementation of activities or further scale up based on MOH investments in the same locations will result in overachievement of these targets.

It is assumed that government and civil society partners will participate in further refinement of subnational targets, identification of key population hotspots and adaptation of evidence based strategies to support achievement of targets. Therefore, further revisions are likely during pre-implementation discussions.

As a TA/TC program, the Caribbean OU does not directly support treatment but provides technical assistance to improve service delivery. Efforts will include strengthening implementation of national linkage to care protocols and guidelines with special consideration for community settings. For example, it is estimated that 55% of PLHIV are eligible for treatment at CD4 350 in Jamaica; however national ART coverage is 28%. In Barbados, it is estimated that 89% of patients known to be eligible were on treatment but this represents 46% of all PLHIV. In 2013, a total of 3,711 PLHIV in the Bahamas were estimated to be eligible for ART, however 2,255 were on treatment. Retention for patients starting ART in 2012 was estimated to be 51% in the Bahamas (2014 GARPR reports). Approximately 75% of PLHIV diagnosed PLHIV in the Tier 1 countries are linked to care and approximately 50% of patients in care were retained in 2012. Preliminary data

show that pre- ART patients are less likely to be retained. Complementary data on new AIDS cases suggest that PLHIV diagnosed in previous years, returned to care when ill and receive AIDS diagnoses. PEPFAR TA/TC activities that reduce attrition and improve clinical monitoring of patients have the potential to impact these trends. PEFPAR's support in priority locations will include returning lost patients to care; initiating ART for eligible patients, improving retention of ART patients and improvement of medication adherence. It is also assumed that health systems will be able to manage higher patient loads, whilst increasing levels of retention, ART coverage and clinical testing. Challenges with 'above site' or site level procurement (leading to stock-outs), health worker retention and service delivery bottlenecks have the potential to impact achievement of results. Delays with scale up and implementation of new strategies would result in failure to meet FY16 targets.

Using the data described above, technical assistance targets have been estimated based on expected national or subnational results for the MOH C&T programs. PEPFAR's contribution to "new care and ART patients" is attributed to identification of new positives through prevention activities. Additionally, activities to strengthen the quality of services for PLHIV and KPLHIV at priority sites will assist MOHs with placing and retaining new patients on treatment (Table 4.1.2), were used to estimate the number of patients who return to care and receive clinical testing and the proportion of these will be expected to initiate treatment (Table 4.1.1).

Key population prevention activities will identify 302 KPLHIV, of which 132 are estimated to initiate treatment. Care and retention interventions (including retention and "return to care" interventions) will place 1,114 new patients on treatment. Retention on treatment will be measured in FY17 -therefore no targets are included for FY16.

There is a need to strengthen data collection and reporting for KP interventions. UNAIDS provides support to countries to develop PLHIV size estimates. Ongoing PEPFAR supported BSS surveys will provide national MSM and FSW population size estimates. Where data are unavailable, PEPFAR estimated the total MSM population size to be 2% of the adult male population and FSW sizes to be 3.8% of the adult female population.

Data limitations include absence of subnational estimates for KP and PLHIV. To overcome this, program results were used to develop proxy estimates of numbers of KP reachable within geographic locations. As a result, the SNU denominators used for target setting do not directly correlate to where individuals live but where C&T services are accessed (for PLHIV) and the social/sexual networks for MSM; and venues were sex workers meet their clients or where sex work occurs. These estimates provide data for locations where interventions will be targeted. The team recognizes, however that PLHIV and KP accessing prevention interventions may be resident in different locations.

Additionally, past monitoring efforts did not account for duplicate contacts or report HTC yield data for key populations. PEPFAR will provide support to NAPs to implement strategies to

improve the quality and use of these data at the site level. MOHs will be supported to implement systems to introduce and improve use of unique identifier codes.

Military programs in Tier I countries will receive TA to monitor quality improvements in reach, HTC, linkage to care and care services provided, as well as evaluation of stigma and discrimination sensitization and mitigation. In addition to the targets indicated, the program will provide near core support to strengthen the delivery of health services for care and treatment. These activities will be monitored through site level cascade data and custom indicators.

Table 4.1.1 ART Targets in Priority Sub-national Units for Epidemic Control[6]

SNU	Total PLHIV	Expected current on ART (2015)	Additional patients required for 80%[7] ART coverage	Additional patients required for 80%[8] ART coverage of eligible	Target current on ART (in FY16) *TX_CURR*	Newly initiated in FY 16 *TX_NEW*
Jamaica_*St.Andrew*	9,119	3,496	2,339	515	3,945	448
Jamaica_*St.James*	5,624	1,690	1,909	785	1,826	136
Jamaica_*St.Ann*	2,770	862	911	357	991	129
Jamaica_*St.Catherine*	3,172	1,093	937	302	1,251	158
Barbados[9]	2,200	1,118	290	64	1,397	179
Bahamas_New Providence	6,042	2,369	1,498	600	TBD	10*
Trinidad and Tobago	TBD	NA	NA	NA	NA	23
Total	28,927	10,628	7,884	2,623	9,410	1,083

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Priority Districts (FY 16)

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART **Jamaica**[10]	-	-	770
Clinical care patients not on ART **Barbados**	-	-	179
Other priority and key populations **Jamaica**	3,365	229	91
Other priority and key populations **Suriname**	940	58	31
Other priority and key populations **Trinidad**	325	33	23
Other priority and key populations **the Bahamas**	200	15	10
Total	4,630	335	1,104

[6] Estimated number of patients on ART in 2013 has been estimated by PEPFAR using 2013 ART data, annual data on new patients. Data on deaths and attrition of ART patients have been included where possible.
[7] Care and treatment targets are based on scale up of treatment according to national eligibility where PEPFAR assists with "closing the gap where eligible patients are not initiated on ART.
[8] Care and treatment targets are based on scale up of treatment according to national eligibility where PEPFAR assists with "closing the gap where eligible patients are not initiated on ART.
[9] TX_CURR for Barbados is estimated based on reaching 95% of those who are eligible for treatment.
[10] Includes patients in priority facilities who were lost to follow-up, returned to care and eligible for treatment.

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (priority SNUs)**	**Coverage Goal (in FY16)**	**FY16 Target**
KP_PREV _Jamaica	**38,519**	**17%**	**6,731**
KP_PREV _Suriname	**6,381**	**23%**	**1,459**
KP_PREV _the Bahamas	**4,408**	**6%**	**250**
KP_PREV_ Trinidad & Tobago	**5,706**	**7%**	**400**
PP_PREV _Suriname_SNU	**6,000**	**3%**	**180**
PP_PREV _Trinidad_ SNU	**120**	**67%**	**80**
Total	**61,134**	**15%**	**9,100**

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control Jamaica			
Target Populations	**Population Size Estimate (priority SNUs)**	**Coverage Goal (in FY16)**	**FY16 Target**
KP_PREV_Kingston & St. Andrew	**7477**	**15%**	**1158**
KP_PREV_Manchester	**1069**	**30%**	**321**
KP_PREV_St Catherine	**5309**	**23%**	**1218**
KP_PREV_St. James	**16943**	**14%**	**2368**
KP_PREV_Trelawney	**1446**	**30%**	**434**
KP_PREV_Westmoreland	**6275**	**20%**	**1232**
Total	**38,519**	**17%**	**6,731**

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control Suriname			
Target Populations	**Population Size Estimate (priority SNUs)**	**Coverage Goal (in FY16)**	**FY16 Target**
KP_PREV_Paramaribo	**5,160**	**21%**	**1064**
KP_PREV_Nickerie	**307**	**54%**	**167**
KP_Marowijne	**914**	**25%**	**228**
Total	**6,381**	**23%**	**1,459**

4.2 Priority population prevention

Tier 1 Countries

4.2 Priority population prevention

PEPFAR CRP seeks to invest in a number of core prevention interventions based on the geographic focus of the program in high disease burden locations to contribute to the 90-90-90 targets and to accelerate epidemic control. Based on Tier 1 countries' clinical cascades, PEPFAR CRP provides intensive technical assistance and support toward activities that address gaps along the continuum of prevention, care and treatment for key populations, particularly on locations where 80% of PLHIV were diagnosed. Targeted prevention efforts will focus on reaching key populations (including MSM, TG, CSW), using a combination of facility, community-based and other HTC strategies to ensure timely linkages and referrals to HIV-related services and to maximize program impact.

In addition to the HIV burden, the availability and capacity of civil service organizations is an important factor in the selection of high volume locations and services sites. PEPFAR CRP will support KP-friendly community based organizations (CBOs) and work with MOH to strengthen HTC, linkage and facility-based services for KPLHIV/PLHIV to increase diagnostics, retention, adherence, documentation. Increased access to services will be achieved through the increased engagement of KP-friendly civil service organizations, the improvement of bi-directional referral networks between CBOs and the ministries of health, the prioritization of monitoring and evaluation, and the incorporation of peer navigators where applicable. The Key Populations Challenge Fund (KPCF) is a central initiative that will complement these investments. Appendix A highlights activities that promote increased prevention, care and treatment services for MSM, TG and CSW.

In Jamaica, short term investments will also be made to strengthen discrimination reporting and redress systems at both the community and facility levels. These activities will be conducted via a mixture of a pilot, direct service delivery and technical assistance. In Suriname, technical assistance and support will extend beyond targeted outreach activities that maximize penetration into the highest risk MSM and PLHIV networks to include cross-border sites between Suriname and Guyana and the integration and reinforcement of anti-S&D messaging and gender equality sensitization activities. In Trinidad and Tobago, the PEPFAR CRP will support increased uptake of HTC and HTC yield in high priority settings—through targeted outreach, the

implementation of evidenced-based interventions targeting HIV testing behaviors (e.g., Popular Opinion Leader), and enhanced HIV screening in priority locations.

4.5 HIV testing and counseling (HTC)

Among Tier 1 countries, PEPFAR CRP seeks to support the expansion of outreach testing to increase diagnosis and yield at the subnational and site level. Evidence-based interventions using the Sexual Transmitted Infection Control Programs (VICITS) model will be also piloted at HTC sites across all Tier 1 countries identified in 4.0 and 4.2. The VICITS model is a combination-prevention package targeted to key populations that includes STI diagnosis and treatment, condom promotion and distribution, Positive Health, Dignity and Prevention (PHDP), HTC, antiretroviral treatment referral and the collection and analysis of key behavioral and biological indicators as a follow-on to reach activities along the continuum.

In Jamaica, expanded social media strategies will also be supported to increase the demand for and uptake of HTC among key populations. PEPFAR will support MOH mobile testing units to expand testing coverage and target key populations' hotspots. At the subnational level, PEPFAR will strengthen the National Referral and Linkage Protocol to ensure that KP tested in outreach settings are enrolled at a treatment site, as well as other PLHIV. To improve overall access and quality of HIV testing, the rapid testing quality improvement initiative (RTQII) will be implemented at PEPFAR supported sites to increase use of the standardized logbook for data collection and analysis; improve the implementation of the Dry Tube Specimen External Quality Assurance (DTS EQA) for quality assurance; and certification of HTC sites and personnel.

In Suriname, PEPFAR will provide support to the national program and MOH supported civil service organizations to increase HTC coverage in high volume/high yield sites based on key population size estimates. Focused laboratory strengthening will contribute to an overall improvement of HTC services through the implementation of the RTQII, which would support improved access and quality of this service including expansion in the use of HIV standardized logbooks to collect more complete testing data. This program will also include expansion of the DTS EQA for monitoring the quality the HIV testing at all sites offering HTC.

Strategic information support will include the implementation of strategies to improve the quality, timeliness and completeness of reporting of key population HTC data. Increased site monitoring and support to improve reporting at key population service

delivery sites and the integration of point of care testing at the select HTC sites will complement the prevention package of services. PEPFAR will employ both direct service and technical assistance approaches. HTC activities remain core investments of key populations programming which contribute to the 90-90-90 targets towards epidemic control. As tailored approaches are integrated into national systems, sustainability is country driven thereby increasing the numbers of key populations with access to high-quality, evidence-based STI and HIV prevention services towards achieving an AIDS-free generation.

In Trinidad and Tobago, community based testing and counseling with linkage to prevention, care, and treatment services will be prioritized to facilitate early diagnosis and access to services for key populations. PEPFAR CRP technical assistance will also expand in-country capacity to strengthen non-governmental organization (NGO) engagement and capacity to deliver targeted prevention interventions across the CoPCT using models, such as peer navigation and technology-based strategies. In targeting hard to reach populations, strategies will prioritize high prevalence geographic areas and high risk/high volume clinics through the promotion of community-based HTC to increase awareness about and demand for HTC and follow-up services. There will also be laboratory strengthening through the implementation of the RTQII to ensure improved access and quality of this service including expansion in the use of HIV standardized logbooks to collect more complete testing data.

4.6 Facility and community-based care and support

Among the Tier 1 countries, PEPFAR will continue to support the strengthening of community-based high volume sites to increase the number of newly diagnosed KP linked to care and referred to treatment. Attention will also be placed on training clinical providers at high volume sites with knowledge, non-discriminatory attitudes and skills to increase the uptake of care and support services. Where applicable, an emphasis will be placed on strengthening facility-based care and support, with a particular focus on contact tracing/partner notification and medication adherence. Technical assistance to countries will strengthen domestic/local program efforts by addressing essential program components that have traditionally posed barriers to early HIV detection, linkages to treatment and care services, and ensuring treatment access and adherence especially among key populations.

PEPFAR Jamaica will focus on monitoring the national linkage protocol, training in PHDP, quality improvement initiatives to increase CD4 and viral load uptake. In the

short-term, PEPFAR Jamaica will support psychosocial services to address mental health issues which are barriers to retention. An evaluation of reasons for lost-to-follow up among KP will be conducted and results will be used to guide both clinic and CBO program activities. Additionally, CBOs will be strengthened to provide PHDP, support retention in care and partner notification.

In Suriname, limited data about the number of KPLHIV in the target geographic locations and proposed sites affects the ability to provide absolute numbers of persons registered in care and support programs; however, results of the planned bio-behavioral survey on FSW will position the PEPFAR program to provide future estimates on FSW linked to care and support services. PEPFAR will continue to support the strengthening of at least two community-based sites that have been identified as providing care and services specifically to FSW and MSM. PEPFAR will invest resources to assist identified organizations with improving data collection and reporting across the continuum of prevention, care and treatment cascade to realize quality data for future program planning. Health systems strengthening activities will include supportive supervision at the site level to improve clinical mentoring and continuous quality improvements to promote adherence and retention in care and address stigma and discrimination where relevant.

Technical assistance efforts will support the implementation of core activities; increase/strengthen the delivery of services to key populations (MSM, SW, TG); and geographically align prevention activities at clinics/sites with the highest prevalence.

4.8 Adult Treatment

In Jamaica, ARVs are procured under the Global Fund (100%). ARVs in Trinidad and Suriname are supplied by the government. In both Jamaica and Trinidad and Tobago, PEPFAR will focus on laboratory support for viral load testing as part of adherence monitoring as well as continue strengthening local capacity to implement CQI programs at treatment sites. In Jamaica, increased QI/QA focus on the adherence counseling program will also include strengthening the current curriculum and retraining adherence counselors and BCC officers to deliver adherence counselling at facilities.

Tier 2 Countries

4.2 Priority Populations Prevention

Across both Tier 2 countries, core combination prevention interventions focusing on MSM, TG and SW in high burden locations will accelerate progress towards the achievement of the 90-90-90 targets and greater epidemic control. Specifically, targeted technical assistance will address continuum of care gaps/barriers and contribute to achieving viral suppression. KPCF is a central initiative that will also complement these investments. Please see Appendix A for core prevention, care and treatment activities for KP, including KPLHIV/PLHIV.

A review of Barbados's national and MSM continuum of care cascades determined that priority should be given to investing in core and near-core interventions to improve linkage to care, increase the number of individuals on ART, and support efforts to improve their adherence and retention on treatment. As the MOH gradually moves to adapt and implement the WHO Treatment 2.0 Guidelines, targeted technical assistance will be provided to enhance the technical capacity and sustainability of the MOH and community-based partners to better address the needs of PLHIV and support their reality on long-term treatment. Given the centralized nature of the delivery of HIV/AIDS services in Barbados, the PEPFAR team will be able to focus interventions on four identified priority health facilities, in the parish of St. Michael where the majority of prevention, care and treatment services are accessed. Priority civil society partners and KP hot spots will be identified in collaboration with the MOH and civil society stakeholders. PEPFAR will continue to facilitate access to condoms and lubricants through active civil society partners and the priority health facilities.

The Bahamas' national HIV/AIDS response has focused primarily on the general population and PLHIV. Targeted MOH prevention efforts have also addressed adolescents, young pregnant women, Creole-speakers and undocumented migrants, MSM, and SW. Due to the disproportionately high HIV burden among MSM and SW, PEPFAR CRP's prevention investments will focus on MSM and SW in high burden settings in New Providence. Short-term evidence-based interventions will be used to increase access to KPs and enhance HTC positive diagnoses yields and are designed to transition to the MOH. The support of KP-friendly CBOs will be scaled up to improve reach to these populations and assist with engagement across the continuum of care.

4.5 HIV Testing and Counselling (HTC)

In Barbados, MOH estimates indicate that 92% of PLHIV have been diagnosed and therefore the country has exceeded the first of the 90% targets for achieving epidemic control. Although, PEPFAR CRP investments will not directly support reach or HTC activities in Barbados, short-term training investments will focus on enhancing the quality assurance and quality improvement of government led HTC and LTC activities.

In addition, the development and implementation of the KPCF HTC for KP curriculum in Barbados will support related uptake, as well as improved clinical services, for these vulnerable populations. PEPFAR CRP will adapt/pilot the VICITS model of integrated STI/Combination HIV prevention services at a priority STI clinic (or appropriate settings). VICITS will focus on a combination-prevention package that includes integrated STI diagnosis and treatment, condom promotion and distribution, HIV counseling and testing, PHDP, ARV referral, and a second-generation HIV surveillance information system for KPs.

PEPFAR CRP will no long support MOH activities or interventions using general population testing approaches to reach priority populations. PEPFAR CRP seeks to support the expansion of outreach testing to increase diagnosis and yield at the subnational and site level. Expanded information communication technology strategies will be supported to increase the uptake of HTC among KPs. MOH HTC outreach efforts will be refined to better reach MSM using "hotspot" data and information from MSM social network engagement. PEPFAR will support different modalities to expand testing coverage, reduce barriers to access, and target KP hotspots. To supplement outreach efforts, the evidence-based Popular Opinion Leader (POL) intervention will be carried out to increase HIV testing (and positive yield) among MSM. At the subnational and site level, PEPFAR CRP will strengthen linkages to care protocols (particularly for community-based rapid testing activities) to ensure that newly diagnosed KP are enrolled into treatment sites for support services.

4.6 Facility and community–based care and support

Across both Tier 2 countries, PEPFAR assistance has been prioritized to support core and near-core TA activities in identified priority health facilities where the majority of patients access ART, care and support services.

In Barbados, 83% of all patients on ART are reported to have achieved viral suppression. PEPFAR CRP strategic, targeted technical assistance will support the MOH in achieving the latter two of the 90-90-90 targets within the next few years. Selected civil society partners will be instrumental in supporting these priority health facilities to address the needs of KP through quality improvement measures relating to the package of care and treatment services. These include enhanced medical literacy and competencies specific to the needs of KPs, anti-stigma and discrimination activities (e.g., sensitization trainings) at HCW and health care facilities levels to improve access to essential services, the use of

more efficient and effective modalities (e.g., ICT) to reduce loss retention in care, and support referrals to key services.

Investments will focus on strengthening KP-friendly CBOs' capacities to provide support (including peer navigation) for MOH delivered PHDP services, including partner notification and medication adherence. Engagement of these CBOs with MOH (high volume) sites will increase retention in care among KPLHIV/PLHIV. PEPFAR CRP will work with the MOH to ensure the success of partner notification and contact tracing activities and to implement evidence-based interventions and targeted TA addressing medication adherence and retention gaps in select priority sites.

4.8 Adult Treatment

In both Barbados and the Bahamas, ARVs are funded by the government. Both countries will benefit from laboratory support for viral load testing to support ART uptake and monitor the effectiveness of treatment programs. Assistance will also be provided to strengthen laboratory capacity for HIV drug resistance testing to support surveillance activities and investigate treatment failures as well as monitoring the quality of laboratory services through participation in an external quality assessment (EQA) program.

5.0 Program Activities to Sustain Support for Other Locations and Populations

5.1 Sustained package of services in other locations and populations

The CRP program will have small scale investments in care and treatment activities in Jamaica outside of the priority parishes. These health facilities in Clarendon and Westmoreland have been selected based on the number of PLHIV served in the parishes and the potential contribution to national outcomes. The activities implemented will include interventions to return lost patients to care, strategies to improve retention, medication adherence and clinical testing for patient management. HTC activities previously supported outside of priority geographic locations and populations have been discontinued and will not be included in the total targets for the program.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Districts

Maintenance Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	***PMTCT_STAT***	**NA**	**NA**
HTC (only maintenance ART sites in FY 16)	***HTC_TST***	**NA**	**NA**
Current on care (not yet initiated on ART)	***CARE_CURR-***	**1,261**	**NA**
Current on ART	***TX_CURR***	**1,027**	**NA**
OVC	***OVC_SERV***	**NA**	**NA**

In addition, military programs in all Tier I countries will benefit from technical assistance to strengthen and sustain existing programs through focused monitoring and evaluation and quality improvement activities. Program support will transition from external implementing partners to USG staff as direct implementers to support effective integration of quality improvements and increased country ownership.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

The cross-cutting goal of the Caribbean PEPFAR laboratory technical assistance is to support countries to improve the quality and availability of diagnostic and monitoring services and systems. This will be done under a tiered laboratory network to meet PEPFAR goals for scaling up core HIV prevention, treatment, and care interventions. In FY2015, the laboratory strategy will build on the achievements of the past years and address the recent UNAIDS 90-90-90 targets to increase HIV diagnosis, reduce attrition and improve linkages and retention within the Continuum. Improving access and quality of HIV rapid testing at the facility and community levels in support of prevention initiatives to reach and test key populations will continue in FY2015. This will be done through implementation of the PEPFAR laboratory innovative HIV Rapid Testing Quality Improvement Initiative (RTQII) in the three focus countries (Jamaica Trinidad and Tobago and Suriname). Programmatic data from HIV treatment cascades among countries in the region show a significant drop between the numbers of people diagnosed positive and those who receive CD4 results. This may contribute to the significant reduction in linkage to care and ART uptake since these countries still depend on CD4 results to commence treatment. More investment in FY2015 will be geared towards ensuring strategic placement of point of care CD4 machines to match patient care needs, enhanced quality assurance, improved data collection and monitoring of program performance. Viral suppression remains a key indicator to measure the impact of treatment interventions and provide evidence of moving toward epidemic control. Despite this, regional continuum of care data shows that coverage and access to viral load (VL) testing continues to be a challenge within certain treatment sites. In FY2015, PEPFAR regional laboratory program in partnership with PAHO, PANCAP, CARPHA, and UNAIDS will adopt the "WHO Technical and Operational Considerations for Implementing HIV VL Testing (2014)" [11] . This will assist countries to strengthen network and logistics to improve access to VL testing. In addition, the PEPFAR Lab program will assist the Government of Jamaica with the procurement of VL reagents to ensure uninterrupted testing and increased coverage. Some continuum of care data show increased VL uptake that did not result in viral suppression. Several factors could be responsible for this including the presence of HIV drug resistance (DR) mutations. Available data from one treatment site in Jamaica shows 12.6% primary HIV DR (Barrow et al, 2013)[12]. In FY2015 more assistance will be provided to ensure full functioning of the existing HIV genotype testing platforms and support for the implementation of HIV DR Surveillance protocols in all tier 1 and 2 countries. This will

[11] WHO (2014). Technical and Operational Considerations for Implementing HIV VL Testing . Interim Technical Update.

[12] Barrow GJ, Hylton-Kong T, Rodriguez N, Yamamura Y, Figueroa JP.HIV-1 drug resistance in treatment-naive chronically infected patients in Jamaica. Antivir Ther. 2013;18(7):941-4

help ensure prompt clinical decision making for patients presenting with virologic failure and provide data to support HIV DR early warning indicators. There will also be targeted support for quality improvement and accreditation of more laboratories directly associated with PEPFAR supported HIV prevention, care and treatment sites to guarantee the release of timely and accurate results in tier 1 countries. To ensure sustainability, there will also be targeted training of staff for recertification of testers/expansion of testing sites, molecular testing for expansion of viral load, and opportunistic infections to include tuberculosis (TB) diagnosis. These activities will improve diagnosis, linkage and retention along the treatment cascade.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
1. Improving access and quality of HIV rapid testing through Rapid Testing Quality Improvement Initiative (RTQII) at KP friendly HTC sites (Jamaica, Suriname, Trinidad) 2. Support Quality monitoring (EQA/DTS) and data collection/analysis (logbooks) at KP friendly HTC sites (Barbados, Bahamas)	1) Increased use of quality assured HIV rapid testing at KP friendly HTC sites 2) Increase in number of KP tested. 3) Increase in number of KP friendly HTC sites using DTS EQA to monitor quality of tests. 4) Increase in the number of KP friendly HTC sites using standardized logbooks for data collection and reporting.	1) Increased use of quality assured HIV rapid testing at KP friendly HTC sites 2) Increase in number of KP tested. 3) Increase in number of KP friendly HTC sites using DTS EQA to monitor quality of tests. 4) Increase in the number of KP friendly HTC sites using standardized logbooks for data collection and reporting.	HLAB $0	HLAB $300,000	13335		X			X	

3. Support the use of EQA/PT to monitor quality of core HIV-related laboratory tests including CD4 and TB (Jamaica, Suriname, Trinidad, Bahamas, Barbados)	1) Increase in number of PLHIV with quality assured CD4 and TB results. 2) Increase in number of PLHIV who are staged and linked to care. 3) Increase in number of PLHIV retained in care and on ART.	1) Increase in number of PLHIV with quality assured CD4 and TB results. 2) Increase in number of PLHIV who are staged and linked to care. 3) Increase in number of PLHIV retained in care and on ART.	HLAB $96,000	HLAB $131,000	13335; 13593; 12668; 12606; 12570			X	X	X	
4. Work with C&T team to strengthen network and logistics to improve access to viral load testing (Jamaica, Suriname, Trinidad, Barbados, Bahamas) 5. Procure viral load reagents (Jamaica)	1) Increase in number of PLHIV on ART with regular viral load results. 2) Increase in number of PLHIV on ART with viral suppression.	1) Increase in number of PLHIV on ART with regular viral load results. 2) Increase in number of PLHIV on ART with viral suppression.	HLAB $251,000	HLAB $281,000	13335; 13593; 12668; 12606; 12570				X	X	X
6. Build regional lab capacity for HIV drug resistance testing to support surveillance activities (Jamaica, Suriname, Trinidad, Barbados, Bahamas)	1) Availability of data to inform policy and guide activities on HIV drug resistance. 2) Increase in number of HIV drug resistance testing done for PLHIV on ART with virologic failure	1) Availability of data to inform policy and guide activities on HIV drug resistance. 2) Increase in number of HIV drug resistance testing done for PLHIV on ART with virologic failure	HLAB $187,000	HLAB $135,000	13335; 13593; 12668; 12606; 12570			X	X	X	X
7. Laboratory quality improvement and accreditation at KP friendly care and treatment Sites (Jamaica, Suriname, Trinidad)	1) Increase in the number of laboratories that are partially or fully accredited. 2) Increase in the number of laboratories which participate in EQA programs. 3) Increases in number of labs that	1) Increase in the number of laboratories that are partially or fully accredited. 2) Increase in the number of laboratories which participate in EQA programs.	HLAB $350,000	HLAB $300,000	13335		X	X	X	X	X

	achieve acceptable pass rate in EQA programs	3) Increases in number of labs that achieve acceptable pass rate in EQA programs									
Support targeted training at KP friendly HIV prevention, care and treatment sites (Tier 2)	Increase in number of healthcare workers trained.	Increase in number of healthcare workers trained	HLAB $40,000	HLAB $35,000	13335; 13593; 12668;			X	X	X	X
Support Quality monitoring (EQA/DTS) and data collection/analysis (logbooks) at KP friendly HTC sites (Regional)	1) Increase in number of KP friendly HTC sites using DTS EQA to monitor quality of test. 4) Increase in the number of KP friendly HTC sites using standardized logbooks for data collection and reporting	1) Increase in number of KP friendly HTC sites using DTS EQA to monitor quality of test. 2) Increase in the number of KP friendly HTC sites using standardized logbooks for data collection and reporting.	HLAB $36,000	HLAB $34,000	13335		X			X	
Strengthen the regional lab referral network capacity for viral load and HIVDR testing to support ART uptake/viral suppression (Regional)	1) Increase in number of PLHIV on ART with regular viral load results. 2) Increase in number of PLHIV on ART with viral suppression.	1) Increase in number of PLHIV on ART with regular viral load results. 2) Increase in number of PLHIV on ART with viral suppression.	HLAB $132,000	HLAB $30,000	13335		X		X	X	X
Strengthen and support laboratory capacity for sexually transmitted infections (STIs) and opportunistic infections (Regional)	1) Increase access to and capacity for STI and OI diagnosis 2)Improve the data available on STI and OI prevalence among key populations living with HIV/AIDS	1) Increase access to and capacity for STI and OI diagnosis 2)Data available on STI and OI prevalence among key populations living with HIV/AIDS	HLAB $150,000	HLAB $207402	16661			X		**X**	

6.2 Strategic information (SI)

There have been improvements in the availability and use of HIV data in the Caribbean region; however, important gaps remain. Deficiencies in strategic information include inadequate documentation of key population coverage, gaps in case surveillance reporting and insufficient monitoring of the continuum of care.

Monitoring of prevention interventions needs to be strengthened. This will ensure that subnational key population data are routinely collected, reported and used in program improvement.

Incomplete reporting of risk factor data, mortality data and inconsistent compliance with national reporting standards negatively impact the quality and timeliness of surveillance data in some countries.

National continuum of care data are available for some countries in the region. However, the data are not monitored or used sufficiently at the site level. Linkage and retention are not consistently monitored across all HTC and care facilities. While laboratory data are captured, the data are not consistently reviewed at the site level to identify gaps in CD_4 and viral testing coverage. This information can improve the quality of services provided to patients in care.

Continuum of care data show low retention and viral suppression rates. The factors that contribute to these low rates need to be better understood in order to improve clinical outcomes of patients and achieve 90% suppression for patients on treatment.

Poor site level data management results in slow reporting to national levels. Sites are therefore unable to adequately use data to inform interventions. Electronic databases would benefit from being able to capture key indicator data such as patient adherence and psychosocial data.

The gaps summarized above impede progress with monitoring epidemic control. To address these, PEFPAR will focus on building MOH capacity to strengthen surveillance and M&E systems and conduct special surveys. A focus will be improving the collection, reporting and use of key population and HIV care and treatment data. These activities build on the ongoing PEPFAR strategic information investments and complement the work of regional partners. Support will be provided "above site" but high burden sites will be prioritized for implementation. It is expected that the MOH will scale up and expand interventions to other priority sites. Using data to inform site level activities and assess progress with reaching epidemic control remains a priority.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
1) Identify: Bio-behavioral survey for FSW. Implementation of FSW and use of data to inform prevention, care and treatment interventions. – **Suriname**	N/A	Formative assessment completed. BBSS Survey instrument and protocol developed	HVSI N/A	HVSI $150,000	UCSF 12542	Not applicable	X			X	
2) Reach/Test: Strengthening of routine data collection and reporting systems to improve site level data quality **for prevention, linkage to care and treatment** especially for KP (using unique identifiers, improving reporting of risk factors etc.)- activities will focus on improving the quality and timeliness of routine KP PREV, HTC related data from MOH and NGO intervention points and will feed into the MSM and SW "cascades". **(Jamaica, Suriname, Trinidad, Barbados , The Bahamas)**	Assessments of gaps in reporting of KP, HTC and C&T data completed	Implementation of site level QI/QA to improve data quality ongoing	HVSI 12688 300,000	HVSI 12688 $580,000	REPDU 12688 ($400,000) MOH Barbados ($20,000) MOH Suriname ($30,000) Trinidad-12668 ($50,000) MOH the Bahamas ($50,000)	Epidemiological and Health data: KP Score:1.6 (Jamaica)	x	x	x	x	x
3) Facilitate national rollout of the UIC (Jamaica)	N/A	Staff trained to improve quality collection of KP data	N/A	HVSI $12,000	MOH Jamaica	Epidemiological and Health data: KP Score:1.6	x	x			
4) Reach/ Test/ Treat: Development of **electronic reporting systems** at HIV testing sites; KP & prevention intervention sites and treatment sites. Implementation of strategies to improve the quality, timeliness and completeness of reporting of HTC; KP and C&T data (**Suriname**	Assessments of gaps in reporting of KP, HTC and C&T data completed	Implementation of site level QI/QA to improve data quality ongoing	HVSI 60,000 HVSI - 50,000 HVSI	HVSI $125,000	CDC Direct TA Suriname MOH-13593 ($50,000) NASTAD	Not applicable	X	X	x	x	

and Trinidad)			25,000 CARPHA		($75,000)						
5) Reach/ Test/ Treat: Geographic Information Systems (GIS) pilot mapping KP facility and community data across the continuum of care in Nickerie which will identify all service providers, the types of services provided, their locations and catchment areas relative to KP hot spots (Suriname)	Mapping in Nickerie completed	Mapping in Paramaribo and Wamca completed	HVSI	HVSI $250,000	LINKAGES 17366	Not applicable	X	X	X	X	
6) Reach: **Purchase - GIS extension software to produce geographical mapping of HIV surveillance cases (Jamaica)**	N/A	Layer multiple demographic and clinical data	N/A	HVSI $1,000	MOH Jamaica	Epidemiological and Health data: KP Score:1.6	X				
7) Site visits/ docket reviews to determine best source and method to capture KP status of patients within treatment sites (Jamaica)	N/A	Information to substantiate how best to collect KP patient bio data	N/A	HVSI $5,000	MOH Jamaica	Epidemiological and Health data: KP Score:1.6	X				
8) Purchase of NVIVO software and SPSS to facilitate data analysis (Jamaica)	N/A	Quality improvement in data analysis	N/A	HVSI $5,000	MOH Jamaica	Epidemiological and Health data: KP Score:1.6		X	X	X	
9) Conduct Focus group discussions with KPs to identify barriers to access to TCS for positive MSM and CSW (Jamaica)	N/A	Identify gaps in continuum	N/A	HVSI $14,500	MOH Jamaica	Epidemiological and Health data: KP Score:1.6			X	X	
10) Analysis of high yield test settings (Jamaica)	N/A	Analysis completed and used to target HTC	N/A	HVSI $12,000	MOH Jamaica	Epidemiological and Health data: KP Score:1.6					
11) Training of sites for roll out of DHIS2 database for HIV patient management (Jamaica)	N/A	Training completed	N/A	HVSI $9,000	MOH Jamaica	Epidemiological and Health data: KP Score:1.6		x	x	x	

12) Evaluation of linkage to care and case management practices in outreach settings (Jamaica)	N/A	Identify gaps in linkage	N/A	HVSI $14,000	MOH Jamaica	Epidemiological and Health data: KP Score:1.6	X	X			
13) **Treat**: Economic Analysis to determine the cost of early initiation of ART (**Jamaica**)	N/A	Assessment completed	N/A	OHSS (in prevention budget)	ICF 13054	??			x		
14) **ART Uptake & Viral Suppression: ART outcome analysis- to include treatment cohort analysis and patient s**urvey to assess factors that contribute to poor clinical outcomes (poor adherence, missed appointments etc.) (**Jamaica**)	Survey instrument and protocol developed	Protocol approved and implemented	HVSI N/A	HVSI $250,000	UCSF 12542	Epidemiological and Health data: Comprehensiveness of viral load data Score:2.8			x		x
16) Cross Cutting: Strengthening of HIV case reporting – with focus on improving reporting of risk factors and KP data through CBS. (**Jamaica, Trinidad, Suriname, Barbados, the Bahamas**)	Assessments of gaps in reporting of KP, HTC and C&T data completed	Implementation of site level QI/QA to improve data quality ongoing	HVSI 60,000 CARPHA	HVSI $742,776	MOH Suriname ($ 20,000) MOH Barbados ($25,000) MOH Trinidad ($50,000) MOH the Bahamas ($ 50,000) ; CARPHA 16661 ($500,000) NASTAD 13534 ($57,776)	Not applicable	x	x	x	x	x
17) Cross Cutting: Leveraging the work PEPFAR through USAID Jamaica has done with the National Reporting and Redress System to examine **i**ncidences of S&D at high volume sites as a barrier to treatment outcomes (retention and adherence).	Prepare research protocol in collaboration with MoH Collect and categorize reported	Examine overall retention and ART adherence levels at reported sites Using secondary	HVSI N/A	HVSI $50.000	RTI 17189	Access and Demand: Rights to access services Score: 0			X		

	incidences of S&D at high volume sites	data from the national treatment database, examine adherence levels of patient cohort who have reported incidences									
18) Cross cutting: Technical Assistance to complete continuum of care/cascade analysis for PLHIV and key populations. Including ART cohort analysis and KP cohort analysis workshops (**Regional**).	Regional meeting held in 2015	Treatment site level cascade data available	HVSI 50,000k	HVSI $150,000	CDC Direct TA PAHO ($100,000) M&E Regional TA ($100,000)	Not applicable		x	x	x	x
19) **Treat:** Technical assistance to monitor implementation of WHO treatment guidelines through "Treatment 2.0 Missions" (**Regional)**	Missions completed in 2 priority countries	C&T program recommendations implemented	HVSI 50,000k	HVSI $75,000	PAHO IM 12575	Not applicable			x		
20) **Retention & Viral Suppression:** TA to monitor and scale up clinical testing of PLHIV CD4, viral load testing (Regional) 21) Implementation of HIV drug resistance monitoring protocol –collaboration with C&T and Laboratory teams needed) –(Jamaica, Trinidad, Suriname Barbados, The Bahamas,)	Site level data reviewed	Site level testing data available and used to improve treatment programs	HVSI N/A	HVSI $195,000	CDC Direct TA PAHO ($75,000) CARPHA-16661 ($120,000)	Not applicable					

6.3 Health System Strengthening (HSS)

HSS activities will focus on Human Resources for Health (HRH) for sustainability, addressing high levels of stigma and discrimination, using Information Communication Technology ICT to increase uptake of services and providing support to improve expenditure data.

Key populations will be included in the design, development and implementation of activities at the site, sub-national and national levels.

According to a World Bank 2009 Study[13] the demand for nurses exceeds supply in the region. Approximately 30% of all approved positions are vacant and annual attrition rates are 8%, with emigration being the main cause. HRH activities will focus on 1) Increasing the cadre of health care workers through clinical mentoring. This will support the provision of comprehensive targeted care, specific to key populations and improve the provision of ART delivery and adherence and screening and treatment for relevant co-morbidities (STIs, TB, and Hepatitis) 2) Development and implementation of a supportive facility monitoring program at high volume care and treatment sites to improve service delivery systems for KPs using the SIMS Core Essential Elements to address quality standards, 3) Development of supervisory teams within health facilities that will champion an enabling environment for key populations and will provide day-to-day supportive supervision for HCWs serving KPs, 4) Strengthening clinic staff ability to collect, analyze and use data for improvement of care to KPs, 5) Implementing QI/QA activities to increase uptake of HTC, improve linkage to care, reduce barriers to retention in care and viral suppression of KPs.

It is critical that reliable, routine expenditure data be available not only for PEPFAR but for the national response so that the financing of the epidemic is well understood as countries scale up to meet their 90-90-90 targets and reach epidemic control. Assistance will be provided for financial and/or technical support for annual national and sub-national expenditure tracking by source of financing for the HIV/AIDS response specific to KPs. High levels of stigma and discrimination against KPs continue to present a major barrier to access services across the continuum. Therefore, structural interventions that address evidence-based predictors or mediators of risk, risk reduction and resilience among key populations are needed. The structural interventions being proposed by the PEPFAR Caribbean Regional team will prioritize efforts to reduce stigma and discrimination across the Continuum.

While the scale and scope of prevention services for KPs are slowly improving in some areas, they remain inadequate to make a sustainable impact on behavior and reduce HIV transmission. Stigmatized and 'hidden' populations such as MSM are using electronic media to expand their social networks and meet individuals with similar sexual orientation. In an effort to increase the scale and scope of HIV/AIDS services for KPs, ICT will be used to improve KP health-seeking behavior, on the demand side, and as a means to increase in-service counseling quality, on the supply side. The use of ICT will be used to motivate people to get tested, obtain their results, promote access to treatment, link people living with HIV to care, support retention in care, and help reduce stigma. Technical

[13] World Bank, 2009: The Nurse Labour & Education Markets in the English-Speaking CARICOM: Issues and Options for Reform: June 2009

assistance will also be provided to improve the reporting of incidences of S&D at treatment sites to allow countries to use this data to better

Short-term technical support will be provided to help country coordinating mechanisms (CCMs), principal recipients (PRs) and sub recipients (SR) unblock bottlenecks to implementation, and resolve systemic problems impeding the effective governance and Global Fund Grant performance. The prime objectives are: to provide urgent, short-term, management-related technical support to Global Fund grantees and to develop the capacity of regional organizations (OECS HAPU, PANCAP and UWI HEU) to offer urgent technical support to improve performance of CCMs, PRs and SRs. GMS's unique form of technical support allows countries to ask for exactly the kind of help they need most to succeed and to move to their next disbursement or phase of funding.

Brief Activity Description	**Deliverables**		**Budget codes and allocation ($)**		**6. Implementing Mechanism(s) ID**	**7. Relevant Sustainability Element and Score**	**Impact on epidemic control in Jamaica**				
	2. 2015	**3. 2016**	**4. 2015**	**5. 2016**			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression

Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control in Jamaica				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
In collaboration with the MOH develop and implement a supportive facility monitoring program at high volume care and treatment sites to improve service delivery systems for key populations (Tier1)	Annual and multi-year performance plans based on initial site assessments which are in alignment with SIMS CEEs to establish site level quality assurance standards for KPs Site visits to follow up on recommendations made during previous visits including the remedial activities from SIMS visits Training and TA based on site specific needs	Site visits to follow up on annual performance plans, recommendations made during previous visits including the remedial activities which result from SIMS visits A supervisory team within the health facility that can provide day-to-day support and supervision. Training and TA based on site specific needs	OHSS $300,000	OHSS $300,000	ITECH 13966			X	X		X

Strengthen the documentation of S&D reporting in the redress system (Jamaica only)	JN+ and JFLAG support groups document S&D cases at the facility level and work with health systems on redress	JN+ and JFLAG support groups document S&D cases at the facility level and work with health systems on redress	OHSS	OHSS	MoH	Access and Demand: Rights to access services Score: 0	X	X	X	X
Provide technical assistance to strengthen the response of the reported S&D incidents (Jamaica only)	Improved system and oversight where cases of HIV related discrimination	Improved system and oversight where cases of HIV related discrimination	OHSS	OHSS	MoH	Access and Demand: Rights to access services Score: 0	X	X	X	X
Provide TA to CBO to develop and implement communication and advocacy plans (Jamaica only)	• Communication and Advocacy plans developed. • Cyber presence established	Train CBO staff to fully implement plan	N/A	N/A	PC		**X**		**X**	
Provide TA to CBOs to improve access to and use of SI (Jamaica only)	Expansion of research repository	Train stakeholders to enter data and utilize SI	N/A	N/A	PC		**X**		**X**	

Provide TA to CBOs to mobilize resources for institutional strengthening (Jamaica only)	• Develop resource mobilization plans with 3 or more CBOs • Train CBO staff	Implement resource mobilization plans	N/A	N/A	PC		**X**		**X**	
Provide TA to MOH to expand systems for tracking clients/patients across the continuum of response (Jamaica only)	Gap and integration analysis for national patient registration system	Train SITU staff to use application software	N/A	N/A	PC			**X**	**X**	**X**
TA to establish MSM-friendly center at tertiary institution (Jamaica only)	• Development of a case management system • Establish clinical and counselling SOPs • Online health resources for MSM	Train staff in case management and SOPs	N/A	N/A	PC		**X**		**X**	

Targeted QA/QI training for HTC/LTC: training on practical quality assurance (QA) and quality improvement (QI) frameworks, methods, and tools to develop feasible, data driven action plans for strengthening HIV testing and counselling (HTC) programs including linkage of HIV positive individuals to care and treatment. (Jamaica and Barbados)	Piloting of 1-2 trainings in priority sites. Refinement of training curriculum based on pilot. Development of action plans.	Delivery of 1-2 trainings in priority sites. Development of action plans	OHSS Jamaica - $89,026 for 2015 only Barbados – ($67,078 for 2015 only	OHSS	ICF 12594	HRH: In-service score = 0	X	X			

Strengthen the postgraduate Diploma in the Management of HIV Infection 12 month distance learning curriculum and practicum to address comprehensive service provision for MSM and other KPs (Trinidad)	An updated 12 month post-graduate HIV distance learning training program which includes the comprehensive care and treatment of MSM and other KPs.		OHSS $90,000		ITECH 13966			X		X	X

In collaboration with the MOH develop and implement a supportive facility monitoring program at high volume care and treatment sites to improve service delivery systems for key populations (Tier 1)	Annual and multi-year performance plans developed based on initial site assessments which are in alignment with SIMS CEEs to establish site level quality assurance standards for KPs Site visits to follow up on recommendations made during previous visits including the remedial activities which result from SIMS visits Training and TA based on site specific needs	Site visits to follow up on annual performance plans, recommendations made during previous visits including the remedial activities which result from SIMS visits Development or strengthening of a supervisory team within the health facility that can provide day-to-day support and supervision. Training and TA based on site specific needs	OHSS $300,000	OHSS $300,000	ITECH 13966			X	X		X

Develop the most appropriate information and communication (ICT) platforms to create the demand for and increase the utilization of services for KPs in high volume districts across the continuum (Suriname, Trinidad and Tobago, Barbados and Bahamas)	GIS activity described under SI at 6.2 will be completed first to help inform this activity	Full roll-out of ICT activities developed (Trinidad and Tobago, Barbados and the Bahamas) Train all platform users at all the KP sites involved (Trinidad and Tobago, Barbados and the Bahamas) All deliverables articulated in 2015 for Trinidad and Tobago, Barbados and the Bahamas will be expected to be achieved in 2016 for Suriname.	OHSS	OHSS $350,000	17366		X	X	X	X	

Implement well-established stigma reduction package (PANCAP Stigma Reduction Framework) tailored to country context in health facilities in Barbados, the Bahamas, Suriname, and Trinidad in collaboration with community partners. Stigma reduction packages include the following: measuring S&D in health facilities through a survey; stigma reduction training, including ToTs; developing facility-level policies, such as codes of conduct; and assisting governments in developing stigma reduction frameworks and monitoring and accountability systems. (Suriname, Trinidad and Tobago, Barbados and Bahamas)	S&D survey reports for identified high volume sites in Barbados, the Bahamas, Suriname, and Trinidad. Health providers and other health care facility staff trained on S&D reduction in selected sites.		OHSS	OHSS $750,000	TBD (Follow on to HPP Futures)			X	X	X	
Implement transgender health activity, building off of previous efforts to understand the health needs of TG in Jamaica, Dominican Republic and	Health providers trained on HIV prevention, care, and treatment services for TG populations.		OHSS	OHSS $250,000	TBD (Follow on to HPP Futures)			X	X	X	

Barbados and expanding to the Bahamas, Trinidad, and Suriname. Working with health providers to improve TG access to competent and affirming health services. This activity approach will include developing partnerships within the TG community to help build programs and services with, by, and for TG persons. For each country, the partner will review existing information and gather more information to fill gaps in knowledge about the TG community, such as health-seeking behavior. The partner will then implement a training program based on the Health Policy Project's previous efforts in Barbados (using the same materials, as applicable), seeking to build healthcare provider capacity to promote knowledgeable, sensitive, accessible and effective HIV/AIDS prevention, care,											

and treatment services for diverse TG populations as an integral part of the Continuum of Prevention, Care and Treatment (CoPCT). (Suriname, Trinidad and Tobago, Barbados and Bahamas)											
The Caribbean Regional Strategic Framework (CRSF) 2014-2018 articulates the vision and collective priorities of Caribbean states through their membership in the Pan Caribbean Partnership Against HIV/AIDS (PANCAP). PANCAP is a multi-sector, multilevel partnership which brings together governments and national HIV programs, PLHIV, and vulnerable communities with international and regional organizations. PEPFAR through USAID/ESC will continue to support the CRSF and efforts to harmonize this expanded regional response to the epidemic in the Caribbean by leveraging its			OHSS	OHSS $270,000	12588			X	X	X	

resources with those of the Global Funds and other donors.											
Establish baseline fiscal data within each Tier 1 country which maps the current national HIV/AIDS response to a sustainable scaled up response. In addition, simultaneously map each host government's financial system to ensure that the data sets are routinely and efficiently collected. Built into this process is a critical capacity building component within the Ministries of Health and also the University of the West Indies Health Economics Unit (HEU) to provide routine	Establish the baseline fiscal data. Map the host Government's financial systems. Build the capacity within the MOHs and the UWI HEU to provide routine sustainable financial data analysis in addition to developing an advocacy platform for domestic resource mobilization.		OHSS	OHSS $475,000 (Suriname $275,000, Trinidad & Tobago $200,000)	17469		X	X	X	X	

sustainable financial data analysis in addition to developing an advocacy platform for domestic resource mobilization. (Suriname, Trinidad and Tobago)											
In the Tier 2 countries there will be a further modified approach. In Barbados the recently completed national health accounts assessment (NHA) will be built on by using the relevant data collected to complete the mapping of the government's financial system. Capacity building within the MOH and the UWI HEU was built into the NHA exercise and the completion of this activity now will enable a	Complete the mapping of the GOBs financial system. Transition the routine sustainable financial data analysis over to the MOH in Barbados. Collect and compile baseline HIV/AIDS response investment data and map current funding gaps and funding flows.		OHSS	OHSS $125,000 (Bahamas $75,000, Barbados $50,000)	17469		X	X	X	X	

smooth transition to the host government and will institutionalize the data collection systems, review and use fiscal-data for decision making for a more efficient and effective National HIV/AIDS response. In the Bahamas, baseline HIV/AIDS response investment data will be collected and compiled to establish a baseline and map current funding gas and funding flows. This work will be initiated in ROP 15 but the primary focus of this activity will be on Trinidad and Tobago and Suriname. (Bahamas & Barbados)											

Provide urgent, short-term, management-related technical support to the Global Fund grantees through Grant Management Solutions (GMS) in the following areas: **Governance and Leadership** – Work directly with the country coordinating mechanisms (CCM) with the coordination of grant activities, and providing grant oversight through sound leadership practices. **Financial and grant management** - Work directly with the principle recipient (PR) to identify ways to strengthen financial and management systems and procedures. **Monitoring and evaluation (M&E) and reporting** –TA assistance on how to use the Monitoring and Evaluation Systems Strengthening Tool - a planning process required by the	Prepare the following documents: • Governance manuals and bylaws • Program implementation manuals • Budgets plans • Procurement and supply management plans • Monitoring and evaluation (or M&E) plans and guidelines. Orientation to the grant oversight dashboard		OHSS	OHSS $175,000	17810		X	X	X	X	

Global Fund- to improving reporting procedures and ensuring adequate M&E staffing. (Regional)											
Develop the capacity of regional organizations (OECS HAPU, PANCAP, UWI HEU) to offer urgent technical support towards improving the performance of the CCMs, PRs and SRs (Regional).	All activities listed above will be done in collaboration with the relevant regional organizations		OHSS	OHSS $75,000	17810		X	X	X	X	
Build a knowledge management platform to document and disseminate evidence-based and innovative local solutions to more effective and efficient KP programming across the continuum of care cascade. Also strengthen partnerships with influential regional partners to accelerate south-to-south learning and strategic regional technical and political leadership in achieving 90-90-90 targets	Establish a KM platform and document/disseminate game-changing technical leadership and programming across the region. Initiate regional "think-tank" events in partnership with regional leaders and institutions	Build on and expand opportunities for cross-regional learning opportunities and support PANCAP and other influential regional entities to strengthen member state accountability to the CRSF 2014-2018 and 90-90-90 targets	OHSS	OHSS $400,000	17809		X	X	X	X	

7.0 Staffing Plan

PEPFAR Caribbean Regional Program (CRP)

The allocation of staff for the Caribbean Regional program has been closely aligned to achieving the goals and objectives of the program. This includes prioritizing the implementation of core activities in Tier 1 countries. In the TA model, it is important to have the right mix of technical, financial and administrative staff. For all agencies, the technical staff have expertise in the areas of HIV prevention, strategic information, and laboratory strengthening. Technical staff will use their expertise in specific technical areas to work with MOHs and other partners to implement core activities along the HIV continuum of care and to adapt successful strategies and activities from other PEPFAR programs to the Caribbean region. The goal is to achieve greater impact. The financial and management staff will ensure proper management of PEFPAR funds for stronger accountability and transparency. The strategic shift – geographic, demographic, and programmatic – in the PEPFAR Caribbean Regional program in 2014 and the necessary adjustments made have been used as a guide to further strengthen and align staffing to program needs in 2015. The cost-of-doing business for most agencies will increase slightly in the next cycle because of travel costs for the SIMS initiative and an additional staff person in keeping with the geographic focus.

CRP Coordinator's Office

The Coordinator's office will be staffed by a Regional Coordinator, a Program Management Specialist, a Data Management Specialist and a Program Assistant. All of these positions are full time and will serve the entire program. The Regional Coordinator manages the development and implementation of the PEPFAR Caribbean Regional Program, as well as the overall day-to-day operation of the PEPFAR CRP, ensuring alignment with the mandate of OGAC.

The Program Management Specialist (PMS) and the Administrative assistant supports the Coordination office. The PMS will also have responsibility for managing the PEPFAR Small Grants Program and the Local Capacity Initiative (LCI) project which is being implemented by PANCAP and the University of the West Indies. The Data Management Specialist will coordinate and manage the overall data requirements of the program with all USG. This person will also be the main point of contact with responsibility for providing guidance and oversight to the overall USG team.

United States Agency for International Development (USAID) Jamaica

The Staffing Plan for USAID Jamaica is based on recommendations from an OGAC Technical Working Group report from the in-country review of the Jamaica PEPFAR program in October 2014. The OGAC TWG report noted an urgent need to quickly transition the Jamaica program according to the PEPFAR pivot, i.e. increased testing, reducing stigma and discrimination, and building the capacity of local partners to ensure that PLHIV in Jamaica remain on a treatment and care cascade to minimize viral loads. Given the increased focus on Jamaica due to its high disease burden, the Jamaica Staffing Plan recommends keeping all but two existing PEPFAR interagency staff, and adding three new positions.

USAID/Jamaica will add two staff to oversee the direction and increased level of focus on the key populations (KP) clinical cascade as it relates to the overall national response, including a USPSC staff , with familiarity in concentrated epidemics (i.e. key populations) and PEPFAR priorities. Currently there is one full-time, local hire health specialist working on PEPFAR activities at USAID/Jamaica. This position manages three IMs, including a government to government (local solution) grant with the Ministry of Health. A large portion of this existing staff's time is dedicated to managing these grants. The USPSA will manage the strategic and overall programmatic visioning for USAID activities. The third position, a local hire for USAID/Jamaica, will work exclusively on Monitoring and Evaluation (M&E), i.e. SIMS, for Jamaica sites.

USAID/Eastern and Southern Caribbean

USAID/Eastern and Southern Caribbean proposes to add two new full-time positions this year, including one Technical Program Manager with expertise in key population HIV/AIDS care and treatment and one Program Assistant. The new Technical Program Manager will be responsible for oversight of expanded key population programming along the continuum of care cascade in the Tier 1 countries of Trinidad and Tobago and Suriname. The new Program Assistant will support USAID's existing Monitoring and Evaluation Program Manager with the additional requirements of SIMS, EA and DATIM administration and management. The existing HIV Prevention Program Manager has effectively transitioned her programmatic responsibilities in the Organization of Eastern Caribbean States (OECS) and will assume management of expanded programming in the Bahamas and re-focused programming in Barbados. USAID's new Health and HIV/AIDS Office Director will oversee USAID/ESC HIV/AIDS programming across the region, including in Guyana.

With the arrival USAID/ESC's new Mission Director in late October 2014, an extensive staffing and management review has been under taken. As a result of this exercise, programmatic and administrative support positions that were previously funded by either

USAID's General Development Office or its Health and HIV/AIDS Office are now jointly funded by all operating units including Guyana. This means that the USAID/ESC staffing plan for the PEPFAR Caribbean Regional Program now supports 18% of the associated costs of these shared support positions which effectively decreases PEPFAR support to these positions compared to previous years. The increase in USAID/ESC's Management and Operational (M&O) costs in ROP 2015 is primarily explained by increased cost in travel and administration required to implement PEPFAR's new SIMS, Expenditure Analysis and DATIM requirements.

Peace Corps

Peace Corps plans to discontinue PEPFAR activities to improve Post effectiveness in other program areas, hence affecting two full-time positions. One position ended in February 2015 and the other will end by February 2016.

Centers for Disease Control and Prevention (CDC) Caribbean Regional Office

CDC's technical staff will work with MOHs and other partners to implement core activities along the HIV continuum of care and to adapt successful strategies and activities from other PEPFAR programs to the Caribbean region. Staff in Tier 1 countries will have a greater role in guiding Ministries of Health to assess program needs and identify gaps, access appropriate TA implementing partners and oversee implementation of activities, as planned. They serve as the on-the-ground CDC liaisons. For Tier one and two countries, CDC CRO Behavioral Scientist leads the prevention team. Together they provide guidance and work hand in hand with the Ministries of Health and the implementing partner, ICF, to improve uptake of HIV testing and counseling (HTC) among key populations, and strengthen the linkage to treatment and care for all newly diagnosed persons. Where core activities will be significantly increased as in the case of Jamaica, an additional technical staff will be recruited while roles and responsibilities of existing staff will be re-focused to provide more support for core activities. There is a Program Specialist - HIV - stationed in Jamaica. Similarly, an HIV Program Specialist is based in Trinidad and Tobago and plays a key role in assisting and supporting the Ministry of Health to implement the work plan.

The three member laboratory team will continue to provide TA to countries and partners to improve the quality and availability of diagnostic and monitoring services and systems under a tiered laboratory network to meet PEPFAR goals for scaling up core HIV prevention, treatment, and care interventions

The strategic information team will continue to provide direct technical assistance to MOHs, work with partners to implement SI activities, and support the interagency PEFPAR team. The SI team will also continue to coordinate and oversee the SIMS initiative. The team will work with Ministries of Health to strengthen case-based surveillance and M&E systems and work with partners to develop

protocols and implement behavioral surveillance surveys in key populations. They will assist countries to analyze their surveillance, program, and survey data to inform programmatic decisions and interventions focusing on key populations.

A Management and Operations team, led by the Deputy Director, provides budget oversight and manages all finance responsibilities related to the PEPFAR budget, cooperative agreements, and contract administration and provides support services for the technical team and the broader program. A Financial Management Specialist provides leadership, coordination, reporting and management of financial support services for CDC CRO agency programs funded under PEPFAR. A Cooperative Agreement Management Specialist/Financial Analyst provides support in coordinating, managing, and tracking CDC cooperative agreement financial and programmatic requirements; ensuring that implementing partner organizations adhere to US Government administrative and financial policies and guidelines; and liaising with Cooperative Agreement partners and CDC Procurement and Grants Office to ensure that reporting requirements are met, and post-award actions are processed in a timely manner. The cost-of-doing business for CDC CRO will increase slightly in the next cycle because of travel costs for the SIMS initiative and an additional LE staff person based in Jamaica.

No additional staff has been recruited to meet the SIMS requirement, although a significant amount of staff time has been diverted to this initiative. A SIMS core implementation team comprised of existing technical staff (a SIMS coordinator, a communications specialist, a data manager, an M&E officer, and an SI expert) has been set up specifically to ensure that all requirements for SIMS are met. This team which has been successful so far will continue and accelerate their work in 2015.

Department of Defense (DOD)

The U.S. DoD has two locally hired program staff who manage programs regionally in Trinidad and Tobago, Suriname and Jamaica with complementary management and programmatic skill sets to adequately provide TA to cover the increased core quality assurance and improvement and monitoring and evaluation activities proposed in the program pivots. The staffing footprint combines a management strategy that blends the administrative competencies and prevention technical expertise of the regional program manager in Barbados with the strategic information and infrastructure strengthening technical strengths of the regional program manager in Jamaica. Program managers' responsibilities include grant and contract management; fiscal oversight, budget management and administration, and reporting; quality assurance site visits;, national stakeholders, staff of key population healthcare service sites, and implementing partners to review progress, performance, and to conduct technical reviews. Program managers are distributed across all technical working groups and will be utilized to support all SIMS requirements in a complementary fashion to ensure that all required elements are adequately covered. The roll-out of SIMS assessments, the reduction in supported sites and the increase in ICASS costs are all factors that will affect the cost of doing business in the next cycle. Program managers' will provide technical oversight to

implementing partners to ensure that cross cutting components are well integrated utilizing prior USG investments i.e. M&E, S&D curriculum, quality improvements are realized and documented, transitional planning is incorporated into program activities.

APPENDIX A CARIBBEAN REGIONAL

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• Pilot and implement best practices and evidence-based interventions	• Enhance psycho-social support	

serving key populations, i.e., HTC, LTC, and Care & Support package
- Implement targeted outreach interventions serving key populations; HTC using mobile testing units where applicable; and LTC improvement pilots in high priority settings
- Adapt/pilot the VICITS model of integrated STI/combination HIV prevention at priority STI clinics or appropriate settings
- Support condoms and lubricants provision for targeted activities and locations to KP
- Use innovative social media and technology based strategies to increase HTC demand in select priority community-based locations and enhance linkages to national and CBO sites
- Strengthen and standardize the package of care for KP-PLHIV; improve KP referral protocols to STIs, FP, SGBV and SRH services and support treatment literacy and adherence support for PHDP services
- Conduct a KP lost to follow-up evaluation and use the findings to inform future adherence support training, particularly for Peer Navigators
- Targeted TA focusing on medication adherence, retention and partner notification/contact tracing
- Implement HIV screening (and linkage) protocols at high volume settings such as STI clinics and emergency departments
- Support KP-friendly CBOs to increase MSM and TG access to core package of prevention, care and treatment services
- Commence implementation of sex workers (male, female and TG) strategic plan
- Review and update national adherence counseling program
- Retrain BCC teams to provide adherence counseling to KP
- TA to improve CBO reach to MSM
- Strengthen surveillance-HIV case reporting
- Conduct patient surveys to assess barriers to adherence and linkage to care (Jamaica)
- M&E support including electronic databases, to improve collection and reporting of KP HTC and C&T data
- Improve access and quality of HIV rapid testing through Rapid Testing Quality Improvement Initiative (RTQII) at KP friendly HTC sites

to address mental health affecting retention in care
- Strengthen the documentation of S&D reporting in the redress system
- Enhance the monitoring of HIV drug resistance and CD4/viral load data collection
- Support condoms and lubricants provision for targeted maintenance activities to militaries
- Develop or strengthen a supervisory team within the health facility that will champion an enabling environment for key populations
- Develop a supportive facility monitoring program at high volume care and treatment sites to improve service delivery systems for KPs
- Develop annual and multi-year performance plans based on initial site assessments.
- Strengthen MOH capacity to provide coaching to QI teams
- Train clinic supervisors and managers to use TrainSMART data to make decisions related to training needs and staffing
- Analysis of high yield test setting
- Conduct Focus Group Discussion with KPs to identify barriers to access to TCS for

	• Support quality monitoring (EQA/DTS) and data collection/analysis (logbooks) at KP friendly HTC sites • Support the use of EQA/PT to monitor quality of core HIV-related laboratory tests including CD4 and TB • Support targeted HIV testing recertification training, expansion of testing sites and molecular testing for expansion of viral load at KP-friendly HIV prevention, care and treatment sites • Laboratory QI and accreditation at KP-friendly care and treatment sites • Strengthen laboratory network and logistics to improve access to viral load testing • Develop clinical mentoring programs to specifically improve capacity to care for KP • Provide site specific care and treatment training and TA focused on addressing KP specific issues • Train and mentor QI teams to implement CQI focused on improving the quality of care & treatment service components of the CoPCT • Engage KP organizations in strengthening the practicum component of the UWI St. Augustine post-graduate Diploma course in the Management of HIV Infection to specifically target care and treatment for MSM and other key populations • Implement a preceptorship program to build the practical skills of healthcare workers to provide comprehensive care and treatment for MSM and other key populations	positive MSM and CSW
Sub-national level	• Training for HCW to strengthen QA/QI related to HTC & LTC service components of the CoPCT • Targeted TA for KP focusing on HTC, key population prevention, LTC, as well as cross cutting issues such as stigma and discrimination • Introduction and training for HCW and CBOs in the use of the new MSM and Transgender Health Blueprint toolkits and guidance • Introduce a peer navigation system to improve LTC and retention where applicable • Train PLHIV and KP community leaders and Peer Navigators at the high volume ART sites and CBOs in PHDP • TA to refine a KP GBV screening tool at high volume ART sites • Strengthen the implementation of the National Referral and Linkage protocol to ensure that KPs tested in outreach settings and "hot spots"	• Structural, human rights, and legal interventions (policy, guidelines) to optimize the intervention environment, specifically related to S&D as a barrier to care, treatment and retention • Targeted TA for the militaries in Tier I countries focusing on HTC, , LTC, as well as cross cutting issues such as gender equality and stigma and discrimination • Develop a social media strategy to promote HTC among KPs

	are enrolled and retained at a treatment site	• Increase sustainability of QI activities by building the capacity of regional teams to lead and champion QI efforts at parish/regional level • Engage local advocacy groups to provide input into developing CQI, clinical mentoring, and training activities for HCWs • Training of sites for roll out of DHIS2 database for HIV patient management
National level	• Develop sex worker strategic plan to inform programming using PLACE survey information • Implement a case management system to enhance treatment and care outcomes • Strengthen national databases for patient monitoring – uptake of CD4, VL, tests, ART adherence and retention • TA to develop a Peer Navigator system to support ART adherence and retention on care • Provide TA to monitor the implementation of the national Referral and Linkage Protocol and assess LTC • Revision and implementation of SOPs for HIV case based surveillance (CBS) • Develop standard procedures to monitor linkage and retention in care • Costing studies on early initiation of ARVs/test and treat • Procure viral load reagents • Build regional lab capacity for HIV drug resistance testing • Strengthen National HIV Management Guidelines in the comprehensive care of KP	• Strengthen monitoring framework for the National HIV-related Discrimination Reporting and Redress System in 1 year (geo mapping) • Provide TA to strengthen the response of the reported S&D incidents (policy) • Monitor the implementation of WHO C&T guidelines • Regional ARV, KP cascade and HIV continuum of care workshops • Conduct BBSS surveys including GIS mapping of hotspots (MSM and FSW) • Monitor the implementation of WHO C&T guidelines • Integrate the comprehensive care of MSM and other KPs into the UWI St. Augustine post-graduate Diploma in the Management of HIV Infection 12 month distance learning didactic curriculum • Support MOH to develop and implement national QI

		institutionalization plan • Train MOH leadership to use TrainSMART data to strategically deploy HIV-trained staff • Purchase of NVIVO software and SPSS to facilitate data analysis • Evaluation of linkage to care and case management practices in outreach settings • Purchase - GIS extension software to produce geographical mapping of HIV surveillance cases • Facilitate national rollout of the UIC • Site visits/ docket reviews to determine best source and method to capture KP status of patients within treatment sites	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
HTC	• Support efforts to increase the KP HIV+ yield in high priority districts through targeted hotspots through TA (Trinidad and Tobago, The Bahamas, Jamaica, Suriname) using various modalities, i.e. mobile units where appropriate (Jamaica, Suriname); innovative information and communication technology-based strategies and (Suriname, Trinidad and Tobago); evidenced based interventions (Bahamas, Trinidad, Suriname) • Adapt/pilot the VICITS model of integrated STI/combination HIV prevention services at priority STI clinics or appropriate settings (Barbados, Jamaica, Suriname, Trinidad and Tobago) • Pilot revised LTC protocols and LTC evidence-based interventions at	• Develop and pilot hospital/emergency department-based HIV screening & linkage protocol focusing on KPs (Trinidad and Tobago) • Develop social media strategy to promote increased HTC among KPs (Jamaica)	

priority HTC sites (Barbados, Bahamas, Suriname, Trinidad and Tobago)
- Implement HIV screening (and linkage) protocols at high volume settings such as STI clinics and emergency departments (Trinidad and Tobago)

Care and Treatment	**Core Activities** • Pilot the VICITS model of STI/combination HIV prevention services at priority sites (Barbados, Jamaica, Suriname, Trinidad and Tobago) • Implement evidence-based HTC/LTC/RIC interventions and targeted TA to address medication adherence and retention, with BCC/ICT support (Barbados, Bahamas, Suriname, Jamaica) • Provide targeted TA related to partner notification/contact tracing in select priority sites (Barbados, The Bahamas, Suriname) • Conduct a KP evaluation on LTFU and use the findings to inform future adherence support training, particularly for Peer Navigators (Jamaica) • TA to develop a peer navigation system to improve LTC and retention (Barbados, Trinidad and Tobago, The Bahamas, Suriname, Jamaica) • Improve the STI, family planning, SGBV and SRH referral protocols and support treatment literacy and adherence support of PHDP services (Barbados, Trinidad and Tobago, The Bahamas, Suriname) and TA to refine and implement a KP GBV screening tool at high volume ART sites and documenting cases for follow-up (Jamaica) • Standardize PHDP package of services and provide support for improved medication adherence (Barbados, Trinidad and Tobago, The Bahamas, Suriname) • Train PLHIV and KP community leaders and Peer Navigators at high volume ART sites in PHDP (Jamaica) • Implement a case management system to enhance treatment and care outcomes (Jamaica) • Support KP-friendly CBOs to increase MSM and TG access to core package of prevention, care and treatment services (Jamaica) • Strengthen the implementation of the National Referral and Linkage protocol to ensure that KPs tested in outreach settings and "hot	**Near-core Activities** • Provide TA to military facilities to provide QA/QI to improve HIV care services; identify and document LTFU (Suriname, Jamaica, Trinidad and Tobago). • Enhance psycho-social support to address mental health needs affecting retention in care (Jamaica) • *Increase sustainability of QI activities by building the capacity of regional teams to lead and champion QI efforts at parish/regional levels (Jamaica, Suriname, Trinidad and Tobago, Barbados)* • *In collaboration with MOH, identify appropriate staff to become National QI Coaches and train them to provide coaching to QI teams (Jamaica, Suriname, Trinidad and Tobago, Barbados)* • *Ensure all planned activities represent the needs of KP by engaging local advocacy groups to provide input when*	**Non-core Activities** • Clinical guidelines for prevention, care and treatment of HIV, STI and TB • TA in the use of Treatment 2.0 Guidelines in the OECS

spots" are enrolled and retained at a treatment site (Jamaica)
- Review and update national adherence counseling program (Jamaica)
- Retrain BCC teams to provide adherence counseling (Jamaica)
- Train and mentor QI teams to analyze the systems at their facility and utilize CQI tools to improve the quality of treatment & care offered and reduce barriers to retention in care and virologic suppression of KPs (Jamaica, Suriname, Trinidad and Tobago, Barbados)
- Strengthen staff ability to collect/analyze and use data for improvement of care to KPs (Jamaica, Suriname, Trinidad and Tobago, Barbados)
- *Develop clinical mentoring programs to support the provision of comprehensive care specific to key populations to improve the provision of ART delivery and adherence, screening and treatment for relevant co-morbidities such as TB, Hepatitis and STIs (Jamaica, Suriname, Trinidad and Tobago)*
- *Provide training and TA based on site specific needs with a focus on issues pertinent to KPs including confidentiality, reduction in stigma and discrimination, national treatment guidelines, comprehensive care guidelines for KPs, psychosocial support, and HIV case management (Jamaica, Suriname, Trinidad and Tobago)*
- *Engage KP organizations to strengthen the practicum component of the UWI St. Augustine post-graduate Diploma in the Management of HIV Infection course to specifically target the care and treatment for MSM and other key populations; mentees will work with KP-experienced mentors to enhance their practicum experience and further address issues of stigma and discrimination (Jamaica, Suriname, Trinidad and Tobago)*
- *Implement a preceptorship program to build the practical skills of healthcare workers to provide comprehensive care and treatment for MSM and other key populations (Jamaica, Suriname)*
- *Strengthen National HIV Management Guidelines in the comprehensive care of KP to include:*
    - *Ability to conduct a focused medical and sexual history with knowledge of sexual practices*
    - *Mental health screening*
    - *Specific risk assessments and risk reduction strategies for KPs*

developing and implementing CQI, clinical mentoring, and training activities for HCWs (Jamaica, Suriname, Trinidad and Tobago)

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	○ *Anorectal examination skills* ○ *STI screening interventions* • *(Jamaica, Suriname, Trinidad and Tobago)*		
Prevention	**Core Activities** • , MoH and CBO sites to improve non-discriminatory service delivery competencies (Suriname, Jamaica, Trinidad and Tobago, The Bahamas, Barbados) • Implementation of evidenced based interventions focused on HTC demand generation among KP (e.g., Popular Opinion Leader) (The Bahamas) • Targeted prevention outreach (KP including TG: The Bahamas, Suriname, Jamaica, Trinidad and Tobago); and MoH sites (Suriname, Trinidad and Tobago, Jamaica, Barbados, The Bahamas); and LTC • Training in the use of new toolkits and guidance focusing on key populations, i.e. MSM and Transgender Health Blueprints, as applicable across the continuum to help facilitate greater linkage to care, retention in care and reducing barriers to accessing care and treatment services • TA to develop and implement a sex worker (male, female and TG) strategic plan to inform programming using PLACE Survey (Jamaica) • TA to improve CBO reach to MSM	**Near-core Activities** • Demand creation at the community level to promote uptake of services, gender equality interventions to promote positive gender norms and behaviors • TA to integrate targeted outreach activities into the military curriculum and to HIV+ members and their partners (Suriname, Trinidad and Tobago). • Provide TA to address stigma and discrimination attitudes and behaviors targeting military HCW • Integrate and promote gender equality intervention to promote positive gender norms and behaviors in military programs (Suriname, Jamaica, Trinidad and Tobago) •	**Non-core Activities**
Program/system support	• Training for HCW to strengthen QA/QI related to HTC & LTC service components of the CoPCT at 1-2 priority sites (Barbados, Jamaica)		

	Cross-cutting		
Laboratory	**Core Activities** • Improve access and quality of HIV rapid testing through	**Near-core Activities** • Strategic plan development, SLMTA	**Non-core Activities** • Construction/ren

	Rapid Testing Quality Improvement Initiative (RTQII) at KP friendly HTC sites (Jamaica, Suriname, Trinidad) • Support quality monitoring (EQA/DTS) and data collection/analysis (logbooks) at KP friendly HTC sites (Barbados, The Bahamas) • Support the use of EQA/PT to monitor quality of core HIV-related laboratory tests including CD4 and TB ((Jamaica, Suriname, Trinidad and Tobago, The Bahamas, Barbados) • Support targeted HIV testing training for the recertification of testers/expansion of testing sites and molecular testing for expansion of viral load at KP friendly HIV prevention, care and treatment sites (Jamaica, Suriname) • Laboratory quality improvement and accreditation at KP-friendly care and treatment sites (Jamaica, Suriname, Trinidad and Tobago) • Work with C&T team to strengthen network and logistics to improve access to viral load testing (Jamaica, Suriname, Trinidad and Tobago, Barbados, The Bahamas) • Procure viral load reagents (Jamaica) • Build regional lab capacity for HIV drug resistance testing to support surveillance activities (Jamaica, Suriname, Trinidad and Tobago, Barbados, The Bahamas)	training and LIS	ovation (funded in prior year)
Strategic Information	**Core Activities** • Provide TA to monitor the implementation of the national Referral and Linkage Protocol and assess LTC (Jamaica) • Strengthen the national databases for patient monitoring (Jamaica) • Strengthen surveillance-HIV case reporting (Barbados, Suriname, Trinidad and Tobago, The Bahamas, Jamaica) • Conduct patient surveys to assess barriers to adherence and linkage to care (Jamaica) • M&E support including electronic databases, to improve collection and reporting of KP HTC and C&T data (Barbados, Suriname, Trinidad and Tobago, The	**Near-core Activities** • Enhance the monitoring of HIV drug resistance and CD4/viral load data collection (Barbados, Suriname, Trinidad and Tobago, The Bahamas, Jamaica) • Conduct BBSS survey including GIS mapping of hotspots (MSM and FSW) (Suriname) • Monitor the implementation of WHO C&T guidelines (Barbados, Suriname, Trinidad and Tobago, The Bahamas, Jamaica)	**Non-core Activities** • OECS support and general M&E training (discontinued)

	Bahamas, Jamaica) • Revision and implementation of SOPs for HIV case based surveillance (CBS) (Barbados, Bahamas, Trinidad and Tobago) • Develop standard procedures to monitor linkage and retention in care (Barbados, The Bahamas, Trinidad and Tobago, Jamaica, Suriname, the OECS) • Conduct costing studies on early initiation of ARVs/test and treat (Jamaica)	• Provide regional ARV, KP cascade and HIV continuum of care workshops (Barbados, Suriname, Trinidad and Tobago, The Bahamas, Jamaica)	
Health System Strengthening	**Core Activities** • TA to strengthen linkages between CSO/CBO and MoH sites in support of the continuum of prevention, care and treatment cascade (The Bahamas, Suriname, Trinidad and Tobago, Barbados) • Train HCWs at high volume ART sites in the rights-based approach to providing and delivering health services to improve linkage and retention at high yield KP-specific sites (Jamaica) • Develop clinical mentoring programs to support the provision of comprehensive care specific to key populations to improve the provision of ART delivery and adherence, screening and treatment for relevant co-morbidities such as TB, Hepatitis and STIs (Jamaica, Suriname, Trinidad and Tobago) • Provide training and TA based on site specific needs with a focus on issues pertinent to KPs including confidentiality, reduction in stigma and discrimination, national treatment guidelines, comprehensive care guidelines for KPs, psychosocial support, and HIV case management (Jamaica, Suriname, Trinidad and Tobago) • Engage KP organizations to strengthen the practicum component of the UWI St. Augustine post-graduate Diploma in the Management of HIV Infection course to specifically target the care and treatment for MSM and other key populations; mentees will work with KP-experienced mentors to enhance their practicum	**Near-core Activities** • Structural, human rights, and legal interventions (policy and guidelines) to optimize the intervention environment, specifically related to S&D as a barrier to care, treatment and retention (The Bahamas, Trinidad and Tobago, Suriname, Barbados) • Strengthen the documentation of S&D reporting in the Redress System at the site level (Jamaica) • Strengthen monitoring framework for the National HIV-related Discrimination Reporting and Redress System in 1 year (geo mapping) (Jamaica) • Provide TA to strengthen the response of the reported S&D incidents (policy) (Jamaica) • In collaboration with MOH, identify appropriate staff to become National QI Coaches and train them to provide coaching to QI teams (Jamaica, Suriname, Trinidad and Tobago, Barbados) • Ensure all planned activities represent the needs of KP by engaging local advocacy groups to provide input when developing and implementing CQI, clinical mentoring,	**Non-core Activities** • Clinical guidelines for prevention, care and treatment of HIV, STI and TB • HIV training curricula and other training materials • TA to MOHs HIV response • Participation with PAHO in the roadmap to strengthen the health workforce in the Caribbean • TA in the use of Treatment 2.0 Guidelines in the OECS • TA in integration of HIV in curriculum of the pre-service institutions • Institutionalizing

experience and further address issues of stigma and discrimination (Jamaica, Suriname, Trinidad and Tobago)

- Implement a preceptorship program to build the practical skills of healthcare workers to provide comprehensive care and treatment for MSM and other key populations (Jamaica, Suriname)
- Strengthen National HIV Management Guidelines in the comprehensive care of KP to include:
    - Ability to conduct a focused medical and sexual history with knowledge of sexual practices
    - Mental health screening
    - Specific risk assessments and risk reduction strategies for KPs
    - Anorectal examination skills
    - STI screening interventions

(Jamaica, Suriname, Trinidad and Tobago)

and training activities for HCWs (Jamaica, Suriname, Trinidad and Tobago)

- Develop or strengthen a supervisory team within the health facility that will champion an enabling environment for key populations and provide day-to-day support and supervision to HCWs serving KPs; supportive supervision will include check-ins regarding challenges of stigma and discrimination for the healthcare worker and within the clinic system (Jamaica, Suriname, Trinidad and Tobago)
- Develop a supportive facility monitoring program at high volume care and treatment sites to improve service delivery systems for KPs to be in alignment with SIMS Core Essential Elements (Jamaica, Suriname, Trinidad and Tobago)
- Develop annual and multi-year performance plans based on initial site assessments. Establish and implement site level quality assurance standards that are in alignment with the SIMS Core Essential Elements; ensure essential HR systems are in place to support healthcare workers including HIV care and treatment-specific position descriptions, performance appraisal processes and individual improvement plans; support the development of retention schemes to sustain quality healthcare care to KPs from qualified healthcare workers (Jamaica, Suriname, Trinidad and Tobago)
- Train clinic supervisors and managers to review TrainSMART data which captures information about who has been trained, in what content, by cadre, and when (Jamaica, Suriname, Trinidad and Tobago)

CPD for HCW in consultation with governments and professional associations

- TA to MOH HRH Planning Units
- TA to decentralize HIV services and integration in primary health care for some countries

		• Increase sustainability of QI activities by building the capacity of regional teams to lead and champion QI efforts at parish/regional levels (Jamaica, Suriname, Trinidad and Tobago, Barbados) • Strengthen the postgraduate Diploma in the Management of HIV Infection 12 month distance learning curriculum and practicum to address comprehensive service provision for MSM and other KPs (Trinidad); support for HCWs to participate in this extended HIV degree program (Jamaica, Suriname, Trinidad)This is a time-limited TA activity to more thoroughly integrate MSM and other KP specific care and treatment issues into the existing post-graduate curriculum (Trinidad and Tobago) • Support the MOH to develop a national HIV QI institutionalization plan that addresses policy, leadership, resources, and structure (Jamaica, Suriname, Trinidad and Tobago, Barbados) • Train MOH leadership to use TrainSMART data to strategically deploy staff who have received required HIV training to provide services at moderate and high volume sites serving KPs (Jamaica, Suriname, Trinidad and Tobago)
Program/ system support	• Accounting staff to implement activities (Jamaica) • Support costs for audit (Jamaica) • Quarterly program data reviews with civil society (Jamaica)	

APPENDIX B Caribbean Regional Program

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$US 3,617,164	**$US 19,682,836**	**$US 23,300,000**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	3,027,336
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	1,622,593
HBHC	Adult Care and Support	2,379,365
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	
HLAB	Lab	
HVSI	Strategic Information	2,995,195
OHSS	Health Systems Strengthening	4,399,180
HVMS	Management and Operations	6,197,929
TOTAL		**23, 300,000**

B.2 Resource Projections

Due to a lack of data, CRP could not use PBAC or EA tools to derive unit cost and total cost. As a result, the CRP has used estimated costs of planned activities based on proposed Caribbean PEPFAR supported sites and historical expenditures. In the case of new activities, for which there were no historical expenditures, costs were calculated using activities of similar scope (e.g., linkage to care pilot vs. retention in care pilot) or in consultation with other colleagues conducting similar activities (e.g., CDC's VICITS program in Central American Program).