

# CARIBBEAN REGIONAL STRATEGIC FRAMEWORK ON HIV AND AIDS 2008-2012



CARICOM

PAN CARIBBEAN PARTNERSHIP



AGAINST HIV/AIDS

*Scaling up the Caribbean's response*

CARIBBEAN COMMUNITY (CARICOM)  
PAN CARIBBEAN PARTNERSHIP AGAINST HIV/AIDS (PANCAP)  
September 2008



## FOREWORD

The achievement of universal access to HIV and AIDS prevention, treatment, care and support services by 2010 is the documented preoccupation of policy-makers and practitioners involved in the Caribbean regional response to the epidemic within the enabling environment of the Pan Caribbean Partnership against HIV and AIDS. It is also the legitimate demand of persons living with and affected by HIV and AIDS.

This second version of the Caribbean Regional Strategic Framework on HIV and AIDS (CRSF 2008-2012) captures the essence of this commitment and provides the strategic direction and programmatic orientation for national and regional governments and other entities to pursue the inescapable objective of universal access.

By design, the new CRSF embraces all CARICOM Member States as well as Cuba, the Dominican Republic, the British and Dutch Overseas Territories, the French Departments of the Americas, and the United States Territories in the Caribbean, thus emphasising the Pan Caribbean nature of the regional response. Furthermore, this strategic response defines the policies and public goods that will be delivered at the regional level while, at the same time, ensuring the provision of tangible benefits at the national level.

The priority areas identified for action have emerged out of the experiences gained in the implementation of HIV and AIDS programmes at both national and regional levels during the preceding five years. Building on the foundation that has been laid in the areas of prevention, treatment, care, and support, this new framework emphasises the relentless need to pursue a responsive human rights agenda, mainstreaming all sectors including civil society organisations, capacity development for the delivery of HIV services, and institutionalising, monitoring, evaluation, and research, and in addition a comprehensive information, education, and communication strategy.

The emphasis placed on gender issues and on vulnerable groups is recognition of the changing epidemiological profile of the epidemic in the Caribbean and is highly commendable. So too, is provision for an indicative cost of the elements of the framework which provides a platform for mobilising sustainable funding for HIV and AIDS in the region.

I take this opportunity to extend appreciation to all our partners of this important PANCAP network and in particular our developing partners without whose support we could not be optimistic about the future.

I am delighted to be associated with this seminal work and pledge the commitment of the political hierarchy colleague Heads of Government of the Caribbean Community for the successful implementation of the Caribbean Regional Strategic Framework.

Dr. the Hon. Denzil Douglas  
Prime Minister  
Saint Kitts and Nevis  
Chairman, PANCAP

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## List of Acronyms

AGM	Annual General Meeting	OIs	Opportunistic infections
AIDS	Acquired Immunodeficiency Syndrome	OVC	Orphans and Vulnerable Children
ARVs	Antiretroviral drugs	PA	Priority area
ART	Antiretroviral treatment	PACC	Priority Areas Coordinating Committee
CAREC	Caribbean Epidemiology Centre	PAHO	Pan American Health Organisation
CARICOM	Caribbean Community	PANCAP	Pan Caribbean Partnership on HIV/AIDS
CBO	Community-based organisation	PCU	PANCAP Coordinating Unit
CCH	Caribbean Cooperation in Health	PEP	Post-exposure prophylaxis
CCHAIs	Core Caribbean HIV/AIDS Indicators	PLACE	Priorities for Local Control Efforts
CRN+	Caribbean Regional Network of People Living with HIV/AIDS	PLWHIV	People living with HIV (and AIDS)
CRSF	Caribbean Regional Strategic Framework	PMTCT	Prevention of mother-to-child transmission of HIV
CSO	Civil society organisation	PNC	Prenatal Care
CCHIII	Caribbean Cooperation in Health Initiative III	QA	Quality assurance
DfID	Department for International Development	RCM	Regional Coordinating Mechanism
DHS	Demographic and Health Survey	RPGS	Regional public goods and services
ENDESA	<i>Encuesta Demográfica y de Salud</i> /Demographic Health Survey, Dominican Republic	RSAs	Regional support agencies
FBO	Faith-based organisation	S&D	Stigma and discrimination
GIPA	Greater involvement of people living with AIDS	STIs	Sexually transmitted infections
HFLE	Health and Family Life Education	SWs	Sex workers
ILO	International Labour Organisation	TB	Tuberculosis
M&E	Monitoring and Evaluation	TWG	Technical Working Group
MCH	Mother and child health	U.K.	United Kingdom
MDG	Millennium Development Goal	UNAIDS	Joint United Nations Programme on HIV/AIDS
MARP	Most at-risk population	UNESCO	United Nations Educational, Scientific and Cultural Organisation
MSM	Men who have sex with men	UNGASS	United Nations General Assembly Special Session on HIV/AIDS
NGO	Non-governmental organisation	US\$	United States dollar
OECS	Organisation of Eastern Caribbean States	UWI	University of the West Indies
		WHO	World Health Organisation



## EXECUTIVE SUMMARY

The Caribbean Regional Strategic Framework (CRSF) 2008–2012 is a call to the nations of the Caribbean to accelerate their individual efforts against HIV and to enhance their regional collaboration with a view to achieving universal access to HIV prevention, treatment, and care for their populations. As both a Millennium Development Goal (MDG 6) and a priority area within the Caribbean Cooperation in Health Initiative III (CCHIII), the response to the HIV epidemic has a very high priority within the region.

Regional collaboration against HIV was strengthened in 2001 with the Declaration of Commitment to the Pan Caribbean Partnership against HIV/AIDS (PANCAP) by the Caribbean Heads of State and Government. The first Caribbean Regional Strategic Framework (CRSF) covered the period 2002–2006, and was later extended through 2007. The first CRSF was not intended to be a substitute for national level actions, but to complement and support them. The same justifications apply to the second Caribbean Regional Strategic Framework.

The new Framework caters to CARICOM Member States, Cuba, the Dominican Republic, the Dutch, British, and U.S. overseas territories, and to the French departments. PANCAP Member Countries and regional institutions are urged to use the Framework to guide development of their own strategic HIV plans.

PANCAP's performance in implementing the first CRSF was reviewed in 2007 through a collaborative process involving countries, regional partners, U.N. bodies, international development agencies, and the PANCAP governing bodies, facilitated by external consultants. A number of key findings emerged from this review and have contributed to the development of the second Regional Framework.

### KEY FINDINGS FROM CRSF 2002-2006

- The success of the Caribbean region as a whole in its response to AIDS depends on the success of HIV programmes in the individual countries and on the coordination of regional agencies in support of individual country efforts.
- The stigma and discrimination experienced by people living with HIV and AIDS, as well as by those population groups perceived to be most-at-risk of infection, constitute major obstacles for regional efforts to provide accessible services for both prevention and treatment. Moreover, the legal frameworks in many countries hinder efforts to combat stigma and discrimination.
- A broadening of the response to the epidemic is needed to ensure that all sectors are included. Sectors such as education and tourism need to become more actively involved in prevention activities, while the role of the private sector and other non-government organisations in this

response also needs to be expanded. Moreover, people infected or affected by the epidemic need to be included in all aspects of the response.

- Preventing future HIV infections is a critical priority, as there is no cure for AIDS and the lifetime cost of treatment is very high. There is a need to reach out to the most at-risk populations, such as commercial sex workers, men who have sex with men, prisoners, people with sexually transmitted infections (STIs), and sexually-active youth.
- Falling AIDS death rates indicate that treatment is working. However, it is estimated that only 50 percent of those in need of treatment with antiretroviral drugs (ARVs) are receiving the care they need.
- The capacity of countries to respond to the epidemic needs to be strengthened through improved human resources, infrastructure, and service delivery systems.
- Weaknesses in monitoring were detected—both in terms of monitoring the epidemic itself and in the individual country and regional responses to it. If lessons are to be learned and high levels of spending on the response justified, the response must be monitored more closely.
- There is need for a coordinated plan of strategic information and communication to consolidate the interconnectivity between regional and national programs, highlight lessons learned, promote awareness of critical elements of the CRSF, catalyse action on policies and programmes, disseminate information on a timely basis, and utilise the variety of communication tools and information and communication technologies (ICT) to reach the widest cross section of the populations at the community, national, regional, and international levels.

The new Framework builds on the achievements of the first CRSF while addressing the weaknesses identified in the evaluation, drawing on lessons learned both from the regional and wider international level.

## VISION

To substantially reduce the spread and impact of HIV in the Caribbean through sustainable systems of universal access to HIV prevention, treatment, care, and support.



The second Caribbean Regional Strategic Framework is based on two underlying principles.

### UNDERLYING PRINCIPLES

- There can be no overall regional success in combating HIV without successful national programmes. The Regional Framework should support and encourage the individual national HIV programmes.
- Regional support to countries will consist of regional public goods and services. These are goods and services that can be more cost-effectively provided from the regional rather than the national level. Consequently, the ability of regional support agencies to provide regional public goods and services is crucial.

The core premise of the new CRSF is that an effective response to the HIV epidemic primarily depends on the commitment, capacity, and leadership of the region's national authorities. Caribbean countries are at the heart of the response and the supporting regional response helps to ensure a favourable policy and legislative environment, adequate resources, good coordination, technical assistance, and support for country responses. This document defines the links and interface between the countries and regional support programmes.

The new Caribbean Regional Strategic Framework 2008-2012 takes a more **country-centred approach**, recognising that success in individual country programmes is essential for overall regional success in **achieving universal access** to HIV prevention, treatment, care, and support.

The Framework is organised around six priority areas that define the strategic objectives for the HIV response in the region as well as the regional goods and services that will be available to support country programmes. Countries will be supported to collect data on a set of core Caribbean HIV indicators.

The six priority areas are:

**1. An enabling environment that fosters universal access to HIV prevention, treatment, care, and support services**

There is a greater emphasis on reducing stigma and discrimination through support for the development of policies, programmes, and legislation that affirm human rights and counter deep underlying social barriers to a successful response.

## 2. An expanded and coordinated multisectoral response to the HIV epidemic

All sectors of society are encouraged to contribute to the HIV response, while greater emphasis will be placed on sectors such as education and tourism.

## 3. Prevention of HIV transmission

There is a renewed emphasis on prevention as the most cost-effective approach, using evidence-based programmes to enable access to services by the most-at-risk populations.

## 4. Treatment, care, and support

Successes in the delivery of antiretroviral therapies are expanded to improve access for those currently not served. Greater attention is paid to the treatment of opportunistic infections and tuberculosis.

## 5. Capacity development for HIV/AIDS services

This cross-cutting priority area brings together the necessary interventions to strengthen national health and other social services needed for a comprehensive response to the epidemic. This includes support to the development of human resources, infrastructure and systems.

## 6. Monitoring, evaluation, and research

Greater emphasis is placed on monitoring and evaluation in order to provide information to guide the HIV response and to demonstrate success.

Information and communication are recognised as cross-cutting elements for the CRSF's six priority areas. These components help keep the various stakeholders informed of developments within the Partnership and engaged in the formulation and implementation of policies and programmes at the national and regional levels.

The funding of country and regional institutional programmes continues to be the responsibility of each Caribbean country and the regional organisations, although PANCAP and its members continue to advocate for additional funding from international partners for both country and regional support agency programmes. The regional programme moves towards a programme approach with the development of coherent and coordinated priority area plans and the development of a pooled funding approach where possible.

# 1 INTRODUCTION

The 2001 Declaration of Commitment to the Pan Caribbean Partnership against HIV/AIDS (PANCAP) by the Heads of State and Government of the Caribbean, meeting in Barbados, marked the launching of PANCAP. Since its inauguration, PANCAP has expanded to become a regional umbrella organisation that brings together national HIV programmes with international and regional organisations involved in the fight against AIDS in the Caribbean. The objectives of PANCAP are as follows:<sup>1</sup>

- To provide a unified vision and direction among all partners in reducing the spread and mitigating the impact of HIV in the Caribbean;
- To coordinate the programmes and activities of partners at the regional level, particularly with respect to the CRSF;
- To increase the flow of resources to the region;
- To act as a “clearinghouse” of information for decision-making;
- To build capacity among partners; and
- To monitor the impact of programmes in Member States and organisations.

As both a Millennium Development Goal (MDG 6) and a priority area within the Caribbean Cooperation in Health Initiative III (CCHIII), the response to the HIV epidemic has a very high priority within the region.

The first Caribbean Regional Strategic Framework (CRSF) covered the period 2002–2006 (later extended through 2007), was

developed in 2002 in response to the growing recognition of HIV as a major development problem in the Caribbean. As both national governments and international donors sought to address its challenges, the importance of coordination at the regional level became evident. The size of the region, its diversity and varying levels of integration, and the multitude of social and economic forces at work in the Caribbean meant that a variety of HIV epidemics were already under way, presenting both opportunities and challenges to a regional approach. The first CRSF articulated the opportunities and challenges common to most of the countries across the region. The Framework identified priorities with regional public good characteristics that could be best addressed collectively at a regional level, while identifying key issues for national level focus that would advance the regional fight against HIV. The objective of the CRSF and of the regional plan of action that flowed from it was to support national efforts to prevent and control the HIV epidemic and mitigate its consequences at the national and regional levels. Its implementation was based on close collaboration among regional level organisations and national programmes. The CRSF was not intended to be a substitute for action at the national level, but to complement it. The same justifications apply to this, the second Regional Strategic Framework.

The CRSF 2002-2006 introduced the concept of regional public goods—goods or services that are best provided at the regional rather than national level, owing to greater efficiency. Examples of such regional public goods include the bulk procurement of drugs and the

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<sup>1</sup> PANCAP (2006), Structure and Governance Arrangements.

development of regional guidelines, protocols, and training programmes. PANCAP plays a pivotal role in the provision of regional public goods, inasmuch as the Pan Caribbean Partnership adds value to the effectiveness of national programmes by providing access to services that individual countries cannot provide cost-effectively on their own. PANCAP does this by lowering national costs, by raising the probability of improving the impact of country prevention and care programmes, and by providing a forum for sharing information and experiences.

The Caribbean Regional Strategic Framework 2008-2012 is based on an evaluation of the institutional implementation and financial underpinnings of the previous 2002-2006 Framework. It builds on the achievements of the first CRSF while addressing weaknesses identified in the evaluation, drawing on lessons learned both from the regional and wider international level.

The core premise of the new CRSF is that an effective response to the HIV epidemic primarily depends on the commitment, capacity, and leadership of the region's national authorities. Caribbean countries are at the heart of the response and the supporting regional response helps to ensure a favourable policy and legislative environment, adequate resources, good coordination, technical assistance, and support for the individual country responses. This document defines the links and interface between the countries and regional support programmes.

There will be a renewed emphasis on prevention, while building on the successes in the delivery of antiretroviral therapies. National health systems will be strengthened to enable the delivery of enhanced HIV services. The contributions of the private, civic, and voluntary sectors will be encouraged while greater emphasis will be placed on the education and tourism sectors. Considerable efforts will be made to further reduce HIV-related stigma and discrimination and to address deep underlying social constraints to a successful response.

*The new Caribbean Regional Strategic Framework 2008-2012 will take a more **country-centred approach**, recognising that success in individual country programmes will be essential for overall regional success in **achieving universal access to HIV prevention, treatment, care, and support.***

Greater emphasis will be placed on monitoring and evaluation activities in order to demonstrate the success of implementation and provide information for a more sensitive response. This will be complemented by more research to inform programme design. Mechanisms for greater accountability of

performance will be developed during the second CRSF period, primarily through the development of a coherent programme approach to regional activities in the Caribbean. Systems will be developed to encourage pooled funding by donors in support of Caribbean programmes.

This document describes the proposed CRSF 2008-2012. Section 2 presents an updated epidemiological profile, a discussion of the particular cultural factors operating in the region and the socioeconomic impact of the HIV epidemic in the Caribbean. Section 3 summarises the lessons learned from CRSF 2002-2006, at both the national and regional levels, in scaling up the response to HIV in the Caribbean. Sections 4 to 6 are the centrepiece of the new Caribbean Regional Strategic

Framework 2008-2012, with its vision and goals (Section 4), guiding principles (Section 5), as well as strategic objectives and expected results (Section 6). Section 7 spells out how the impact of the scaling up of national and regional responses over the coming five years will be measured, monitored, and evaluated. Section 8 describes how the implementation of the new

CRSF will be coordinated and monitored, and how accountability is defined. In the last section, Section 9, the estimated costs of the regional support are presented, together with the financing mechanism for the resources mobilised and preferably pooled funding from international multilateral and bilateral development partners.





## 2 HIV/AIDS IN THE CARIBBEAN

### 2.1 The Epidemiology of HIV and AIDS in the Caribbean

The Caribbean has, after sub-Saharan Africa, the second highest HIV prevalence rates in the world. The overall adult HIV prevalence in the Caribbean was estimated at 1% in 2007,<sup>2</sup> but this regional average encompasses considerable variations in national infection rates, ranging from nearly 0 to 3.8% (see Table 2). In many countries of the region the shift from low prevalence to a generalised epidemic has already occurred. It is currently estimated that 230,000 people are living with HIV in the region. Haiti and the Dominican Republic together account for 75% of all HIV cases in the Caribbean.

*"The Caribbean has, after sub-Saharan Africa, the second highest HIV prevalence rates in the world."*

The number of AIDS cases reported annually in the 21 CAREC member countries have increased from the first recorded cases in 1982 to around 2,500 per year by 2004, dropping slightly from a high in 2003. Some countries have reported recent falls in reported AIDS cases and AIDS-related deaths. The primary mode of transmission is sexual intercourse, mainly heterosexual.

There is a higher rate of infection among men (a male to female ratio of 2:1). However, the proportion of women infected is increasing (Figure 1). Surveillance data show that in 1985, 20% of reported AIDS cases were females but that proportion reached 42% by 2003.<sup>3</sup> The incidence of HIV infection among women aged 15-24 years is 3 to 6 times that of men.

Table 1: HIV/AIDS in the Caribbean in 2007

- Adult HIV prevalence was estimated at **1.0%** (range 0.9%-1.2%);
- HIV prevalence among the most-at-risk populations **5% - 33%** (data up to 2005);
- Some **17,000** (15,000-23,000) people were newly infected in 2007;
- An estimated **11,000** (9,800-18,000) people died of AIDS in the Caribbean;
- AIDS is the leading cause of death among persons aged 25 to 44 years.

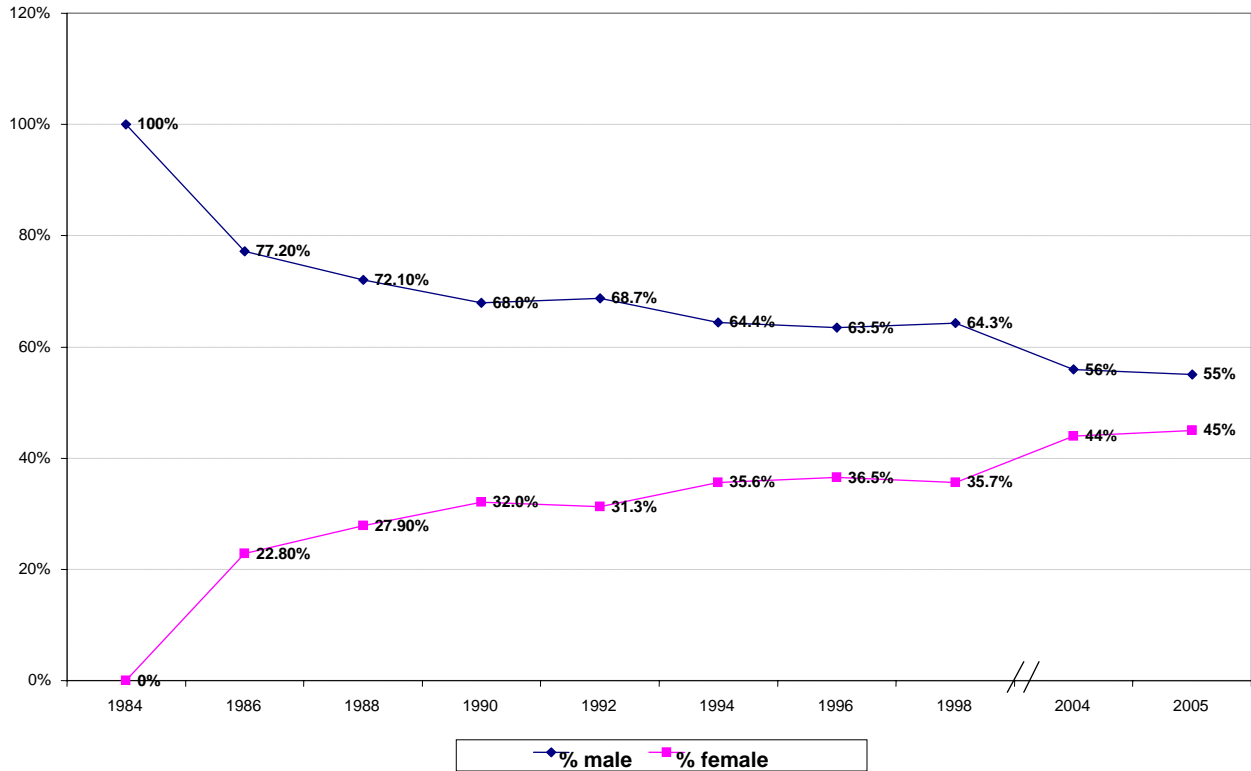
Source: UNAIDS (2007), AIDS Epidemic Update, December 2007.

<sup>2</sup> UNAIDS (2007), AIDS Epidemic Update, December 2007.

<sup>3</sup> CAREC & PAHO (2007), The Caribbean HIV/AIDS Epidemic and the Situation in Member Countries of the Caribbean Epidemiology Centre (CAREC), February 2007.



Figure 1: Distribution of Reported AIDS cases by Sex, CAREC Member Countries 1984-2005



Source: CAREC (2006), CAREC Surveillance Report.

HIV prevalence rates in young people range from 0.08% to 3.2% (Table 2). Young people have yet to adopt consistently safer-sex behaviours; have difficulty accessing sexual, reproductive and HIV health services; and young women in particular are subject to pressures for intergenerational and/or transactional sex. Forced sexual debut is an issue affecting approximately 20% of young people.<sup>4, 5</sup>

<sup>4</sup> CAREC & PAHO (2007), see footnote 3.

<sup>5</sup> OECS (2007), Behavioural and Surveillance Survey in Six Countries of the Organisation of Eastern Caribbean States (OECS) 2005-2007.



Table 2: HIV Prevalence (Adult, Youth and MARP) in Selected Caribbean Countries, 2005

Country	Adult HIV prevalence	Youth HIV prevalence	MARP prevalence
Bahamas	3.3%		
Barbados	1.5%	1.8%	
Belize			Prisoners: 5%
British Overseas Territories	0.11 to 1.15%*		
Cuba	< 0.2%		MSM: 5.2% (1988)
Dominican Republic	1.1% (DHS)	2.2% (ENDESA 2002)	MSM: 10 to 12% Drug users: 5% (2000)
Guyana	2.4%		
Haiti	2.2% (DHS); 3.8% (UNAIDS)		
Jamaica	1.5%	1.5% (2005 ANC sentinel surveillance)	MSM: 10-33% SW: 9% STI clinic attendees: 4.6% (2005)
St. Lucia		1.2%**	
St. Vincent & the Grenadines		2004: 0.1%; 2005: 0.08%	
Suriname	1.9%		MSM: 18%
Trinidad & Tobago	2.6%	3.2%	

Sources:

(1) Adults: UNAIDS (2007), AIDS Epidemic Update. UNAIDS/WHO (2006) Report on the Global AIDS Epidemic.

(2) Youth: UNAIDS (2006), UNGASS reports for each of the selected countries, unless stated otherwise.

(3) MARP: CAREC & PAHO (2007), The Caribbean HIV/AIDS Epidemic and the Situation in Member Countries of CAREC, February 2007. Caribbean Technical Expert Group (2004), Strengthening the Caribbean Regional Response to the HIV Epidemic: Report of the Caribbean Technical Expert Group Meeting on HIV Prevention and Gender, draft working document, 28-29 October 2007, Jamaica.

Notes: \* British Overseas Territories: DfID (2007), Taking Action against HIV in the UK Overseas Territories: Project Memo. \*\*Based on sentinel surveillance AIDS registry & government population statistics estimates.

### The HIV epidemic among the most-at-risk populations (MARPs)

The current stage of the HIV epidemic in the Caribbean suggests that the regional epidemic will be fuelled by infections within population groups that are particularly vulnerable and more at risk to infection. Therefore, there is a need to focus efforts on these vulnerable populations. Within the Caribbean, a number of such vulnerable groups have been identified:

- Men who have sex with men (MSM) represent approximately 10% of HIV transmission in the Caribbean. The few studies of MSM estimate high HIV rates ranging from 5 to 33% (Table 2). Research

has shown<sup>6</sup> self-stigmatisation among MSM in the region and the extent to which they disguise their orientation through bisexual activity.

- Commercial sex workers include both men and women. Sex workers are highly vulnerable to sexually transmitted infections (STIs). Reported HIV infection rates among sex workers vary from 9 to 31%.
- People living with HIV (PLHIV). Because of the risk of stigmatisation, PLHIV often do

<sup>6</sup> Russell-Browne, P. (1998), Gay Research Initiative on AIDS Prevention in the Caribbean: A Technical Report, Trinidad, CAREC/PAHO/WHO.

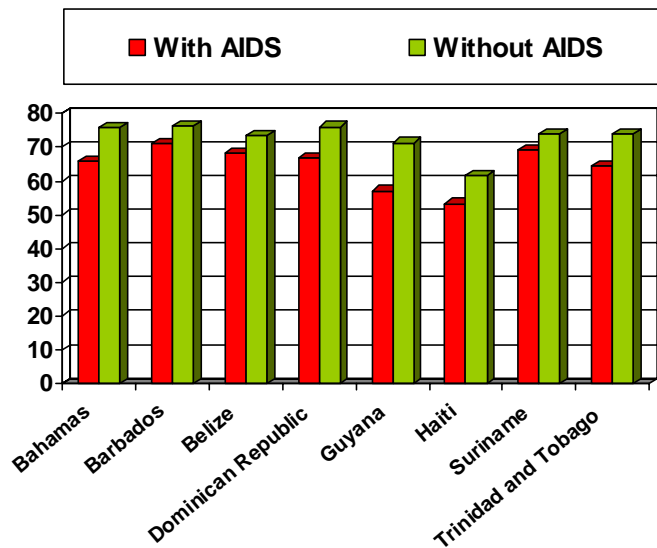
not disclose their status, thus increasing the potential for spreading infection. A study of PLHIV reported that nearly 40% do not use condoms and that over 25% did not know their partner's HIV status. Less than one third had disclosed their own status to their sexual partner(s).<sup>7</sup>

- STI clinic attendees have HIV rates that are higher than the general population. In Jamaica,<sup>8</sup> between 1997-2005, HIV rates among STI clinic attendees ranged from 3.8 to 7.1%.
- Prisoners: In 2004-2005, HIV rates among prisoners in six OECS countries ranged from 2 to 4%.<sup>9,10</sup> In Belize, a 5% rate was found among the prison population in 2004.

These rates are 2 to 3 times higher than in the general population.

- Mobile and migrant populations. Migrant populations may not have the power to protect themselves, or might participate in high-risk sexual activity for survival. Migrants may experience language and/or legal barriers to accessing services and, in many instances, access to health services is quite limited among these groups.
- Drug users. Cocaine use has been associated with high levels of HIV prevalence (5% in the Dominican Republic in 2000). Unsafe injecting drug use is responsible for a minority of HIV infections, but contributes significantly to the spread of HIV in Bermuda and Puerto Rico.

Figure 2: Life Expectancy at Birth 2010, Selected Caribbean Countries  
Source: US Census Bureau, 2002.



<sup>7</sup> CRN+/CHRC (2007), Quality of care for people living with HIV and AIDS in Antigua, Grenada, Trinidad & Tobago.

<sup>8</sup> Ministry of Health of Jamaica (2007), National HIV/STI Prevention and Control Programme - HIV/AIDS in Jamaica, National Strategic Plan 2007-2012, draft October 2007.

<sup>9</sup> CAREC & PAHO (2007), see footnote 3.

<sup>10</sup> OECS (2007), see footnote 5.

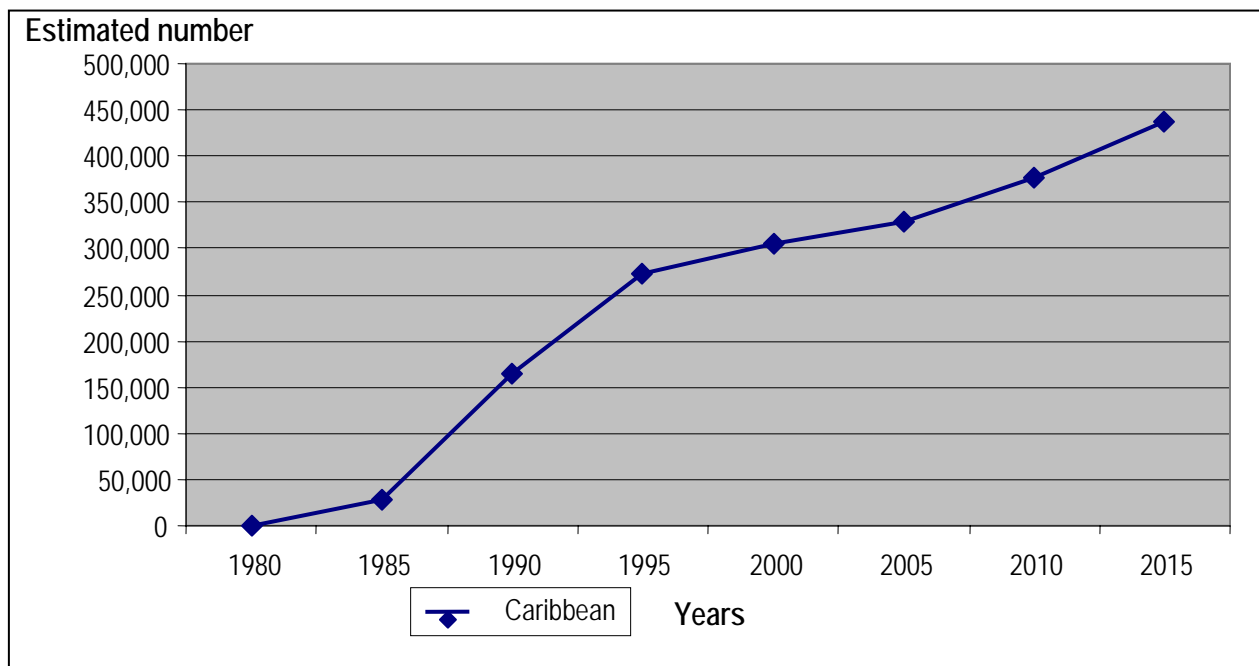
## The future of the HIV epidemic in the Caribbean

The negative impact of the HIV epidemic on demographic trends in the Western hemisphere has been well documented. According to 2002 estimates of the U.S. Census Bureau, if current trends continue, life expectancy will be reduced by at least ten years by the end of 2010 due to AIDS in hard-hit countries such as Haiti, Guyana, and the Bahamas (Figure 2).

Despite progress made, estimates indicate that the HIV epidemic will continue to grow in the Caribbean over the next five years (Figure 3). Using a moderate case scenario,<sup>11</sup>

WHO/UNAIDS projections show that the average increase in the total population living with HIV during the period 2005-2015 will be around 13%. As the number of people with HIV increases, Caribbean countries will face a serious challenge in providing care and treatment. Based on these projections, the number of PLHIV in the Caribbean in need of treatment will more than double—from 58,000 to 120,000—during the period 2005-2015.

Figure 3: Estimated Number of PWHIV (Adults) in the Caribbean, 1980-2015 (Moderate Scenario)



Source: WHO/UNAIDS estimates, 2005.

<sup>11</sup> WHO/UNAIDS developed projections based on three scenarios: low, moderate, and high. They indicate the progression of the epidemic according to the level of response, with high being rapid progression of the epidemic as a result of inadequate response. For this situation analysis, the moderate scenario was used.

## 2.2 Cultural and Lifestyle Issues Affecting the HIV Epidemic in the Caribbean

There are several aspects of Caribbean culture and lifestyle which continue to influence the HIV epidemic in the region.

- Stigma and discrimination against PLHIV, homosexuals, and sex workers discourage these individuals from accessing prevention, treatment, and care services. Many countries in the region have existing legal statutes that reinforce prejudices, which hinder the design of prevention interventions for these populations.
- Risky sexual behaviour such as transactional sex, commercial sex, multiple and concurrent sexual partnering, casual sex, cross-generational relationships, and inconsistent condom use all contribute to the HIV epidemic. Persons who establish regular sexual relations frequently stop using a condom without being aware of their partner's HIV status and one or both of them may continue to have other partners.
- Caribbean gender roles are also contributing to the spread of HIV. Women may be submissive to men in sexual decision making, a role that puts them at risk of HIV infection as a result of male behaviour patterns and limited power to negotiate condom use. Gender-based violence, including forced sex and rape, are also a problem. However, some young women are willing to use sex in order to gain favours, cash, or material things.

Social and peer pressure encourages boys to prove their masculinity through actions that include early sexual debut, multiple sex

partners, and at times physical force against women. Unfortunately, in some social settings, boys who show a preference for reading and academic pursuits are at risk of being considered 'suspect' by their peers and likely to become the subject of gender taboos.

While injecting drug use is not a problem in most Caribbean countries, crack/cocaine users have higher rates of HIV owing to risk behaviours. Alcohol consumption is a concern as excessive alcohol intake can impair judgment and thus increase HIV risk.

There is considerable migration between states in the Caribbean for both formal and informal work. The growth of tourism in the region has been accompanied by an increase in population movement and in the sex industry. The CARICOM Single Market and Economy will facilitate easier population movement. Migrant populations in many countries are encountering difficulty in accessing services, including those for HIV, as a result of legal, language, and other barriers.

## 2.3 The Economic Impact of HIV in the Caribbean

In the Caribbean, HIV risk is closely intertwined with poverty. Poverty remains high in the region, some countries having 15 to 30% of the population living below the poverty line. There are high levels of unemployment, especially among youth and females. Female heads of household are more likely to be both unemployed and living in poverty. Both factors increase women's dependence on men and limit their abilities to make decisions on sexual relations, placing them at risk of infection.

At the household level, AIDS results in both the loss of income and increased spending on health care. The income effects of this lead to reduced savings, and reduced spending on basic needs such as nutrition and education.

There is little empirical evidence of the effect of HIV/AIDS on the economies of the Caribbean. Studies conducted for some countries in the region<sup>12, 13, 14, 15</sup> had forecast a significant negative impact on their economies as a result of the epidemic, but experience has shown that the negative effects of the spread of HIV and AIDS were overestimated.

International experience shows that an HIV epidemic does have a significant harmful impact on national economic performance. Small island Caribbean states are highly dependent on remittances and only one or two sources of foreign exchange (tourism and mono-cultural agriculture), which are highly vulnerable to global competition and to the effects of a significant increase in HIV. What is at stake for the economies of the Caribbean is not simply a

negative economic experience, but the very capacity of the economic system to hold together. Economic activity will suffer as a result of lost productivity due to AIDS and premature deaths among economically-active adults.

The longer-term impact of HIV on welfare and development is probably more serious than the economic analyses suggest. Estimates of the AIDS impact on economic performance usually do not take into account the loss of “social capital” or the long-term damage accruing to human capital, as children’s education, nutrition, and health suffer both directly and indirectly as a consequence of HIV. The effects of lowered investment in the human capital of the younger generation will affect economic performance for decades to come, well beyond the timeframe of most economic analyses. The provision of HIV prevention, treatment, care, and support services places a tremendous burden on the health sector as well as on the national social support system and services.

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<sup>12</sup> CAREC/UWI. Modelling and Projecting HIV and its Impact in the Caribbean: The Experience of Trinidad & Tobago and Jamaica, 1997.

<sup>13</sup> Theodore, K. HIV/AIDS in the Caribbean - Economic Issues, Impact and Investment Response, Commission on Macroeconomics and Health Working Paper series, Paper No. WG 1:1, March 2001.

<sup>14</sup> McLean, R. Modelling and Projecting the Economic Impact of HIV/AIDS in the Caribbean: The Case of Guyana. A report produced as part of the European-Union-sponsored project, *Strengthening the Institutional Response to HIV/AIDS/STI in the Caribbean*, UWI-Health Economics Unit, September 2004.

<sup>15</sup> Laptiste, C. Estimating the economic impact of HIV/AIDS in Suriname. A report produced as part of the European-Union-sponsored project, *Strengthening the Institutional Response to HIV/AIDS/STI in the Caribbean*, UWI-Health Economics Unit, September 2004.



# 3 LESSONS LEARNED

The following are some of the key lessons learned from the implementation of CRSF 2002-2006.

## 3.1 The Enabling Environment

Complex cultural and social factors in the Caribbean that contribute to high risk behaviours limit the effectiveness of HIV prevention approaches. These issues are compounded by laws which, in many countries, constrain HIV programmes from addressing sensitive social issues and result in an environment that is not supportive of disclosing HIV status. For example, legislation that makes male homosexuality a crime deters the development of programmes in support of MSM. Similarly, current laws constrain the provision of services to sexually-active girls and boys under the legal age of consent.

The establishment of a supportive environment is imperative for achieving universal access and must incorporate important lessons learned from the implementation of the 2002-2006 CRSF:

- HIV is a national developmental issue that requires the integration of HIV policy and programmes into national development plans.
- The commitment of political and civic leaders and the provision of resources at the regional and national levels are necessary to successfully implement programs and achieve universal access.
- Development and implementation of appropriate policies at regional and national

levels are essential to remove barriers to universal access.

- Greater effort must be put into eliminating HIV stigma and discrimination and normalising HIV.
- Legal constraints that hinder access to services must be removed. The capacity to address these constraints at the national level must be strengthened.
- HIV programmes need to take account of the factors that contribute to HIV vulnerability in the region, particularly those related to gender and poverty. Social support systems need to be established or strengthened.
- Policies and strategies that address the needs of orphans and vulnerable children must be developed.
- The increasing feminisation of the epidemic must be addressed.

## 3.2 The Multisectoral Approach

### The importance of national leadership

Leadership at the national level is essential for achieving a well coordinated multisectoral response. Most countries have established a national authority in charge of the response to HIV. Unfortunately, many of these authorities have been operating for only a few years and still have limited capacity to adequately organise the response between the various sectors.

### Inclusion of key sectors

All sectors of society need to be involved in the HIV response. While many community-based organisations (CBOs), non-governmental (NGOs) and faith-based organisations (FBOs) are involved in the provision of HIV services, their managerial and technical capacities frequently require strengthening. Education, tourism, and other key sectors must also be

emphasised. For example, the importance of education sector policies and programmes aimed at influencing the behaviours of young people was recognised by the region's Ministers of Education.<sup>16</sup> These programmes are to be rolled out to all countries in the region.

### Greater involvement of people living with HIV

The last five years have seen an increase in the representation of people living with HIV in national and regional bodies. Stronger networks are needed and their capacity for advocacy and support must be improved. Their involvement is critical for the design of programmes to better meet their needs.

### The world of work

The majority of persons who are HIV-positive are between the ages 15-49 years, the age group that constitutes the bulk of any workforce. Given the negative socioeconomic consequences of the HIV epidemic, more employers are recognising the importance of the workplace as an access point for HIV prevention, treatment, and support. The private sector and trade unions have a critical role to play.

### Sustainable financing of national efforts is necessary

Most countries have been successful in mobilising financial resources for the implementation of their national HIV strategic plans. However, most Caribbean countries

continue to rely on external funding to support their HIV response, particularly in the provision of antiretroviral treatment. During the next five years, countries will need to plan for sustainability through cost-effective management of human and other resources, and better integration of ongoing interventions into health and social systems.

## 3.3 Comprehensive Prevention Programmes

### Renewed emphasis on prevention programmes is necessary

The current emphasis on treatment needs to be balanced with an increased emphasis on prevention, in terms of both coverage and resources.

*The majority of persons who are HIV-positive are between the ages 15-49 years, the age group that constitutes the bulk of any workforce.*

### Access and utilisation of HIV testing services have to be expanded

According to estimates, most persons living with HIV do not know they are infected. Access to HIV testing and risk reduction counselling needs to increase significantly.

### Targeted prevention programmes for those most-at-risk is crucial

Targeted prevention interventions for the most-at-risk and vulnerable populations such as sex workers, men who have sex with men, persons with multiple sex partners, migrant populations, and prisoners need to be scaled up in all countries.

### Further development of behaviour change communication strategies is required

Behaviour change communication strategies that seek to address personal risk as well as

<sup>16</sup> Port-of-Spain Declaration on the Education Sector's Response to HIV and AIDS of CARICOM Ministers of Education (June 2006) and the Roseau Declaration on the Education Sector's Response to HIV & AIDS of OECS Ministers of Education (January 2007).

social vulnerability must be developed and implemented.

#### **Acceptability and access to condoms needs to be increased**

Strategies to expand condom availability, accessibility, and use among the most-at-risk populations, youth, and heterosexual men have to be given renewed focus.

#### **The supply of safe blood has to be sustained**

Most countries have established programmes for *safe blood supply* and screening of all donated blood. These successes must be sustained and enhanced.

#### **Reduced transmission of HIV from mother to child is achievable**

Programmes of prevention of mother-to-child HIV transmission (PMTCT) have been widely implemented across the Caribbean and some countries have managed to achieve transmission rates of less than 5 percent. However, despite the presence of PMTCT services, significant numbers of eligible women in some countries do not take advantage of these services. Continued efforts are required to ensure access to this service for all those who need it.

### **3.4 Comprehensive Treatment, Care, and Support Programmes**

In 2007, an estimated 11,000 persons died of AIDS in the Caribbean, making AIDS the leading cause of death among adults in the region. Several countries have shown decreased mortality rates as a result of improved access to antiretroviral treatment (ART).

#### **ARV treatment coverage must be sustained and expanded**

It is estimated that currently only 50% of those in need of ART are receiving it. Decentralisation of services has been shown to increase the uptake of treatment, care, and support services. Continued efforts will be needed to ensure universal access to ARV services in the coming years.

#### **STIs and opportunistic infections including TB need to be better managed**

Both tuberculosis and sexually transmitted infections are associated with higher rates of HIV transmission. Countries need to find approaches that maximise opportunities for integrated treatment and prevention interventions. Access to treatment for opportunistic infections must be ensured for all persons who require this service.

#### **Integration of HIV treatment into primary health care has helped to decrease stigma and normalise HIV**

Delivery of HIV treatment and care services within general medicine clinics of the primary health care setting has markedly reduced the stigma associated with specialised HIV clinics.

### **3.5 Capacity Development**

#### **Human resources capacities need to be strengthened**

In spite of great efforts made by the countries over the last five years, the human resource capacity is insufficient with respect to number, skills, and various competencies. There is a need to ensure that all pre-service tertiary training adequately addresses the knowledge and skills required to prevent HIV infection and, where relevant, equips trainees to provide gender-sensitive, non-discriminatory HIV services in

the health, education, legal, social welfare, and other sectors. Continuing education to maintain and improve the skills of workers already involved in the provision of services is also necessary.

### **Health systems need to be strengthened**

HIV services are best delivered by integrating them within general health services, particularly at the primary level of care. The aspects of health service delivery systems most in need of strengthening include information systems, quality assurance, laboratory services, and procurement services, to enable them to adequately respond to the demands of universal care and treatment.

### **Management capacity must be improved**

During the first CRSF, the slow utilisation of available funds and program implementation delays raised questions about the capacity of countries and regional organisations to implement planned activities. Efforts need to be made during the second CRSF to improve the management capacity of HIV programmes at all levels.

## **3.6 Monitoring, Evaluation, and Research**

The establishment of surveillance and regular monitoring and evaluation systems is still an outstanding task for many countries. This limits a country's ability to assess progress and reduces accountability. Too many programmes are based on anecdotal evidence rather than operational research. Important lessons learned include:

### **Monitoring, Evaluation, and Research**

- The establishment of effective surveillance and monitoring & evaluation systems cannot be further delayed
- Evidence-based decision making needs to become standard practice in the Caribbean, thus enabling strategies and activities to be adjusted in response to knowledge about success or failure.
- Baseline data for agreed upon indicators must be collected as a matter of urgency and performance monitored against these at appropriate intervals.
- A regional research agenda is required to identify priorities for seeking evidence for the most important policy and programme decisions.

## **3.7 Coordination, Accountability, and Financing of the Regional Response**

### **Roles and responsibilities of PANCAP members require better definition**

Since its creation in 2001, PANCAP has grown to over eighty members, with new members joining annually. However, PANCAP's capacity to coordinate the regional response has been hindered by a number of managerial, structural, and financial problems. The roles and responsibilities of PANCAP members need to be better defined and accountability strengthened.

### **Coordination of agencies working in the region needs to be improved**

The many agencies working in the Caribbean in support of country programmes need to be better coordinated to ensure that the best possible use is made of limited available resources and to maximise the efficiency of the response.

### **A harmonised response is required**

The web of support to individual countries and regional support agencies is inefficient because of multiple contracting and procurement rules and agencies, duplicated reviews, and competing priorities. The region needs to move towards a regional programme approach for the support provided to countries by regional institutions. A requirement for better harmonisation is the establishment of efficient and effective administrative and procurement procedures with defined levels of accountability to enable the channelling of funds in support of both regional and national plans.

### **Accountability must be enhanced**

The present multiple strands of accountability to national authorities, to PANCAP, and to international funding partners needs to be simplified so that the performance of countries and their regional partners in achieving their objectives can be better assessed. A core set of indicators needs to be defined and used to demonstrate performance at the country and regional levels.

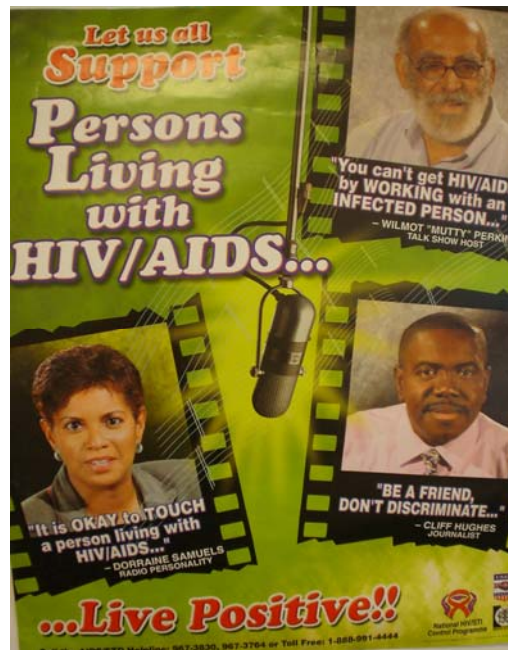
### **Sufficient and sustainable financing is required for the HIV response**

Currently the Caribbean receives approximately US\$13-14 per capita for HIV.<sup>17</sup> However, many countries in the region are ineligible for global funding. Poor absorptive capacity and limited

<sup>17</sup> PANCAP (2006), Report on the Caribbean Regional Consultation on universal access (14 & 15 February 2006, Jamaica), including (1) Report of the COCTs Sub-regional consultation (26-27 January 2006, St. Maarten) and (2) Report of the OECS Sub-regional consultation (23-24 January 2006, St. Lucia).

human resources in some countries slows the expansion of the HIV response. The Caribbean must adequately prepare itself to become financially sustainable as donor priorities change and funding expires and/or shifts to other parts of the world. Many of the countries in the region are small with small populations,

challenging the practicality of the countries becoming self-sufficient. PANCAP has the mandate to accelerate the response to universal access, lead, harmonise, and align efforts in the fight against HIV in the region. An important strategy for the region in achieving sustainability is to exploit the institutional capacity advantages available within the region and increase efficiency in the use of resources.



### **Support from the international community is important**

Assistance to countries and regional efforts against HIV from many institutions, including the U.N. and bilateral partners, was key in establishing the basis for successful programmes in the region. It is important that the financial and technical support provided during the first Framework period continues during this second period.

### **The coordinating role of PANCAP's Project Coordination Unit (PCU) has to be strengthened**

The "projectised" activities carried out by the PCU have distracted the Unit from its overall primary role of coordinating and monitoring the Caribbean regional response. The coordinating role of the PCU needs to be reemphasised.

## 4 VISION AND GOALS

In 2001, Caribbean heads of state and government representatives joined leaders of 189 nations at the first United Nations General Assembly Special Session on HIV/AIDS (UNGASS). They unanimously adopted the Declaration of Commitment on HIV/AIDS, acknowledging the epidemic to be a “global emergency and one of the most formidable challenges to human life and dignity.” This Commitment was reaffirmed at the meeting of UNGASS in June 2006. The Caribbean Regional Strategic Framework 2008-2012 and activities of PANCAP are based on the UNGASS Declaration.

### VISION

To substantially reduce the spread and impact of HIV in the Caribbean through sustainable systems of universal access to HIV prevention, treatment, care, and support.

The Framework will facilitate comprehensive, *country-driven processes* with involvement of all relevant stakeholders, including government, civil society, the private sector, PLHIV, and vulnerable groups. Regional support will accelerate the achievement of universal access to HIV services.

Caribbean partners commit themselves to achieving the following goals related to HIV prevention, treatment and impact mitigation:

### GOALS

- *By 2012, to reduce the estimated number of new HIV infections by 25%.*
- *By 2012, to reduce mortality due to HIV by 25%.*
- *By 2012, to reduce the social and economic impact of HIV and AIDS on households by 25%.*



# 5 GUIDING PRINCIPLES AND STRATEGIC APPROACHES

The countries of the Caribbean are called upon to endorse and apply the following **guiding principles** and **strategic approaches** in further developing their own policies, plans, and programmes:

## *Inclusiveness and greater involvement of people living with AIDS (GIPA)*

The meaningful involvement of people living with and affected by HIV and other most-at-risk persons in the design, implementation, monitoring and evaluation of the national response to HIV is vital.

### 5.1 Guiding Principles

#### Political leadership

Political commitment is required to achieve a sustained and effective Caribbean response to HIV.

#### Good governance

A successful national and regional HIV response requires leadership that mobilises and manages resources in an effective, transparent and accountable manner.

#### Countries at the centre

Success in individual country programmes is essential for overall regional success. The CRSF is to guide, support, and encourage the individual national HIV programmes.

#### Multisectoral approach

The HIV epidemic is not only a health issue; it also has economic, social, and cultural dimensions. The response requires the ongoing commitment, support, and involvement of all sectors of society.



#### Equity

National HIV responses should ensure that all persons have equal access to prevention, treatment, care, and support services.

#### Human rights

Equality before the law and freedom from discrimination must be respected, protected, and fulfilled. Implementing the ten key principles of the ILO Code of Practice on HIV/AIDS will ensure human rights are upheld in the workplace.

#### Evidence-based approach

All interventions must be based on the available data and international best practices.

#### Sustainability

The effects of the HIV epidemic will be with us for generations, so it is important that the programmes designed and implemented are sustainable over the long term.

## 5.2 Strategic Approaches

### Regional Public Goods and Services

Regional public goods and services refer to those which can be more efficiently provided from the regional than national level. These will be provided by the regional support agencies (RSAs).

### Prevention

In the absence of a cure for AIDS and with the high lifetime costs associated with treatment, preventing future HIV infections remains a priority.

### Strengthening health and social systems

Effective health and social systems are critical to the delivery of HIV programmes. Both systems need to be strengthened to provide sustainable, good quality support to the HIV response.

### Monitoring and evaluating programmes

Monitoring the implementation and outcomes of the national and regional HIV response is necessary to improve programme design and management and justify support from international partners.

### Information, Education, and Communication Strategy

Enabling a better understanding of the guiding principles and the other strategic approaches to the disease, fostering informed citizen participation, facilitating advocacy centred on evidence-based information, promoting the universal application of the PANCAP vision, rendering accountability among partners, educating individuals about their rights and obligations in the process of universal access to HIV/AIDS prevention, care and treatment, and conveying critical messages to promote behaviour change and progress in the fight against AIDS.



## 6 STRATEGIC OBJECTIVES

The overall intention of the Caribbean Regional Strategic Framework is to provide a basis for reducing the spread and impact of HIV/AIDS in the Caribbean. The Framework identifies priority action areas, focused on supporting national level activities of expanded intersectoral HIV/AIDS programmes, through promotion of a strengthened, effective, and coordinated regional response to the epidemic.

The priority action areas respond to the challenges described in the previous sections, and are:

1. An enabling environment that fosters universal access to HIV and AIDS prevention, treatment, care, and support services;

2. An expanded and coordinated intersectoral response to the HIV/AIDS epidemic;
3. Prevention of HIV transmission;
4. Treatment, care, and support;
5. Capacity development for HIV/AIDS services; and
6. Monitoring, evaluation and research.

These priority areas are the six strategic components that build upon the prior Caribbean Regional Strategic Framework (2002-2006), but have been revised to reflect the current status of the epidemic in the Caribbean and to incorporate the approaches set out in the guiding principles detailed above. The following pages describe each of these priority areas in more detail.

Each of the following sections on the *six priority areas* begins with a brief description of the focus of the priority area in question followed by the associated strategic objectives. The expected results associated with the successful implementation of country interventions in the Caribbean region are listed for each of the strategic objectives, followed by the indicator that will be used to gauge the overall success of priority area implementation. Note that, in order for a practical list of indicators to be recommended, not all strategic objectives will have an indicator (see section 7).

With country programmes at the heart of the CRSF, the regional interventions—described as regional goods and services—are listed to show the regional support that will be available to country programmes to achieve the strategic objectives for each *priority area*.

<b>PRIORITY AREA 1:</b>	<b>PROMOTE AN ENABLING ENVIRONMENT THAT FOSTERS UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT, CARE, AND SUPPORT</b>
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Several factors in the Caribbean hinder access to HIV prevention, treatment, care, and support programmes in the region. The political and social environments fail to adequately protect human rights, especially those of vulnerable groups. The prevailing social and cultural norms are intolerant of behaviours which are perceived as threatening to strong religious customs. Despite considerable progress, HIV-related stigma and discrimination persist. Unequal gender relationships and other disparities contribute to the continued spread of HIV and limit access to services. Many Caribbean countries have underdeveloped social welfare systems that fail to protect vulnerable groups. In addition, many governments are not sufficiently integrating HIV interventions into existing social and development programmes.

*Priority Area 1 will continue to support efforts to address these wider issues in which the CRSF will operate. Three strategic objectives have been defined for the period of the Framework:*

### STRATEGIC OBJECTIVES FOR NATIONAL HIV RESPONSES

- ◆ To develop policies, programmes, and legislation that promote human rights, including gender equality, and reduce socio-cultural barriers in order to achieve universal access.
- ◆ To reduce the stigma and discrimination associated with HIV and vulnerable groups.
- ◆ To reduce the economic and social vulnerability of households.

**STRATEGIC OBJECTIVE 1.1: To develop policies, programmes, and legislation that promote human rights, including gender equality, and reduce socio-cultural barriers in order to achieve universal access.**

*Expected national results:*

- Caribbean countries have legislation that addresses issues related to the legal, ethical, and human rights of those infected with, or affected by HIV.
- Caribbean countries have policies and systems that ensure all residents have access to HIV services including HIV policies to ensure condom access and provide services to minors and the populations most at risk.
- Formative research utilised to design strategies and programs that empower men and women to be less vulnerable to infection and more able to access services.
- Integration of gender equality into national and regional HIV responses.

- Persons providing HIV services (e.g., health workers, teachers, and social workers) are supported to implement best practice guidelines.
- Increased participation of vulnerable groups in the response to HIV.

**STRATEGIC OBJECTIVE 1.2: To reduce the stigma and discrimination associated with HIV and vulnerable groups.**

*Expected national results:*

- Working in partnership with PLHIV and other vulnerable groups, national AIDS commissions, civil society, public and private sector groups are able to develop, implement, and monitor national programs to tackle stigma and discrimination.
- Advocacy on HIV and related human rights issues provided by national opinion leaders.

**STRATEGIC OBJECTIVE 1.3: To reduce the economic and social vulnerability of households.**

*Expected national results:*

- Baseline studies of PLHIV and their families to inform the development of programmes to mitigate the social, psychological, and economic impact of HIV at the community level.
- Poverty reduction programmes have policies and interventions to reduce the social and economic impact of HIV on PLHIV households.
- Programmes developed to reduce the vulnerability of children orphaned due to AIDS and to support children living with HIV (e.g., through increased social, financial, and legal support).

**INDICATOR:**

National Composite Policy Index (areas covered: gender, stigma and discrimination, and human rights).

*Regional public goods and services will be available to support country programmes to achieve these strategic objectives and establish policy environments that facilitate universal access to services.*

## REGIONAL PUBLIC GOODS AND SERVICES

- ◆ Development of and advocacy for the adoption of model policies and legislation for social protection and improved access to prevention and treatment services (for most-at-risk populations and vulnerable groups including minors).
- ◆ Advocacy for regional policies addressing HIV-related migration issues.
- ◆ The establishment of a regional Stigma and Discrimination (S&D) Unit that:
  - Provides technical assistance for country programs addressing S&D;
  - Develops model policy and legislation addressing issues related to legal and human rights of PLHIV;
  - Supports countries with operational research on S&D, with a strong gender focus;
  - Disseminates best practices and tested methodologies on reducing S&D;
  - Advocates, at regional level, on HIV and related human rights issues.
- ◆ Technical assistance to increase country capacity for conducting gender analysis and sensitivity:
  - Conduct research on social, legal, and economic factors, including gender power relations, that increase the vulnerability of women and men to HIV;
  - Provide a regional training programme in gender mainstreaming and gender analysis for persons developing HIV programs;
  - Design and implement pilot projects to test interventions for reducing the vulnerabilities of men and women and roll out region-wide if successful.
- ◆ Socioeconomic impact studies, cost-effectiveness studies, and national HIV spending assessments conducted to advise governments on appropriate HIV-related policies and programmes.



**PRIORITY  
AREA  
2:**

**AN EXPANDED AND COORDINATED  
MULTISECTORAL RESPONSE TO THE HIV EPIDEMIC**

An expanded and well-coordinated multisectoral response is essential to control the HIV epidemic. The purpose is to increase technical, political, and financial support to maximise the HIV response in each sector and achieve the widest possible coverage of services. Countries will focus on the consolidation, further development, and strengthening of the HIV responses within the education and tourism sectors, as well as on the implementation of HIV workplace policies and programmes in both government institutions and private-sector businesses. Participation in the response will be increased through strengthening the organisational and managerial capacities of PLHIV networks as well as of other civil society organisations (NGOs, CBOs, and FBOs).

*Priority Area 2 will continue to support efforts to ensure increased participation in the response. Five strategic objectives have been defined for the period of the Framework:*

**STRATEGIC OBJECTIVES FOR NATIONAL HIV RESPONSES**

- ◆ To enhance, in all Caribbean countries, the ownership of national HIV programmes and the responsibility for driving the response to the epidemic.
- ◆ To strengthen the multisectoral response to HIV, including involvement of key government organisations, NGOs, CBOs, FBOs, PLHIV networks, the private sector, trade unions, and vulnerable groups.
- ◆ To promote and protect the health of students and staff, and to mitigate the impact of HIV on the education system.
- ◆ To scale up the HIV response in tourism and any other sector the country considers important.
- ◆ To support national public and private sector organisations to introduce comprehensive workplace policies and programmes.

**STRATEGIC OBJECTIVE 2.1: To enhance, in all Caribbean countries, the ownership of national HIV programmes and the responsibility for driving the response to the epidemic.**

*Expected national results:*

- Political, non-partisan commitment for national HIV programmes.
- National financial contributions to HIV programmes increased.

- Countries include HIV in development plans with the aim of achieving a sustainable response.
- National HIV programmes organised in keeping with the U.N. “Three One’s” principle.

**STRATEGIC OBJECTIVE 2.2: To strengthen the multisectoral response to HIV, including involvement of key government ministries, NGOs, CBOs, FBOs, PLHIV networks, the private sector, trade unions, and vulnerable groups.**

*Expected national results:*

- National HIV multisectoral coordinating mechanisms are strengthened and include all relevant public and private sector partners.
- Capacity developed within each sector to effectively participate in the national response and to develop and integrate HIV policies, programmes, and services within their sector.
- Focal persons and/or units responsible for the HIV response identified in each sector.
- People with HIV and other most-at-risk populations assisted to form support groups and networks and empowered to be effective advocates and partners.
- Strengthened capacity of NGOs, CBOs, FBOs and the private sector to contribute more effectively to the HIV response (see Strategic Objective 3.3).

**STRATEGIC OBJECTIVE 2.3: To promote and protect the health of students and staff, and to mitigate the impact of HIV on the education system.**

*Expected national results:*

- Caribbean countries have introduced overarching education sector HIV policies.
- HIV education and awareness activities conducted in the school community.
- Curriculum development and education programmes based on effective strategies for behaviour change, skills development, and participatory learning, all set in the context of health promotion for responsible lifestyles, have been developed.
- Access to youth-friendly health and social services ensured.
- All primary, secondary, and tertiary level students participate in well-designed and gender-sensitive health and family life skills and HIV/STI prevention education programmes.

**STRATEGIC OBJECTIVE 2.4: To scale up the HIV response in the tourism sector.**

*Expected national results:*

- Caribbean countries have adopted and implemented HIV workplace policies and programs in the tourism and/or other sectors.
- Programmes to raise awareness and improve prevention throughout the tourism and/or other sectors have been developed and implemented (see Priority Area 3).

**STRATEGIC OBJECTIVE 2.5: To support national public and private sector organisations to introduce comprehensive workplace policies and programmes.**

*Expected national results:*

- Workplace policies and programmes have been adopted, disseminated, implemented and their results documented.
- Formal and informal sector employees benefit from HIV workplace programmes.

**INDICATORS:**

- Domestic and international AIDS spending by categories and financing sources.
- National Composite Policy Index (areas covered: workplace programmes, civil society involvement).
- Percentage of schools that provided life skills-based HIV education in the last academic year.
- Number of countries that have integrated HIV policies, programmes, and services in education and tourism sectors.
- Percentage of enterprises/companies and public sector institutions with HIV workplace policies and programmes in place.

*The regional public goods in this Priority Area are as follows:*

#### REGIONAL PUBLIC GOODS AND SERVICES

- ◆ Facilitation of collaboration between Caribbean countries to ensure the equitable development of HIV programmes across the region.
- ◆ Technical assistance for the development of 5-year national HIV strategic plans and their corresponding annual implementation plans and budgets.
- ◆ Documentation and dissemination of best practices and lessons learned about coordinating multisectoral actions for the HIV response.
- ◆ Development and dissemination of regional model policies for the education and tourism sectors.
- ◆ Advocacy and support for the adoption and implementation of the ILO/UNESCO HIV/AIDS workplace policy for the education sector in the Caribbean.
- ◆ Support implementation of Health and Family Life Education policies and programmes across the region.
- ◆ Promotion of regional agreements with tourism stakeholders on the implementation of HIV prevention activities.
- ◆ Research on the impact of HIV and AIDS at the workplace and on factors that influence the implementation of effective HIV workplace policies and programmes.
- ◆ Support for the development of networks of PLHIV and MARPs.
- ◆ Technical assistance to build the capacity of NGOs, CBOs, FBOs, and networks in the areas of organisational development, leadership, advocacy, and HIV programming with emphasis on prevention.
- ◆ Establishment and maintenance (on the PANCAP website) of a database of NGOs, CBOs, and FBOs working on HIV.
- ◆ Regional advocacy for more private sector involvement in the HIV response

**PRIORITY  
AREA  
3:**

**PREVENTION OF HIV TRANSMISSION**

The HIV epidemic in the Caribbean is primarily due to sexual transmission, mainly heterosexual. Surveys conducted in the countries of the region suggest that there is an adequate level of knowledge about HIV in the Caribbean, although it has yet to sufficiently change behaviours. Prevention efforts in the new CRSF will address the various issues that increase the vulnerability of both men and women to HIV and roll out national strategies that are based on regional and international best practices. Countries will implement specific targeted interventions among most-at-risk populations including SW, MSM, drugs users, prisoners, and migrant populations.

Prevention interventions will need to go beyond individual and interpersonal approaches to develop strategies that address the social context that supports risky behaviours. Effective behaviour change communication strategies must take account of issues relating to poverty, gender, and other cultural and social norms. Elimination of stigma and discrimination towards people living with HIV will be promoted (see Priority Area 1), but PLHIV can play a greater role in preventing the further spread of HIV. This framework proposes enhanced efforts towards voluntary disclosure of HIV status and positive prevention in a more supportive environment.

*The following strategic objectives have been defined for Priority Area 3 for the period of the Framework:*

**STRATEGIC OBJECTIVES FOR NATIONAL HIV RESPONSES**

- ◆ To prevent sexual transmission of HIV.
- ◆ To reduce vulnerability to sexual transmission of HIV.
- ◆ To establish comprehensive, gender-sensitive, and targeted prevention programmes for children (9-14 years old) and youth (15-24 years old).
- ◆ To achieve universal access to targeted prevention interventions among the most-at-risk populations (such as, MSM, SW, drug users, prisoners, and migrant populations).
- ◆ To provide services for the prevention of mother-to-child transmission of HIV to all pregnant women and their families.
- ◆ To strengthen prevention efforts among PLHIV as part of comprehensive care.
- ◆ To reduce vulnerability to HIV through early identification and treatment of other sexually transmitted infections (STIs).

### **STRATEGIC OBJECTIVE 3.1: To prevent sexual transmission of HIV.**

#### *Expected national results:*

- Universal access to HIV testing and counselling services ensured through an expansion of HIV testing sites, including provider-initiated (rapid) testing.
- Condom acceptability and accessibility improved and expanded.
- Condom negotiation and condom use skills strengthened.
- Healthy and responsible sexual behaviour, attitudes, and practices promoted and increased through innovative behavioural change communication strategies.

### **STRATEGIC OBJECTIVE 3.2: To reduce vulnerability to sexual transmission of HIV.**

#### *Expected national results:*

- Research on the social determinants and vulnerability to HIV conducted and disseminated.
- Capacity to design and implement behaviour change communication addressing social vulnerability enhanced.
- Continued advocacy with governments to create an enabling environment to support safer sexual behaviours (see Priority Area 1).

### **STRATEGIC OBJECTIVE 3.3: To establish comprehensive, gender-sensitive and targeted prevention programmes for children (9-14 years old) and youth (15-24 years old).**

#### *Expected national results:*

- Access to accurate, gender-sensitive information and skills on adolescence, sexuality and their HIV/STI vulnerability ensured for young people particularly within school settings.
- Improved Behaviour change communication programmes to address youth, developed and implemented.
- Comprehensive condom programmes for youths developed, addressing the accessibility and availability of condoms as well as condom negotiation skills.
- Youth-led comprehensive HIV behaviour change communication prevention programmes developed.
- Peer education programmes for school and community-based youth strengthened.
- Access for out of school youth to HIV prevention and other services ensured.
- National policies ensuring access to HIV testing and counselling for minors developed.
- Civil society organisations supported to reach youths with programs to reduce their HIV vulnerability, including life skills and income-generating activities.

### **STRATEGIC OBJECTIVE 3.4: To achieve universal access to targeted prevention interventions among most-at-risk populations (such as MSM, SW, drug users, prisoners, and migrant populations).**



*Expected national results:*

- Targeted behaviour change communication interventions to increase safer sexual practices among most-at-risk populations developed and implemented.
- Improved health seeking behaviour including early HIV/STI diagnosis and treatment promoted.
- Access to HIV testing and counselling ensured.
- National policies based on regional best practices developed to facilitate the design of prevention programmes for vulnerable groups.
- Peer education programmes for MARPs developed, especially SW and MSM.
- HIV/STI policies and prevention services are implemented in the prison system.
- Innovative approaches to secure access to HIV preventive services by migrant populations implemented.

**STRATEGIC OBJECTIVE 3.5: To provide services for the prevention of mother-to-child transmission of HIV to all pregnant women and their families.**

*Expected national results:*

- Service delivery capacity of prevention of mother-to-child transmission sites strengthened and the geographic coverage at primary care facilities expanded.
- Community mobilisation and referral networks to include prevention of mother-to-child transmission of HIV strengthened.
- PMTCT Plus programmes introduced.
- Positive prevention promoted for PLWHIV at PMTCT sites

**STRATEGIC OBJECTIVE 3.6: To strengthen prevention efforts among PLHIV, as part of comprehensive care (see Strategic Objective 4.5).**

*Expected national results:*

- Increased safer sex practices by PLHIV.
- Increased disclosure of HIV status by PLHIV to their sexual partners.
- Increased social support for PLHIV to facilitate disclosure of HIV status and safer sex practices.

**STRATEGIC OBJECTIVE 3.7: To reduce vulnerability to HIV through early identification and treatment of other sexually transmitted infections (STI).**

*Expected national results:*

- Increased access and utilisation of STI services through:
  - Increased early treatment for STIs resulting from greater public awareness of the symptoms and of the consequences of STIs if left untreated.
  - STI treatment and counselling services provided in all primary health centres.

- National standards for the clinical management and care of STIs, including guidelines for the syndromic management of STIs, are utilised for service provision.
- Availability of drugs for treatment of STIs secured.
- Staff responsible for providing treatment and counselling for STIs trained and supervised.
- Simple diagnostic technology for diagnosis of aetiological agents for STIs introduced.
- HIV testing offered to all persons attending STI clinics.

#### INDICATORS:

- Percentage of young women and men aged 15-24 years and other at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.
- Percentage of young women and men aged 15 – 24 who have had sexual intercourse before age 15.
- Percentage of young women and men aged 15-24 years reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner.
- Percentage of SW reporting condom use the last time they had sex with a client.
- Percentage of men reporting condom use the last time they had anal sex with a male partner.
- Prenatal HIV prevalence among young women aged 15-24 years.
- Percentage of infants infected with HIV born to HIV-infected mothers.
- Percentage of youth aged 15-24 years who received HIV testing in the last twelve months and know the results.
- Percentage of the most-at-risk populations who received HIV testing in the last twelve months and know the results.
- Percentage of estimated most-at-risk populations (MSM, SW, youth aged 15-24 years) reached with behaviour change communications.
- Percentage of HIV-positive pregnant women receiving a complete course of ART prophylaxis to reduce the risk of mother-to-child transmission.

*The regional public goods and services that will support the prevention of HIV transmission at the country level are as follows:*

## REGIONAL PUBLIC GOODS AND SERVICES

- ◆ Providing technical assistance to countries concerning HIV prevention.
- ◆ Sharing of best practices for prevention and promotion strategies:
  - Facilitate research and understanding of the social determinants of sexual behaviour and factors leading to increased vulnerability to HIV infection.
  - Collection and dissemination of best practices, resource materials, and guidelines on prevention interventions, stigma reduction, HIV testing/counselling, provider training, peer education, and on other related topics.
  - Development of regional behaviour change communication strategies on HIV.
- ◆ Addressing youth:
  - Identification of regional best practices concerning youth behaviour change communication strategies through research and programme evaluation.
  - Support the development and implementation of regional best practices for youth outreach, peer education, and Health and Family Life Education (HFLE) programmes.
  - Support peer counselling of youth through NGOs across the Caribbean.
  - Expansion of the regional condom social marketing programme targeted at youth.
  - Facilitate training of youth in HIV prevention.
- ◆ Addressing MARPs:
  - Improved understanding of the role of MARPs in the regional epidemiology of HIV.
  - Advocate for the inclusion of representatives of MARPs at all levels of decision-making related to policy and implementation.
  - Facilitate research on MARPs to improve prevention programs.
  - Research on drug use and HIV.
  - Disseminate lessons learned and best practices with respect to MARPs.
  - Development of regional peer education training materials for MSM and SW.
  - Training of providers to deal with MSM, SW, and other marginalised groups.
  - Support countries in developing HIV services for migrant populations.
- ◆ Addressing pregnant women and their families:
  - Technical assistance to countries in PMTCT and PMTCT Plus.
  - Dissemination of the regional PAHO/CAREC Guidelines for PMTCT.
  - Communication strategy for PMTCT in the Caribbean countries developed.

- ◆ Addressing PLHIV:
  - Research to increase understanding of constraining and facilitating factors for disclosure of HIV status
  - Collation and dissemination of best practices related to positive prevention methodologies for PLHIV.
  
- ◆ Addressing STIs:
  - Update guidelines for clinical management of STIs.
  - Support countries in their efforts to conduct training in STI management.
  
- ◆ Facilitate strengthening of HIV and STI surveillance at the country level.

**PRIORITY  
AREA  
4:**

**TREATMENT, CARE, AND SUPPORT**

Caribbean countries have made significant strides in providing treatment, care, and support services for PLHIV, but gaps still exist. The priority is to reach those PLHIV still in need of treatment and to improve the quality of treatment and adherence. The management of STIs, tuberculosis, and opportunistic infections will also be improved (see Priority Area 3). HIV services will be further decentralised and integrated within existing primary health care services, while the links between prevention and treatment services will be enhanced. Comprehensive care will include nutritional and psychosocial support as well as services for orphans and children made vulnerable by HIV and their families (see Priority Area 1).

*The following strategic objectives will be achieved through the CRSF:*

**STRATEGIC OBJECTIVES FOR NATIONAL HIV/AIDS RESPONSES**

- ◆ To increase access to treatment, care, and support services for persons living with HIV.
- ◆ To improve the management of tuberculosis (TB), opportunistic infections (OIs), and sexually transmitted infections (STIs) through early identification and treatment.
- ◆ To improve access to nutritional and psychosocial services for persons living with HIV.

**STRATEGIC OBJECTIVE 4.1: To increase access to treatment, care, and support services for persons living with HIV.**

*Expected national results:*

Universal access to antiretroviral (ARV) treatment and increased adherence to treatment and care achieved through:

- Increased access to treatment by expanding the number of treatment sites.
- Staff trained with updated HIV management protocols (see Priority Area 5).
- Laboratory research to support ARV treatment and monitoring available.
- Confidentiality for clients strengthened through national policies on privacy and confidentiality.
- Ongoing training of PLHIV and support groups in comprehensive self-care and prevention.
- Availability of drugs and other HIV commodities ensured (see Priority Area 5).
- Systems to monitor treatment and adherence established.
- Mechanisms for the prevention, monitoring, and surveillance of HIV drug resistance established.

**STRATEGIC OBJECTIVE 4.2: To improve management of tuberculosis (TB), opportunistic infections (OIs), and sexually transmitted infections (STIs) through early identification and treatment.**

*Expected national results:*

- All HIV infected persons are screened for TB and all patients with TB are screened for HIV.
- Improved diagnostic facilities for detecting TB, OIs, and STIs in place.
- Service providers trained in the management of TB, TB/HIV co-infection (see Priority Area 5), STIs, and OIs.
- PLHIV able to recognise the symptoms of TB, OIs, and STI and seek early treatment.
- Standardised case management of TB, OIs, and STIs in place.
- The availability of drugs for treating TB, OIs, and STIs ensured (see Priority Area 5).

**STRATEGIC OBJECTIVE 4.3: To improve access to nutritional and psychosocial services for persons living with HIV.**

*Expected national results:*

- Staff responsible for providing nutritional and psychosocial services trained with updated HIV management information (see Priority Area 5).
- Availability of nutritional supplements ensured.
- Referral systems to social support services established, including poverty alleviation interventions.
- Care and support for children made vulnerable by HIV addressed.

**INDICATORS:**

- Percentage of persons starting first-line ART who are still on ART 12 months later.
- Percentage of women, men, and children with advanced HIV infection receiving ART.
- Number and percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.
- Percentage of respondents reporting STI symptoms in the last 12 months who sought care at a service provider with personnel trained in STI care.
- Current school attendance among orphans and non-orphans aged 10-14 years.



*The regional public goods and services that will support the provision of treatment, care, and support at the country level are as follows:*

## REGIONAL PUBLIC GOODS AND SERVICES

- ◆ Provide technical assistance for training in HIV treatment, care, and support and for implementing programmes to manage HIV, TB, and STIs.
- ◆ Update and disseminate regional guidelines on HIV and TB treatment, care, and support.
- ◆ Develop an HIV training curriculum for regional educational institutions.
- ◆ Facilitate research on issues related to the treatment of HIV, TB, and STIs, with a view to improving service access and quality.
- ◆ Develop regional mechanisms for HIV pharmacovigilance and for the prevention, monitoring, and surveillance of HIV drug resistance.
- ◆ Facilitate the establishment of referral mechanisms to available social support services.
- ◆ Create a regional resource directory that maps service providers, technical expertise, and selected commodities to facilitate sharing across countries.
- ◆ Develop a regional procurement process for commodities and supplies to allow smaller countries to pool resources and benefit from economies of scale.

**PRIORITY  
AREA  
5:**

**CAPACITY DEVELOPMENT FOR HIV/AIDS SERVICES**

Many Caribbean countries have shortages of skilled human resources, significant weaknesses in health infrastructure, and limited social support systems that seriously constrain the implementation of a comprehensive response to the HIV epidemic. The need for capacity development in all sectors involved in the fight against HIV is a recurrent theme in the other Priority Areas of the CRSF. Expanding services in order to achieve universal access will require some infrastructural improvements and development of delivery systems in the health and social sectors to ensure the efficient delivery of quality services. This section highlights the need for human resources as well as infrastructural and systems development.

*Two strategic objectives have been defined for this Priority Area:*

**STRATEGIC OBJECTIVES FOR NATIONAL HIV RESPONSES**

- ◆ To train relevant workers in all sectors to provide HIV prevention, treatment, care, and support services.
- ◆ To strengthen health and social systems and improve infrastructure to provide comprehensive and integrated HIV services.

**STRATEGIC OBJECTIVE 5.1: To train relevant workers in all sectors to provide HIV prevention, treatment, care, and support services.**

*Expected national results:*

- Human resource needs assessment for the provision of HIV services carried out.
- Pre-service HIV training curricula for professionals in all sectors are developed and introduced.
- In-service training is provided to ensure adequate numbers of health workers are trained in required diagnostic and clinical management skills.
- Training programmes provided for relevant workers in all sectors to ensure gender-sensitive and non-discriminatory HIV services to the public.
- Specific training programs developed in HIV prevention, especially for persons working with most-at-risk populations and youth.
- HIV programmes and plans are gender-sensitive (see Priority Area 1).
- Appropriate persons trained in HIV programme management, monitoring, evaluation, and other specialised skills needed to achieve universal access.

**STRATEGIC OBJECTIVE 5.2: To strengthen health and social systems and improve infrastructure to provide comprehensive and integrated HIV services.**

*Expected national results:*

- Strong national leadership of HIV Programme in place in all countries.
- Vertically managed HIV services integrated into the existing primary health care delivery systems.
- Infrastructure improved to facilitate the delivery of HIV services of an acceptable standard.
- Surveillance, monitoring, and evaluation; management information systems, and research capacity strengthened.
- Laboratory services for diagnosis, clinical staging, and monitoring treatment outcomes accessible.
- Human resources management system established and functioning, securing appropriate staffing for the provision of HIV services.
- Quality assurance systems for HIV services established and functioning.
- Effective systems for the management and regulation of strategic public health supplies including HIV medicines, diagnostics, and other commodities are operational.
- Safe blood supply ensured and maintained through careful donor screening.
- Infection control and access to post-exposure prophylaxis (PEP) for workers accidentally exposed in health care settings ensured.
- Strengthened referral systems and networks of social agencies and organisations to facilitate access for PLHIV and others in need to social support programmes.
- Improved capacity of social support organisations including poverty alleviation interventions such as income generation projects.

**INDICATORS:**

- Number of countries that have integrated HIV services into primary health care services.
- Number of persons trained by client and service area.

*The regional public goods and services that will support the capacity development for HIV services at the country level are the following:*

## REGIONAL PUBLIC GOODS AND SERVICES

- ◆ Supporting implementation of HIV-related training at the national level.
- ◆ Supporting national human resources development through the inclusion of appropriate courses in all pre-service training programmes:
  - Development of guidelines for carrying out national human resource needs assessment, with a view to providing comprehensive HIV services.
  - Development of HIV training curricula for pre- and in-service HIV education.
  - Technical assistance for the delivery of training for persons providing HIV services.
- ◆ Strengthening national systems:
  - Facilitating countries receiving technical assistance and additional resources to strengthen surveillance, monitoring, and evaluation and management information systems.
  - Guidelines, tools, and support for decentralisation and integration of HIV services into existing systems.
  - Technical assistance for countries to support implementation of service delivery models which promote decentralisation, integration, and task shifting (TB, STIs, mother and child health, gender, mental health, primary care, chronic disease).
  - Normative guidelines for comprehensive HIV services, including quality assurance systems.
  - Assistance to countries in accessing quality laboratory services for HIV, STI, and TB management, including diagnosis, care, monitoring, and treatment.
  - Operational research and assessment of new technologies and algorithms for laboratory services and support for their implementation in countries.
  - Drafting and dissemination of regional guidelines for quality-assured blood collection and use.
- ◆ The coordination of regional efforts for the production, joint procurement, and common quality control systems for HIV commodities.

Monitoring and evaluation (M&E) systems are inadequate in many Caribbean countries. This has resulted in empirical use of interventions without evidence of their effectiveness and a limited understanding of the HIV epidemic in the region. Monitoring, evaluation, and research will provide information for decision-making, increase understanding of the factors that drive the HIV epidemic, and strengthen advocacy efforts for resources from national and international agencies. A regional research agenda will be developed, research capacity strengthened, and HIV-related research facilitated. Research findings will be disseminated throughout the region to ensure that the lessons from each country can be used to guide policy development and programme design.

Caribbean countries will also commit themselves to collecting data on a minimum set of Core Caribbean HIV indicators (CCHI), appropriately disaggregated by sex and age, to track progress in implementing this CRSF.

*The following strategic objectives will be achieved through the CRSF:*

### STRATEGIC OBJECTIVES FOR NATIONAL HIV RESPONSES

- ◆ To track progress in the implementation of national HIV responses and of the CRSF.
- ◆ To develop appropriate evidence-based policies, practices, and interventions through the use of research findings and M&E data.

**STRATEGIC OBJECTIVE 6.1: To track progress in the implementation of national responses and of the CRSF.**

*Expected national results:*

- M&E plan implemented with timely and reliable data on key indicators produced.
- HIV surveillance system established.
- HIV data analysed and utilised to provide information for management of programmes.
- Generation of reports and other useful products for stakeholders.

**STRATEGIC OBJECTIVE 6.2:** To develop appropriate evidence-based policies, practices, and interventions through the use of research findings and M&E data.

*Expected national results:*

- Country policy-making, programme design, and planning based on international best practices and research findings, including epidemiological, behavioural, economic, operational, and innovative research.
- Countries utilise research and programme data in their HIV advocacy efforts.
- Research results, lessons learned, and databases on HIV from Caribbean countries and other regions compiled and disseminated at the national level.
- National research agenda developed and surveys conducted.

**INDICATORS:**

National HIV monitoring & evaluation plan linked to national strategic plan and addressing its objectives is developed.

*The regional public goods and services that will support monitoring, evaluation, and research efforts at the country level are as follows:*

**REGIONAL PUBLIC GOODS AND SERVICES**

- ◆ Providing support to develop and implement national M&E plans:
  - Technical and financial support, including templates and guidelines, for collecting data on indicators such as the *Core Caribbean HIV and AIDS Indicators*.
  - Develop national capacity to analyse data and use it in policy and programme development.
  - Provision of technical and financial support, where appropriate, for multi-country special studies including KABP, BSS, and studies involving MARP.
- ◆ Providing research information to inform national policy and programme development:
  - Disseminate international best practices regarding HIV services.
  - Develop and implement a regional research agenda.
  - Develop mechanisms to support countries in implementing the research agenda and incorporating research results into policies and programmes.
  - Develop databases with M&E data for use in advocacy efforts at the national, regional, and international levels.
  - Promote the use of existing forums to disseminate research results throughout the region.

# 7 MONITORING AND EVALUATION THROUGH CORE CARIBBEAN INDICATORS

Monitoring and evaluation of the implementation of this Caribbean Regional Strategic Framework is a regional priority and will be done by tracking a core set of indicators. Caribbean countries will commit to collecting a minimum data set of the Caribbean Core HIV/AIDS indicators, appropriately disaggregated by sex and age, to enable gender analysis. As part of the CRSF, regional agencies will work with PANCAP Member Countries to develop plans to support the countries in building capacity to collect data for these indicators or, where a multi-country survey approach is more suitable, assisting in their collection. The capacity of countries will be strengthened in analysis, data utilisation, and research.

There are three levels of indicators:

**Impact indicators** will measure the degree to which CRSF goals have been achieved and the

These indicators are summarised below.

overall success of country and regional programmes and interventions.

- **Outcome indicators** will measure achievements in the strategic objectives of the six priority areas. The proposed *Core Caribbean HIV/AIDS Indicators (CCHAI)* include many indicators required for country reporting to UNGASS,<sup>18</sup> and PANCAP Member Countries are asked to commit to the collection of these indicators.
- **Activity indicators** will measure the delivery of the regional public goods and services of the CRSF (see Annex 2). The regular monitoring and follow-up of the degree of achievement of these indicators will be the mechanism to monitor the performance of the CRSF itself.

## Monitoring and evaluation of the PANCAP goals

GOAL	INDICATOR
To reduce the estimated number of new HIV infections by 25%.	Percentage of persons aged 15 – 49 years infected with HIV in the last year <i>Target: Reduced by 25% between 2008 and 2012.</i>
To reduce mortality due to HIV.	Percentage of persons aged 15 – 49 years with AIDS that died in the last year <i>Target: Reduced by 25% between 2008 and 2012.</i>
To reduce the social and economic impact of HIV and AIDS on households.	Household expenditure on HIV and AIDS. <i>Target: 25%</i>

<sup>18</sup> UNGASS numbers relate to the indicator numbers as set out in the UNGASS Guidelines on Construction of Core Indicators: 2008 Reporting.



**Monitoring and evaluation of Implementation of CRSF  
through Core Caribbean HIV/AIDS Indicators (CCHAI)**

	Indicator	Data Collection	Measurement Tool
<b>Enabling Environment</b>			
1.	National Composite Index	Every 2 years	Desk review and key informant interviews
<b>Multisectoral Response</b>			
2.	Domestic and international AIDS spending by categories and financing sources. ( <i>UNGASS requirement.</i> )	Ad hoc	National AIDS spending or financial resource flow surveys
3.	Number of countries that have integrated HIV policies, programmes, and services into education and tourism sectors. ( <i>Not an UNGASS requirement.</i> )	Annual	Programme monitoring
4.	Percentage of registered enterprises/companies and public sector institutions which have HIV/AIDS workplace policies and programmes. ( <i>Not an UNGASS requirement.</i> )	Every 2 years	Workplace survey
5.	Percentage of schools that provided life skills-based HIV education in the last academic year. ( <i>UNGASS requirement.</i> )	Every 2 years	School-based survey
<b>Prevention</b>			
6.	Percentage of young people aged 15-24 years and other at-risk populations (MSM, SW) who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. ( <i>UNGASS requirement.</i> )	Every 4-5 years Every 2 years	Population-based surveys (youth) Behavioural surveys (MARP)
7.	Percentage of youth aged 15-24 years and most-at-risk populations [MSM, SW], who received HIV testing in the last twelve months and who know the results. ( <i>UNGASS requirement.</i> )	Every 4-5 years Every 2 years	Population-based surveys (youth) Behavioural surveys (MARP)
8.	Percentage of most-at-risk populations (MSM, SW, youth aged 15-24 years) reached with HIV prevention programmes. ( <i>UNGASS requirement.</i> )	Every 2 years	Behavioural surveys
9.	Percentage of women and men aged 15-49 years who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse. ( <i>UNGASS requirement.</i> )	Every 4-5 years	Population-based surveys (youth)

10.	Percentage of SW reporting condom use at last sex with a client. <i>(UNGASS requirement)</i>	Every 2 years	Behavioural surveys
11.	Percentage of men reporting condom use the last time they had anal sex with a male partner. <i>(UNGASS requirement)</i>	Every 2 years	Behavioural surveys
<b>Indicator</b>		<b>Data Collection</b>	<b>Measurement tool</b>
<b>Prevention</b>			
12.	Number and percentage of HIV-positive pregnant women receiving a complete course of ART prophylaxis to reduce the risk of mother-to-child transmission. <i>(UNGASS requirement.)</i>	Annual	Programme monitoring and estimates
13.	Percentage of infants with HIV born to HIV-infected mothers. <i>(UNGASS requirement.)</i>	Annual	Programme monitoring or estimate
14.	Percentage of young people aged 15-24 years infected with HIV. <i>(UNGASS requirement.)</i>	Annual	Sentinel surveillance
<b>Treatment, Care, and Support</b>			
15.	Number and percentage of women, men, and children with advanced HIV infection receiving antiretroviral therapy. <i>(UNGASS requirement.)</i>	Annual	Programme monitoring and estimates
16.	Number and percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV. <i>(UNGASS requirement.)</i>	Annual	Programme monitoring
17.	Number and percentage of persons starting first-line ART still on ART after 12 months. <i>(UNGASS requirement)</i>	Every 2 years	Programme monitoring
<b>Capacity Development</b>			
18.	No. of persons trained by client and service area. <i>(Not an UNGASS requirement.)</i>	Annual	Programme monitoring
<b>Monitoring &amp; Evaluation</b>			
19.	National HIV M&E plan linked to national strategic plan and addressing its objectives is developed. <i>(Not an UNGASS requirement.)</i>		Country report

### **Monitoring and evaluation of the performance of the regional support**

In addition to the above indicators, a number of activity indicators will monitor the delivery of regional public goods and services by regional support agencies for each priority area. These indicators will be reviewed on a regular basis in order for PANCAP to supervise the effective implementation of the CRSF (Section 8.2).

Indicator		Frequency of Collection	Measurement Tool
1	Number of model policies developed by RSAs	Annually	Program monitoring
2	Number of persons trained through regional initiatives by service area (per country)	Annually	Program monitoring
3	Number of countries receiving technical assistance by service area	Annually	Program monitoring
4	Number of research projects initiated at the regional level	Annually	Program monitoring
5	Number of model programs developed by RSAs	Annually	Program monitoring

# 8 COORDINATING AND MONITORING MECHANISMS

## 8.1 Coordinating implementation of the CRSF

Coordination of HIV programmes takes place at two levels:

1. At the *country level*, this will be undertaken by the national authorities in each country.
2. At the *regional level*, this will be undertaken through the coordination of support provided to the individual countries by regional support agencies to ensure support is available when required by the country and to avoid duplication when regional agencies provide similar types of assistance to countries.

The following discussion outlines the mechanism within PANCAP for coordinating regional support to country programmes.

Coordination of regional support interventions is undertaken through preparation of coordinated regional plans for each Priority Area. The **Priority Areas Coordinating Committee (PACC)** is responsible for coordinating the planning of all agencies working in each Priority Area.

A number of other *Regional Support Agencies*<sup>19</sup> (RSAs) provide support to country programmes within each Priority Area through a list of regional public goods and services (see Section 6).

The **PANCAP Coordinating Unit** will provide secretariat support to the PACC.

### Priority Areas Coordinating Committee

The role of the Priority Areas Coordinating Committee is:

- To coordinate the annual planning of all Regional Support Agencies within each Priority Area;
- To coordinate and monitor implementation of planned interventions, keep track of overall progress, and evaluate the progress and impact on a regular basis.
- These responsibilities are carried out through quarterly planning and monitoring meetings.

### PANCAP Coordinating Unit (PCU)

The PCU will have three distinct roles in the implementation of the CRSF 2008-2012:

#### A role as PANCAP Secretariat

As the body responsible for supporting and coordinating the organs of PANCAP (the Annual General Meeting, the Regional Coordinating Mechanism, the Priority Areas Coordinating Committee, and any necessary technical working groups), the PCU has the following roles:

- Organisational, administrative, and financial support to PANCAP meetings;
- Support the PACC in the coordination of regional Priority Area plans with agreed regional intervention indicators;
- Receiving and collating regional intervention indicators into a (bi-) annual regional programme performance report to the PANCAP Regional Coordinating Mechanism and Annual General Meeting, respectively;
- Contracting an independent agency to perform periodic external technical audits on the regional programme; and

<sup>19</sup> Annex 1 makes reference to the websites of some of the potential Regional Support Agencies.

- Resource mobilisation on behalf of PANCAP and its members.

#### A role as a Support Agency

The PCU will retain a role in undertaking some regional interventions. These will include its current role as a repository of information on national and regional activities to enable sharing of lessons learned and dissemination of best practices. It will also continue to have a role in advocacy across the Caribbean region and in promoting the multisectoral approach to respond to the HIV epidemic.

#### A role as Financing Agent

The PCU, in liaison with the CARICOM Secretariat, is currently the fund holder for donor partner funds (e.g., World Bank, Global Fund), granting these to regional support agencies to undertake the agreed activities. The coordinating and reporting responsibilities for any donor funds granted for the new Framework on a similar basis will be undertaken by the PANCAP Coordinating Unit, acting as the financing agent.

## 8.2 Monitoring and evaluating the CRSF

The highest PANCAP governing bodies are the **Annual General Meeting (AGM)** and the **Regional Coordinating Mechanism (RCM)**. The RCM, on behalf of the AGM, will ensure the monitoring and evaluation of achievements towards universal access to prevention, treatment, care, and support and the positive impact of CRSF interventions on reversing the spread of HIV in the Caribbean.

#### PANCAP Annual General Meeting

The Pan Caribbean Partnership on HIV/AIDS has open membership to all governments and (national, regional, and international) organisations involved in the Caribbean response to HIV, united through the signing of the Partnership Commitment. There are currently more than eighty organisations considered as members of PANCAP.

The principal formal expression of PANCAP is through the Annual General Meeting of members. The stated role of PANCAP's AGM<sup>20</sup> is to:

- Provide overall guidance and policy direction for the work of PANCAP;
- Monitor the progress of HIV interventions executed at both the regional and national levels;
- Advocate for advancement of PANCAP ideals within and between sectors; and
- Support the mobilisation of resources for a scaled-up response to the HIV epidemic.

The AGM acts as the forum for the accountability of PANCAP Member Countries, the designated regional support agencies, and partners in the implementation of the Caribbean response to HIV. It also acts as the annual forum for information exchange and networking.

#### PANCAP Regional Coordinating Mechanism

The Regional Coordinating Mechanism has the following responsibilities:<sup>21</sup>

- Provide policy guidance on the effective management and operation of PANCAP;
- Advise on the implementation, monitoring, and evaluation of the CRSF on HIV and

<sup>20</sup> Drawn from PANCAP (2006), Structure and Governance Arrangement, June 2006.

<sup>21</sup> Drawn from PANCAP (2006); see footnote 22.

other related initiatives that may emerge from time to time;

- Monitor adherence of partners to the approved strategic priorities of PANCAP and direct the implementation of its work programme;
- Review the work plans and technical reports of core partners in relation to the implementation of the CRSF on HIV and other initiatives approved by PANCAP; and
- Approve and direct all projects to be executed under the aegis of PANCAP.

The RCM acts as PANCAP's board of directors, providing strategic direction to the organisation on behalf of the PANCAP membership and is responsible for monitoring, on behalf of the AGM, the performance in each Priority Area. It presents annual reports for each Priority Area to the AGM. This PANCAP body also provides management direction to the PCU. The PACC (Section 8.1) acts as a sub-committee of the RCM.

A need for occasional ad hoc technical working groups is anticipated to support the RCM in investigating specific issues as they arise.

### 8.3 Defining lines of accountability

In order to achieve universal access to prevention, treatment, care, and support, PANCAP commits its members to join forces to scale up the regional response to HIV, and to increase accountability for the delivery of agreed interventions under this Framework and its resulting work plans. The **technical accountability** requested from the various partners is listed below.

#### Country HIV Authorities

- Country HIV authorities are responsible to their national governments for the performance of the national HIV programmes.
- Country HIV authorities are accountable to their external partners for the activities they fund.
- Country HIV authorities are accountable to PANCAP for achieving the agreed goals and core Caribbean indicators defined in the CRSF.

#### Regional Support Agencies (RSAs)

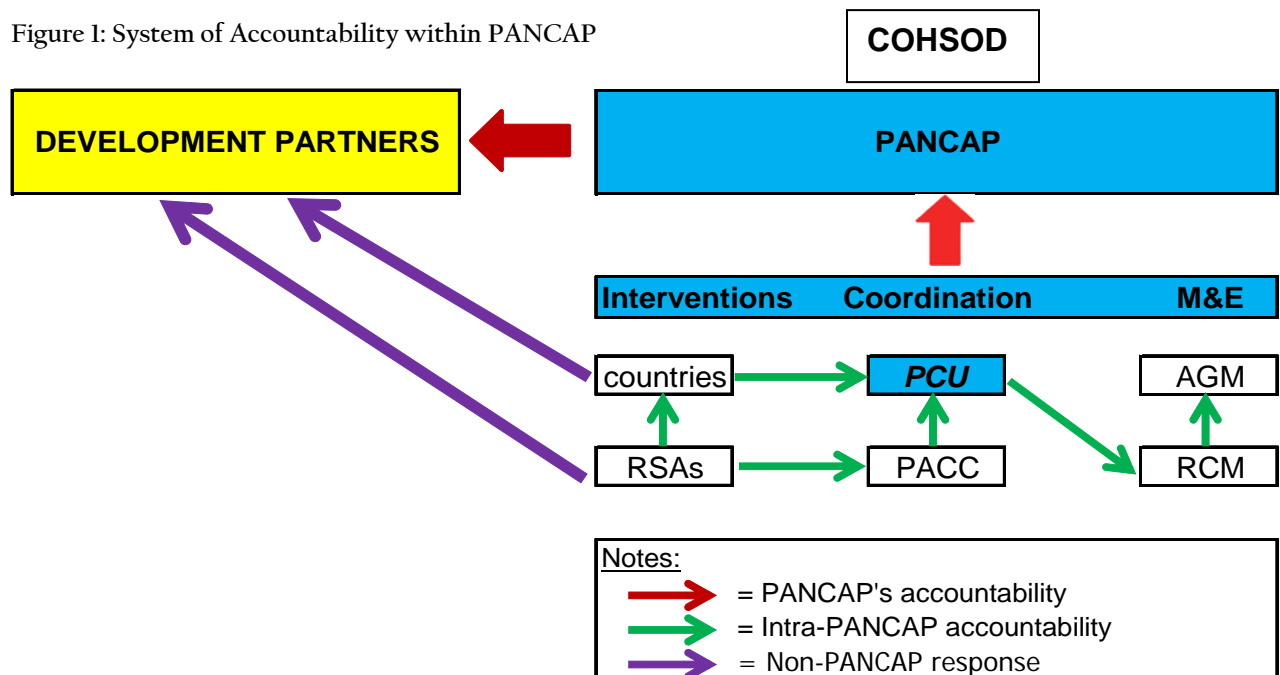
- RSAs are accountable to countries for providing the regional public goods and services agreed in annual work plans.
- RSAs are accountable to PANCAP for the provision of the regional public goods and services as agreed in the annual work plans for each Priority Area.

#### PANCAP bodies

- The Priority Areas Coordinating Committee (PACC) is responsible to the PANCAP Regional Coordinating Mechanism (RCM) for coordinating the planning and implementation of all regional supporting interventions in the six Priority Areas.
- PCU is responsible to the PANCAP RCM for the coordination of reporting on the deliverables and outputs described in the annual work plans.
- The PANCAP RCM is responsible to PANCAP Annual General Meeting (AGM) for timely reporting on the progress and performance of the implementation of CRSF and progress made towards achieving goals and indicators.
- The PANCAP RCM, on behalf of the AGM, is accountable to the external partners for the deliverables they fund.

A system of accountability is envisaged as depicted in Figure 1.

Figure 1: System of Accountability within PANCAP



Through the Priority Area planning process in which the regional support agencies of each Priority Area develop annual work plans, a series of performance indicators will be agreed on for measuring the success of the implementation of the regional public goods and services. These indicators will be reported on by all support agencies and collated into bi-annual and annual reports to the RCM and PANCAP as a whole. Collation will be carried out by the PCU in its role as secretariat of the RCM.

In most cases, where support agencies are funded directly by external partners, they are likely to be required to provide separate technical reports to their funders in addition to reports required by PANCAP. However, where such work plans and reports submitted to PANCAP are sufficiently robust, individual funders may accept the reports to the PCU in

lieu of individual project reports; a strengthening of the “U.N. Three One’s” approach in the region.

Periodic external technical audits, undertaken by independent technical experts, of the performance of each Priority Area will be carried out as an independent check on internal reports.

In its role as financing agent, the PCU will continue to be responsible for reporting on both technical and financial aspects of each programme to the relevant donor. The reporting requirements to the donor might be different from the requirements for PANCAP, although every effort will be made to try to streamline reporting requirements in line with the “Three One’s” principle.



## 9 FINANCING MECHANISMS

The estimated total cost of the Caribbean Regional Strategic Framework 2008-2012 is on the order of US\$55 million (see Annex 3 for more details). This amount includes both the cost of (1) delivering the regional public goods and services to the Caribbean countries to complement their own responses to the HIV

epidemic, and (2) the coordination and monitoring responsibilities of PANCAP bodies. The cost of implementing the national responses has not been estimated as these are planned and budgeted for in the individual national strategic plans of all Caribbean countries.

Table 3: Estimated Costs of the Regional Component of the CRSF 2008-2012 (in US\$)

	Estimated Cost (US\$)
<b>1. Delivery of Regional Public Goods and Services by Priority Areas</b>	<b>45,719,850</b>
Priority Area 1. An enabling environment that fosters universal access to HIV prevention, treatment, care, and support services	6,337,300
Priority Area 2. An expanded and coordinated intersectoral response to the HIV epidemic	9,156,900
Priority Area 3. Prevention of HIV transmission	11,287,600
Priority Area 4. Treatment, care, and support	2,000,000
Priority Area 5. Capacity development for HIV services	9,208,050
Priority Area 6. Monitoring, evaluation, and research	7,730,000
<b>2. PANCAP Coordinating and Monitoring Bodies</b>	<b>8,027,360</b>
<b>3. Information, Education, and Communication Strategy to Support CRSF Implementation</b>	<b>2,000,000</b>
<b>Subtotal</b>	<b>55,747,210</b>
<b>3. Contingency (5% of subtotal)</b>	<b>2,787,360</b>
<b>Total</b>	<b>58,534,570</b>

The table above demonstrates the emphasis on prevention interventions, with Priority Area 3 accounting for the largest share (25%) of all costs. With the exception of Priority Area 4, all other priority areas each account for 15% to 20% of the total cost for the delivery of regional public goods and services. While treatment is primarily a responsibility for the individual countries, all other areas anticipate significant regional support.

The cost of the PANCAP bodies includes estimates of staff and operational costs for the

coordination of the Pan Caribbean Partnership through its coordinating (PCU, PACC) and monitoring (RCM, AGM) bodies. This cost includes provisions made for technical working group meetings and PANCAP delegations for high-level international missions. A contingency of 5% of total overall anticipated expenditures has been included.

Funds for the provision of the regional public goods and services and coordination and the monitoring of the Caribbean Regional Strategic Framework 2008-2012 will be mobilised

through PANCAP and are most likely to come from international bilateral and multilateral development organisations, as was the case for the first CRSF.

In their efforts to scale up their HIV response, Caribbean countries are highly dependent on national public and private financing sources, coming from their governments' consolidated budgets and household out-of-pocket expenditures. However, most Caribbean countries face problems in financing their own 5-year HIV programmes from these national financial resources in competition with demands from other essential national interventions (e.g., in education, infrastructure, environment, and social welfare). Therefore, they will continue to seek additional external funding to bridge their financing gap for the HIV response. PANCAP is committed to support the countries in their efforts to mobilise resources for the implementation of their national HIV programmes through high-level advocacy and dialogue with potential donors.

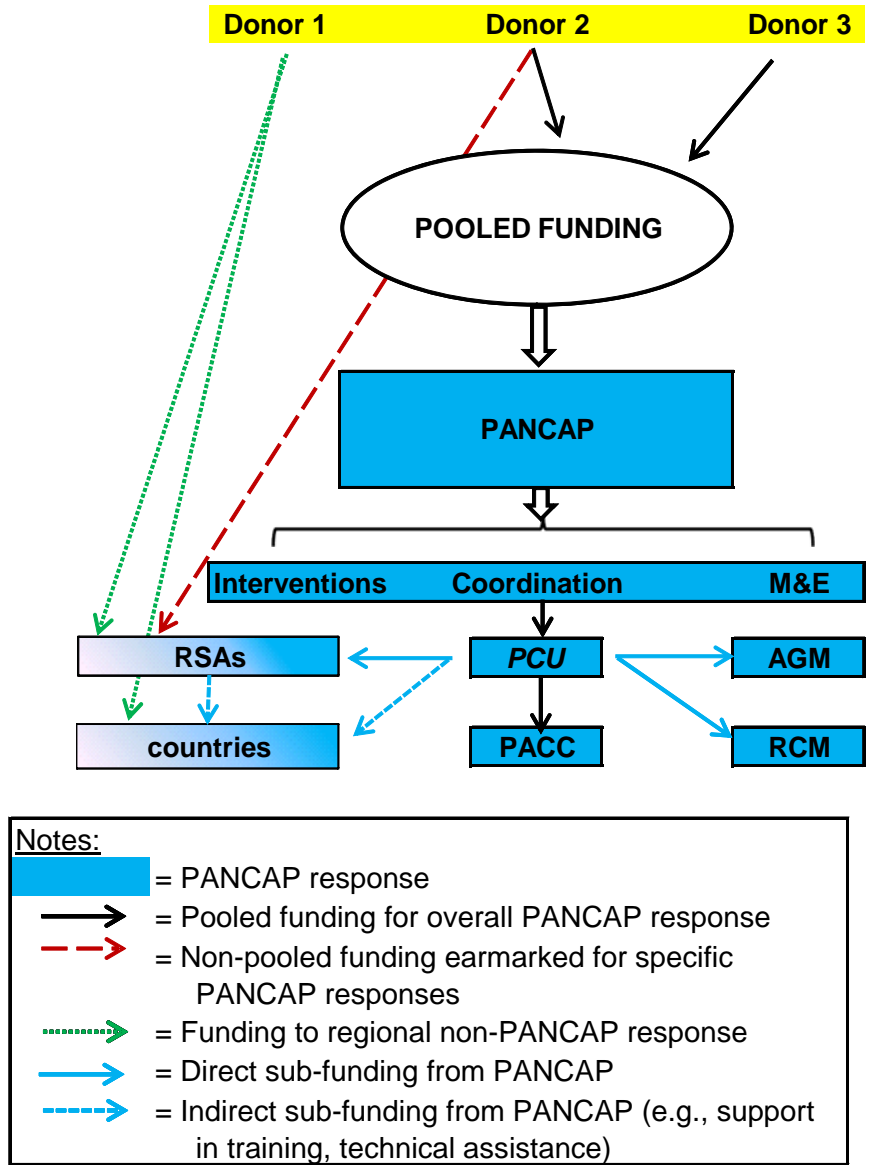
The way resources are mobilised, disbursed and spent has important effects on the operationalisation of the Caribbean Regional Strategic Framework. Under the CRSF 2002-2006, some international donors transferred funds to PANCAP, through the PCU, earmarked for specific priority areas. In addition there were direct transfers to a variety of regional institutions and to individual Caribbean countries. Further complications resulted from sub-granting, by some regional agencies, to transfer funds to recipients for interventions in selected countries. This resulted in a situation where different donors finance the Caribbean HIV response through a complicated web of transfers. Although this funding mechanism provides considerable freedom, the process is inefficient, resulting from the duplication of the various procurement, disbursement, reporting, and accountability procedures of the various donors.

In order to avoid these inefficiencies and in line with harmonisation and alignment efforts urged by the Paris Declaration on Aid Effectiveness, countries in other regions have worked with their international development partners to develop systems that enable a **pooling of funds** in a basket to finance an agreed programme of work. This financing mechanism is more efficient and transparent because all funds are pooled and managed by one financing agent, which, in PANCAP's case, would be the Regional Coordinating Mechanism. The RCM, based on agreements with funders, and with the PCU providing its secretariat, will be responsible for decisions on how funds are to be allocated on an annual basis over the three action categories (regional interventions, coordination, and monitoring) and, within the regional interventions the allocations between the six Priority Areas.

In order to allow some flexibility for donors that do not wish to pool their funds, preferring instead to earmark them for the PANCAP regional response as defined in this CRSF, direct non-pooled earmarked funding for specific regional responses or direct funding to the HIV plans and interventions of countries and regional supporting agencies remains possible (see Figure 2). Allocations from the pooled resources will need to take any earmarked funding into account when making resource allocation decisions, in order to avoid duplication of similar activities and thus a waste of resources.

This financing mechanism also allows donors to transfer funds to the funding pool and to earmark or ring-fence those funds for specific priority areas or regional support agencies. Other donors may be interested in funding PANCAP activities but not through the resource pool. In this case, their money would flow directly to a support agency for specific CRSF-related interventions.

Figure 4. Mixed, Pooled, and Earmarked Funding Mechanism for PANCAP/CRSF



The Caribbean countries are the ultimate beneficiaries of PANCAP funding, as they gain from the regional public goods and services that are provided to them by the regional support agencies.

Regional institutions active in the HIV response will continue to seek their own funding, but also receive (pooled or direct) funds through PANCAP to support the Caribbean countries to

achieve the goals of the CRSF by 2012. The RCM will manage and monitor the “value for money” contributed by these regional support agencies.

The PANCAP coordinating and monitoring bodies are likely to require funds from Caribbean governments (through CARICOM) in addition to the pooled or directly earmarked donor support.

All recipients of pooled funds will be accountable to PANCAP, following agreed common rules and procedures for accounting, procurement, and reporting. In turn, PANCAP will be accountable to the donors that have pooled their funds in the PANCAP basket. An annual external audit of the performance of the regional support agencies and PANCAP coordinating and monitoring will be required and will be financed from PANCAP funds.

### Country Resource Needs

All Caribbean countries have significant resource needs with respect to implementing their HIV strategic plans. Table 3 provides only the estimated cost of the regional component of

the CRSF, namely the cost of delivering the regional public goods and services and the coordination and monitoring responsibilities of PANCAP bodies.

While all Caribbean countries have HIV strategic plans only a few countries have actually determined their costs and are in a position to identify the gap in their funding needs. This shortcoming needs to be addressed so that all the countries estimate the cost of their strategic plans. Once this is done, it will be possible to identify the funding gap for each country and for the region as a whole.



# 10 ANNEXES

## Annex I. List of International and Regional Agencies Active in the Caribbean

### Caribbean Agencies

Caribbean Community (CARICOM): [www.caricom.org](http://www.caricom.org)

Caribbean Association of Industry and Commerce (CAIC): [www.caic.org.tt](http://www.caic.org.tt)

Caribbean Broadcast Media Partnership on HIV/AIDS (CBMP): [www.cbmphiv.org](http://www.cbmphiv.org)

Caribbean Coalition of National AIDS Programme Coordinators (CCNAPC): [www.ccnapc.org](http://www.ccnapc.org)

Caribbean Conference of Churches (CCC): [www.ccc-caribe.org](http://www.ccc-caribe.org)

Caribbean Regional Network of People Living with HIV/AIDS (CRN+): [www.crnplus.org](http://www.crnplus.org)

Caribbean Vulnerable Communities Coalition (CVC): [www.cvccoalition.org](http://www.cvccoalition.org)

PANCAP (Pan Caribbean Partnership on HIV/AIDS): [www.pancap.org](http://www.pancap.org)

### Regional Health Organisations

Caribbean Epidemiology Centre (CAREC): [www.carec.org](http://www.carec.org)

Caribbean Health Research Council (CHRC): [www.chrc-caribbean.org](http://www.chrc-caribbean.org)

Pan American Health Organisation (PAHO): [www.paho.org](http://www.paho.org) & [www.cpc.paho.org](http://www.cpc.paho.org)

University of the West Indies (UWI):

Caribbean HIV/AIDS Regional Training (CHART): [www.chartcaribbean.org](http://www.chartcaribbean.org)

Health Economics Unit (HEU): [sta.uwi.edu/FSS/centre/heu.asp](http://sta.uwi.edu/FSS/centre/heu.asp)

HIV/AIDS Response Programme (HARP): [www.uwiharp.uwi.edu](http://www.uwiharp.uwi.edu)

### Development Agencies

Canadian International Development Agency (CIDA): [www.acdi-cida.gc.ca/index-e.htm](http://www.acdi-cida.gc.ca/index-e.htm)

Department for International Development of the United Kingdom (DfID): [www.dfid.gov.uk](http://www.dfid.gov.uk)

European Union (EU): [ec.europa.eu/europeaid/index\\_en.htm](http://ec.europa.eu/europeaid/index_en.htm)

Germany - Gesellschaft für Technische Zusammenarbeit (GTZ) & Kreditanstalt für Wiederaufbau (KfW):

[www.gtz.de/en](http://www.gtz.de/en) & [www.kfw-entwicklungsbank.de/EN/Home/index.jsp](http://www.kfw-entwicklungsbank.de/EN/Home/index.jsp)

Inter-American Development Bank (IDB): [www.iadb.org](http://www.iadb.org)

United States Agency for International Development (USAID): [www.usaid.gov](http://www.usaid.gov)

World Bank (WB): [www.worldbank.org](http://www.worldbank.org)

### United Nations Agencies

International Labour Organisation (ILO): [www.ilocarib.org.tt](http://www.ilocarib.org.tt)

Joint United Nations Programme on HIV/AIDS (UNAIDS): [www.unaids.org](http://www.unaids.org)

United Nations Children's Fund (UNICEF): [www.unicef.org](http://www.unicef.org)

United Nations Development Fund for Women (UNIFEM): [www.unifemcar.org](http://www.unifemcar.org)

United Nations Educational, Scientific and Cultural Organisation (UNESCO): [www.unesco.org](http://www.unesco.org)

United Nations Office on Drugs and Crime: [www.unodc.org](http://www.unodc.org)

United Nations Population Fund (UNFPA): [www.unfpa.org](http://www.unfpa.org)

### **International Collaborating Agencies**

U.S. Centers for Disease Control and Prevention (CDC): [www.cdc.gov](http://www.cdc.gov)

Clinton Foundation: [www.clintonfoundation.org](http://www.clintonfoundation.org)

Constella Futures: [www.constellagroup.com](http://www.constellagroup.com)

Education Development Centre (EDC): [www.edc.org](http://www.edc.org)

International Federation of Red Cross and Red Crescent Societies (IFRC): [www.ifrc.org](http://www.ifrc.org)

International HIV/AIDS Alliance (IHAA): [www.aidsalliance.org](http://www.aidsalliance.org)

Population Services International (PSI): [http://www.psi.org/where we work/caribbean.html](http://www.psi.org/where_we_work/caribbean.html)

## Annex 2. Caribbean Regional Strategic Framework Matrix

STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATOR
<b>Priority Area 1. An enabling environment that fosters universal access to HIV and AIDS prevention, treatment, care, and support</b>			
<i>CCHAI 17. National Composite Policy Index</i>			
SO 1.1. To develop policies, programmes, and legislation that promote human rights, including gender equality, and to reduce socio-cultural barriers with a view to achieving universal access.	ER 1.1.1. Caribbean countries have legislation that addresses issues related to the legal, ethical, and human rights of those infected with, or affected by, HIV.	RPGS 1.A. Development of and advocacy for adoption of model policies and legislation for social protection and improved access to prevention and treatment services (for most-at-risk populations and vulnerable groups including minors).  RPGS 1.B. Advocacy for regional policies addressing migration issues relating to HIV.  RPGS 1.C. Technical assistance to increase country capacity to conduct gender analysis and sensitivity:  1.D.1. Conduct research on social, legal, and economic factors, including gender power relations, that increase vulnerability of women and men to HIV;  1.D.2. Design and implementation of pilot projects to test interventions to reduce the vulnerabilities of men and women and roll out region-wide if successful.	National Composite Policy Index, covering the areas of gender, stigma and discrimination, and human rights.
	ER 1.1.2. Caribbean countries have policies and systems that ensure all residents have access to HIV services including HIV policies to ensure condom access and provision of services to minors and most-at-risk populations.		
	ER 1.1.3. Formative research utilised to design strategies and programs that empower men and women to be less vulnerable to infection and more able to access services.		
	ER 1.1.4. Integration of gender equality into national and regional HIV responses.		
	ER 1.1.5. Persons providing HIV services (e.g., health workers, teachers, and social workers) are supported to implement best practice guidelines.		
	ER 1.1.6. Increased participation of vulnerable groups in the response to HIV.		
SO 1.2. To reduce stigma and discrimination associated with HIV and vulnerable groups.	ER 1.2.1. Working in partnership with PLHIV and other vulnerable groups, National AIDS Commissions, and civil society, public and private sector groups enabled to develop, implement, and monitor national programs to tackle stigma and discrimination.	RPGS 1.D. Establishment of a regional Stigma and Discrimination (S&D) Unit that: <ul style="list-style-type: none"> <li>▪ 1.C.1. Provides technical assistance for country programs addressing S&amp;D;</li> <li>▪ 1.C.2. Develops model policy and legislation addressing issues related to legal and human rights of PLHIV;</li> <li>▪ 1.C.3. Supports countries with operational research on S&amp;D, with a strong gender focus;</li> <li>▪ 1.C.4. Disseminates best practices and tested methodologies on reducing S&amp;D; and</li> <li>▪ 1.C.5. Advocates at the regional level on HIV and related human rights issues.</li> </ul> RPGS 1.E. Socio-economic impact studies, cost-effectiveness studies, and national HIV spending assessments conducted to inform governments on appropriate HIV-related policies and programmes.	
	ER 1.2.2. Advocacy on HIV and related human rights issues by national opinion leaders.		
SO 1.3. To reduce the economic and social vulnerability of PLHIV households	ER 1.3.1. Baseline studies of PLHIV and their families to inform the development of programmes to mitigate the social, psychological, and economic impact of HIV at the community level.		
	ER 1.3.2. Poverty reduction programmes have policies and interventions to reduce the social and economic impact of HIV on PLHIV households.		
	ER 1.3.3. Programmes developed to reduce the vulnerability of children orphaned due to AIDS and to support children living with HIV (e.g., through increased social, financial and legal support).		



STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATORS
<b>Priority Area 2. An expanded and coordinated intersectoral response to the HIV epidemic</b>			
<p>CCHAI 2. Domestic and international AIDS spending by categories and financing sources.</p> <p>CCHAI 1. National Composite Policy Index (areas covered: workplace programmes, and civil society involvement).</p> <p>CCHAI 4. Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year.</p> <p>CCHAI 3. Number of countries that have integrated HIV policies, programmes, and services into education and tourism sectors.</p> <p>CCHAI 4. Percentage of registered enterprises/companies and public sector institutions that have HIV/AIDS workplace policies and programmes.</p>			
SO 2.1. To enhance, in all Caribbean countries, the ownership of national HIV programmes and the responsibility for driving the response to the epidemic.	ER 2.1.1. Political, non-partisan commitment for national HIV programmes encouraged.	<p>RPGS 2.A. Collaboration on HIV in the Caribbean, including the overseas territories and countries, fostered through the support activities of regional organisations in order to ensure the equitable development of HIV programmes across the Caribbean.</p> <p>RPGS 2.B. Methodologies for the elaboration of 5-year national HIV strategic plans and their corresponding annual implementation plans and budgets.</p> <p>RPGS 2.C. Documentation and dissemination of best practices and lessons learned around coordinated multisectoral actions for the HIV response.</p> <p>RPGS 2.D. Draft and dissemination of regional model policies for the education and tourism sectors.</p> <p>RPGS 2.E. Advocacy for the adoption and support for implementation of the ILO/UNESCO workplace policy.</p> <p>RPGS 2.F. Systematisation and dissemination of HFLE experience in the region.</p> <p>RPGS 2.G. Promotion of regional agreements with tourism operators, hotel chains, etc., on the identification and implementation of HIV prevention activities.</p> <p>RPGS 2.H. Research on the impact of HIV and AIDS on the workplace in key sectors (e.g., health, education, agriculture, tourism) as well as on factors that influence the development and implementation of HIV workplace policies and programmes.</p> <p>RPGS 2.I. Support the development of inter-country networks of MARPs.</p>	<ul style="list-style-type: none"> <li>▪ Domestic and international AIDS spending by categories and financing sources.</li> <li>▪ National Composite Policy Index (areas covered: workplace programmes, civil society involvement).</li> <li>▪ Percentage of schools that provided life skills-based HIV education in the last academic year.</li> <li>▪ Number of countries that have integrated HIV policies, programmes, and services in education and tourism sectors.</li> <li>▪ Percentage of enterprises/companies and public sector institutions with HIV workplace policies and programmes in place.</li> </ul>
	ER 2.1.2. National financial contributions to HIV programmes increased.		
	ER 2.1.3. National HIV programmes operationalised in accord with the “Three One’s” principle.		
SO 2.2. To establish a well coordinated intersectoral response, facilitating meaningful and informed involvement of a wider range of partners, including key government ministries, NGOs, CBOs, FBOs, PLHIV networks and the private sector.	ER 2.2.1. Strengthened national HIV intersectoral coordinating mechanisms (staff, management and implementation procedures, information sharing, decision-making and accountability) established to include all relevant public and private sector partners.		
	ER 2.2.2. Capacity developed within each sector to effectively participate in the national planning process and to develop and integrate HIV into the programmes and services offered by key ministries, including the identification of focal persons or units responsible for the HIV response in each sector.		
SO 2.3. To maximise the resources of the education sector to promote and protect the health of students and staff and to mitigate against the impact of HIV on the education system itself.	ER 2.3.1. Caribbean countries have introduced overarching education sector HIV policies.		
	ER 2.3.2. HIV and AIDS public education and awareness activities targeting the school community implemented.		
	ER 2.3.3. Access has been secured to youth-friendly services (reproductive health, mental health, nutrition services) for peer educators and sexually-active students.		
	ER 2.3.4. Curriculum development and education programmes based on effective strategies for behaviour change, skills development, and participatory learning, all set in the context of health promotion for responsible lifestyles, have been developed.		
	ER 2.3.5. All primary, secondary, and tertiary level students participate in well-designed and gender-sensitive health and family life skills and HIV/STI prevention education programmes.		
SO 2.4. To scale up the HIV	ER 2.4.1. Caribbean countries have adopted and		

STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATORS
<b>Priority Area 2. An expanded and coordinated intersectoral response to the HIV epidemic</b>			
response throughout the tourism sector.	<p>implemented HIV workplace policies in the tourism sector.</p> <p>ER 2.4.2. Educational programmes to raise awareness and improve prevention throughout the tourism sector have been developed and implemented (See Priority Area 3).</p>	<p>RPGS 2.J. Building and strengthening the capacity of NGOs, CBOs, FBOs, and networks to work with national organisations in areas related to organisational development, leadership, advocacy and HIV/AIDS programming with emphasis on prevention.</p> <p>RPGS 2.K. Development of a database for NGOs, CBOs, and FBOs working on HIV/AIDS to be accessible through the PANCAP website.</p> <p>RPGS 2.L. Regional advocacy for more private sector involvement in the HIV response.</p>	
SO 2.5. To mobilise and support key national public and private sector employers and unions to assess HIV workplace issues and to introduce comprehensive workplace programmes.	ER 2.5.1. Workplace policies and programmes have been adopted, disseminated, implemented, and their results documented.		
SO 2.6. To facilitate further involvement of PLHIV, civil society organisations, non-governmental organisations, community-based organisations, and faith-based organisations in the HIV response.	<p>ER 2.6.1. People with AIDS, and other key populations at high risk empowered and supported to form country level support groups and networks and become advocates for their own needs (GIPA).</p> <p>ER 2.6.2. Strengthened capacity of NGOs, CBOs, and FBOs, including national and inter-country networks of MSM, SW and other MARPs to be involved actively in the HIV response (see SO 3.3).</p> <p>ER 2.6.3. Caregiver networks, support groups, and agencies likely to provide social welfare services identified and the necessary support established.</p>		

STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATORS
<b>Priority Area 3. Prevention of HIV transmission</b>			
<p>CCHAI 6. <i>Percentage of young women and men aged 15-24 years and other at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.</i></p> <p>CCHAI 9. <i>Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse</i></p> <p>CCHAI 10. <i>Percentage of SW reporting condom use at last sex with a client.</i></p> <p>CCHAI 11. <i>Percentage of men reporting condom use the last time they had anal sex with a male partner.</i></p> <p>CCHAI 14. <i>Prenatal HIV prevalence among the population aged 15-24 years.</i></p> <p>CCHAI 13. <i>Percentage of infants born to HIV-infected mothers who are infected.</i></p> <p>CCHAI 7. <i>Percentage of youth aged 15-24 years and most-at-risk populations who received HIV testing in the last twelve months and who know the results.</i></p> <p>CCHAI 8. <i>Percentage of estimated most-at-risk populations (MSM, SW, youth 15-24 years) reached with behaviour-change communications.</i></p> <p>CCHAI 12. <i>Percentage of HIV-positive pregnant women receiving a complete course of ART prophylaxis to reduce the risk of mother-to-child transmission.</i></p>			
SO 3.1. To prevent the sexual transmission of HIV infection	ER 3.1.1: Universal access to HIV testing and counselling services, ensured through implementation of provider-initiated (rapid) testing and counselling.	RPGS 3.A: Information-sharing and exchange of best practices concerning prevention and promotion strategies: 3.A.1: Advocacy for rapid assessments of venues (e.g., PLACE studies) to demonstrate where HIV prevention interventions would be most cost-effective; 3.A.2: Qualitative research and analysis that measures changes in men's and women's attitudes, practices, and knowledge regarding HIV/AIDS; 3.A.3: Collection and dissemination of information on best practices and interventions aimed at minimising risky sexual behaviours and changing, positively, attitudes towards people living with HIV; 3.A.4: Development of regional behaviour change communication strategies on HIV (based on information gained from the above); 3.A.5: Dissemination of the WHO/UNAIDS guidelines for provider-initiated HIV counselling and testing; 3.A.6: Strengthening of regional capacity in HIV counselling and testing through training.	<ul style="list-style-type: none"> <li>▪ Percentage of young women and men aged 15-24 years and other at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.</li> <li>▪ Percentage of young women and men aged 15 – 24 who have had sexual intercourse before age 15.</li> <li>▪ Percentage of young women and men aged 15-24 years reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner.</li> <li>▪ Percentage of SW reporting condom use the last time they had sex with a client.</li> <li>▪ Percentage of men reporting condom use the last time they had anal sex with a male partner.</li> <li>▪ Prenatal HIV prevalence among young women aged 15-24 years.</li> </ul>
	ER 3.1.2: Acceptability promoted and access to condoms improved.		
	ER 3.1.3: Healthy and responsible sexual behaviour, attitudes, and practices promoted and increased through innovative behavioural change communication strategies.		
SO 3.2. To establish comprehensive, gender-sensitive and targeted prevention programmes for children (9-14 years old) and youth (15-24 years old)	ER 3.2.1. General access secured to reliable, accurate, and gender-sensitive information on adolescence, sexuality, and their vulnerability concerning HIV and AIDS for this population.		
	ER 3.2.2. Behaviour change communication programmes, tailored to address youth, implemented.		
	ER 3.2.3. Condom use promoted through distribution in youth-oriented environments and expansion of effective condom marketing programmes targeted at youth.		
	ER 3.2.4. Youth-led comprehensive HIV prevention programmes developed.		
	ER 3.2.5. Peer education programmes for school- and community-based youth strengthened.		
	ER 3.2.6. Access secured for out of school youth to HIV prevention and other services.		
	ER 3.2.7. Access to HIV testing secured for the 15-24 years age group.		

STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATORS
<b>Priority Area 3. Prevention of HIV transmission</b>			
SO 3.3. To achieve universal access to targeted prevention interventions to reach and support the most at risk populations (MSM, SW, drug and substance abusers, prisoners, and mobile/migrant populations)	ER 3.2.8. Civil society organisations encouraged to continue their efforts to reach “youth on the block” with life-skill and income-generating activities.	<p>RPGS 3.B: Addressing youth:            3.B.1: Identification of regional best practices peer education strategies through research and programme evaluation.            3.B.2: Development and support the implementation of regional best-practice-structured youth outreach, peer education, and HFLE programmes.            3.B.3: Support peer counselling of youth through NGOs across the Caribbean region.            3.B.4: Expansion of the regional condom social marketing programme targeted at youth.            3.B.5: External training of youth in HIV control and prevention.</p> <p>RPGS 3.C: Addressing MARPs:            3.C.1: Strengthening the understanding of the role of vulnerable groups in the regional epidemiology of HIV/STI;            3.C.2: Encouragement of the inclusion of representatives of the Caribbean MSM and SW communities at all levels of decision-making related to HIV policy and implementation.            3.C.3: Development of regional peer education training materials for MSM and SW.            3.C.4: Research on SW (transgender, male sex workers, links to tourism industry).            3.C.5: Research on the impact of drug and substance abuse and its role in HIV transmission;            3.C.6: Share lessons learned with all Caribbean countries regarding national prevention and promotion strategies targeted at MARPs;            3.C.7: Training of providers to deal with MSM &amp; SW (in leadership, procurement)            3.C.8: Support countries in developing innovative approaches to provide services to mobile/migrant populations.</p>	<ul style="list-style-type: none"> <li>▪ Percentage of infants infected with HIV born to HIV-infected mothers.</li> <li>▪ Percentage of youth aged 15-24 years who received HIV testing in the last twelve months and know the results.</li> <li>▪ Percentage of the most-at-risk populations who received HIV testing in the last twelve months and know the results.</li> <li>▪ Percentage of estimated most-at-risk populations (MSM, SW, youth aged 15-24 years) reached with behaviour-change communications.</li> <li>▪ Percentage of HIV-positive pregnant women receiving a complete course of ART prophylaxis to reduce the risk of mother-to-child transmission.</li> </ul>
	ER 3.3.1. Targeted behaviour change communication interventions developed and implemented to increase positive sexual practices and encourage early HIV/STI diagnosis and treatment among most vulnerable groups.		
	ER 3.3.2. Access to HIV testing ensured.		
	ER 3.3.3. National policies, based on regional best practices, developed to guide the design of prevention programmes for vulnerable groups.		
	ER 3.3.4. Peer education programmes for MSM developed.		
	ER 3.3.5. Peer education programmes for SW developed.		
	ER 3.3.6. To ensure that HIV/STI policies and appropriate prevention strategies and services are available and implemented in the prison system.		
ER 3.3.7. To develop and implement innovative approaches to secure access to HIV services by mobile/migrant populations.			
SO 3.4. To provide to all pregnant women and their families easily accessible prevention services to prevent mother-to-child HIV transmission.	ER 3.4.1. Service delivery capacity of prevention of mother-to-child transmission sites strengthened, and the geographic coverage at primary care facilities expanded.		
	ER 3.4.2. Community mobilisation and referral networks to include prevention of mother-to-child transmission of HIV strengthened.		
	ER 3.4.3. PMTCT Plus programmes introduced.		
SO 3.5. To strengthen prevention efforts among PLHIV, as part of comprehensive care.	ER 3.5.1. Increased practice of safer sex by PLHIV.		
	ER 3.5.2. Increased disclosure of HIV status by PLHIV to their sexual partners.		
SO 3.6. To reduce vulnerability to HIV and AIDS through early identification and treatment of sexually-transmitted infections (STIs)	<p>ER 3.6.1. Increased access and utilisation of STI services through:</p> <ul style="list-style-type: none"> <li>▪ Increased early treatment for STIs resulting from greater public awareness of the symptoms of STIs and their ill effects if left untreated; and</li> <li>▪ STI treatment and counselling services provided in all primary health centres.</li> </ul>		

STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATORS
<b>Priority Area 3. Prevention of HIV transmission</b>			
	ER 3.6.2. National standards for the clinical management and care of STIs, including guidelines for the syndromic management of STIs, are utilised for service provision.	<p>RPGS 3.D: Addressing pregnant women and their families:</p> <p>3.D.1: Support the dissemination of the regional PAHO/CAREC Guidelines for the Care of HIV-Infected Pregnant Women and the Prevention of Mother-to-Child Transmission (including ARV prophylaxis for pregnant women, efforts to have facility births, PMTCT Plus, and testing of babies) and provide technical assistance in their introduction;</p> <p>3.D.2: Comprehensive, research-based planning methodology for an effective communication strategy for PMTCT in the Caribbean countries</p> <p>3.D.3: Advocacy for extension of PMTCT services to PMTCT Plus programmes, addressing family members as well the infected women;</p> <p>3.D.4: Increase regional capacity in PMTCT and PMTCT Plus in the Caribbean.</p> <p>RPGS 3.E: Addressing PLHIV:</p> <p>3.E.1: Studies directed at obtaining better knowledge and understanding of constraining and facilitating factors for disclosure of HIV status by PLHIV</p> <p>3.E.2: Collation and dissemination of best practices related to positive prevention methodologies for PLHIV.</p> <p>RPGS 3.F: Addressing STI:</p> <p>3.F.1: Preparation of regional guidelines for the clinical management of STIs</p> <p>3.F.2: Support countries in their efforts to conduct training in STI management.</p>	
	ER 3.6.3. Availability of drugs for treatment of STIs secured.		
	ER 3.6.4. Staff responsible for provision of STI treatment and counselling trained and supervised.		
	ER 3.6.5. Simple diagnostic technology for diagnosis of aetiological agents for STIs introduced.		
	ER 3.6.6. HIV testing conducted for all consenting persons attending STI clinics.		



STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATORS
<b>Priority Area 4. Treatment, care, and support</b>			
<p><i>CCHAI 1.7. Percentage of persons starting first-line ART who are still on ART 12 months later.</i></p> <p><i>CCHAI 15. Women, men &amp; children with advanced HIV infection receiving Anti-Retroviral Therapy.</i></p> <p><i>CCHAI 16. Estimated HIV positive incident TB cases that received treatment for TB and HIV.</i></p>			
<p>SO 4.1. To expand access to treatment, comprehensive care and services that are enabling, supporting, confidential, and decentralised.</p>	<p>4.1. Universal access to ARV treatment achieved through widely available and accessible services and increased adherence to treatment and care by 2012 through:</p>	<p>RPGS 4.A. Support to human resources development for treatment, care, and support services:</p> <p>4.A.1. Support countries in their efforts to train and update knowledge and skills of health staff;</p> <p>4.A.2. Support countries in their efforts to conduct training in the management of OIs;</p> <p>4.A.3. Support countries in their efforts to conduct training in the management of TB and TB/HIV.</p> <p>RPGS 4.B. Support to carry out research studies to analyse the issues related to access and quality of care in the region, disseminate results and when relevant develop and support the implementation of appropriate strategies.</p> <p>RPGS 4.C. Development, updating, and dissemination of regional guidelines related to treatment, care, and support:</p> <p>4.C.1. Development of paediatric HIV guidelines, care of HIV exposed and HIV infected children.</p> <p>4.C.2. Development of guidelines for the prevention, diagnosis, and treatment of opportunistic infections in adults, adolescents, and children.</p>	<ul style="list-style-type: none"> <li>▪ Percentage of persons starting first-line ART who are still on ART 12 months later.</li> <li>▪ Percentage of women, men, and children with advanced HIV infection receiving ART.</li> <li>▪ Number and percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.</li> <li>▪ Percentage of respondents reporting STI symptoms in the last 12 months who sought care at a service provider with personnel trained in STI care.</li> <li>▪ Current school attendance among orphans and non-orphans aged 10-14 years.</li> </ul>
	<p>ER 4.1.1. Staff responsible for service provision trained with updated knowledge of HIV management protocols (see Priority Area 5).</p>		
	<p>ER 4.1.2. Increased number of decentralised treatment sites.</p>		
	<p>ER 4.1.3. Improved confidentiality for clients established.</p>		
	<p>ER 4.1.4. Availability of drugs and other HIV commodities secured (see Priority Area 5).</p>		
	<p>ER 4.1.5. Systems for proper treatment follow-up established.</p>		
	<p>ER 4.1.6. Mechanisms for monitoring and evaluation of adherence to, and suitability of, treatment protocols established and fully operating.</p>		
<p>SO 4.2. To reduce vulnerability to HIV and AIDS through early identification and treatment of opportunistic infections (OIs).</p>	<p>ER 4.2.1. PLHIV able to recognise the symptoms of OIs and seek early treatment.</p>	<p>RPGS 4.D. Establishment of regional mechanisms for the prevention, monitoring, and surveillance of HIV drug resistance and for HIV pharmacovigilance.</p>	
	<p>ER 4.2.2. Regional guidelines for the management of opportunistic infections available and disseminated.</p>		
	<p>ER 4.2.3. Medical staff trained in the management of opportunistic infections.</p>		
	<p>ER 4.2.4. Proper diagnostic facilities for identification of OIs are available.</p>		
	<p>ER 4.2.5. The availability of drugs for the treatment of OIs is secured.</p>		
	<p>ER 4.2.6. Standardised case management of OIs in all sites where ARV treatment is provided.</p>		

STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATORS
<b>Priority Area 4. Treatment, care, and support</b>			
SO 4.3. To improve TB management especially in those infected with HIV.	ER 4.3.1. TB service providers trained in the management of TB and TB/HIV (see Priority Area 5).		
	ER 4.3.2. All HIV infected persons are screened for TB and, when relevant, proper treatment and treatment follow-up is carried out.		
	ER 4.3.3. Improved capacity of laboratories to conduct diagnostic tests for TB and drug resistance is in place (see Priority Area 5).		
	ER 4.3.4. All patients diagnosed with TB are screened for HIV.		
	ER 4.3.5. The availability of drugs for the treatment of TB is secured (see Priority Area 5).		
	ER 4.3.6. Follow-up of TB patients to ensure completion of treatment is carried out.		



STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATORS
<b>Priority Area 5. Capacity development for HIV/AIDS services</b>			
<i>CCHAI 18. Number of persons trained by client and service area.</i>			
SO 5.2. To strengthen health systems and infrastructure with a view to improving capacity to provide comprehensive and integrated HIV and AIDS services.	ER 5.1.1. Human resources needs assessment for the provision of HIV services carried out.	<p>RPGS 5.A. Preparation and delivery of training-of-trainers courses to support implementation of HIV related training at national level, including the development of a specialised cadre of Caribbean professionals capable to deliver this training and technical assistance.</p> <p>RPGS 5.B. Support to national human capacity development through the inclusion of appropriate HIV gender-sensitive courses in all pre-service training programmes:</p> <p>5.B.1. Development of guidelines for carrying out national human resources needs assessment for provision of comprehensive HIV services.</p> <p>5.B.2. Development of generic gender-sensitive HIV training tools and modules for pre-service HIV education.</p> <p>5.B.3. Introduction of gender-sensitive HIV training curriculum in all pre-service training programmes.</p> <p>5.B.4. Development of a resource base of consultants, information and tools relevant to HIV/AIDS/STI training.</p> <p>RPGS 5.C. Support countries in their efforts to provide in-service training and updating knowledge on HIV and AIDS for service providers:</p> <p>5.C.1. Elaboration of teaching and education materials.</p> <p>5.C.2. Technical assistance for the organisation and delivery of in-service training on clinical and non-clinical skills for the provision of comprehensive HIV services.</p> <p>RPGS 5.D. Strengthening national health systems:</p> <p>5.D.1. Guidelines, tools and support for decentralisation and integration of HIV services into existing primary health care systems.</p> <p>5.D.2. Normative guidelines for comprehensive HIV health care services including QA systems.</p>	<ul style="list-style-type: none"> <li>▪ Number of countries that have integrated HIV services into primary health care services</li> <li>▪ Number of person trained by client and service areas</li> </ul>
	ER 5.1.2. Pre-service HIV training curricula for various cadres of professionals in all sectors (e.g., lawyers, teachers, social workers, police and prison officers) are developed and introduced.		
	ER 5.1.3. Innovative, cost-effective and technologically appropriate in-service training is provided to ensure adequate numbers of health workers are trained in: <ol style="list-style-type: none"> <li>1. Rapid testing for HIV;</li> <li>2. Provision of ARVs;</li> <li>3. Comprehensive care of opportunistic infections;</li> <li>4. Diagnosis and treatment of STIs; and</li> <li>5. Recognition and management of TB.</li> </ol>		
	ER 5.1.4. Innovative, cost-effective, and technologically-appropriate in-service training programmes are made available to lawyers, social workers, police and prison officers, etc., with a view to promoting HIV and gender-sensitive services for the public.		
	ER 5.1.5. Harmful gender stereotyping and discriminatory practices by health and social service providers eliminated.		
	ER 5.1.6. Appropriate cadres of workers, in the required numbers, trained in gender assessment to ensure the gender sensitivity of HIV programmes and plans (see Priority Area 1).		
	ER 5.1.7. Appropriate cadres of workers, in the required numbers, trained in the management, monitoring, and evaluation of HIV programmes and plans.		
SO 5.2. To strengthen health systems and infrastructure with a view to improving capacity to provide comprehensive and integrated HIV and AIDS services.	ER 5.2.1. Vertically-managed HIV and AIDS services integrated into the existing primary health care delivery systems.		
	ER 5.2.2. Infrastructure (e.g., buildings, utilities, and equipment) available to ensure appropriate standards of HIV and AIDS services.		
	ER 5.2.3. Treatment sites are accessing the		

STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATORS
<b>Priority Area 5. Capacity development for HIV/AIDS services</b>			
	necessary laboratory services for diagnosis, clinical staging, and the monitoring of treatment outcomes.	5.D.3. Promote and work with countries to support the implementation of service delivery models which promote decentralisation, integration, and task shifting (e.g., TB, STI, MCH, gender, mental health, primary care, chronic disease).  5.D.4. Assistance to countries for the strengthening of existing mechanisms for the implementation of quality laboratory services in support of HIV diagnosis, care, and treatment monitoring, as well as for TB-related laboratory services.  5.D.5. Operational research and assessment of new technologies and algorithms for laboratory services and support for their implementation in countries.  5.D.6. Drafting and disseminating of regional guidelines for quality-assured blood collection and use.  5.D.7. Dissemination of Caribbean clinical guidelines for PEP management.  5.D.8. Support countries in training health workers in the regional clinical guidelines for PEP management.  RPGS 5.E. The provision of HIV-related reference laboratory services.  RPGS 5.F. The coordination of regional efforts for the production, joint procurement, and common quality control systems for HIV and AIDS commodities.	
	ER 5.2.4. Human resources management system established and operating, securing appropriate staffing of health services for the provision of HIV services.		
	ER 5.2.5. Quality assurance systems for comprehensive health care established and operating.		
	ER 5.2.6. Effective systems for the management and regulation of strategic public health supplies including HIV medications, diagnostics, and other commodities are operational.		
	ER 5.2.7. Strengthened capacity in the quality assurance, evaluation, and rational use of medications and other commodities.		
	ER 5.2.8. Safe blood supply, through careful donor screening, ensured and maintained.		
	ER 5.2.9. Infection control and access to Post Exposure Prophylaxis (PEP) for workers accidentally exposed in health care settings ensured.		

STRATEGIC OBJECTIVES	EXPECTED RESULTS	REGIONAL PUBLIC GOODS AND SERVICES (RPGS)	RPGS INDICATOR
<b>Priority Area 6. Monitoring, evaluation, and research</b>			
<i>CCHAI 19. National HIV M&amp;E plan linked to national strategic plan and addressing its objectives is developed.</i>			
SO 6.1. To track progress in the implementation of National HIV responses and of the CRSE.	ER 6.1.1. M&E plan implemented with timely and reliable data on key indicators produced.	RPGS 6.A. Providing support to develop and implement national M&E plans.  6.A.1. Technical and financial support, including templates and guidelines, for the collection of data on indicators such as the Core Caribbean HIV and AIDS Indicators.  6.A.2. Develop national capacity to analyse data and use it in policy and programme development.  6.A.3. Provision of technical and financial support, where appropriate, for multi-country special studies including KABP, BSS, and studies among MARP.  RPGS 6.B. Providing research information to inform national policy and programme development:  6.B.1. Disseminate international best practices with respect to HIV services.  6.B.2. Establishment and undertaking of a regional research agenda.  6.B.3. Development of mechanisms to support countries in implementing the research agenda and incorporating research results into policies and programmes.  6.B.4. Development of databases with M&E data for use in advocacy efforts at the national, regional and international levels.  6.B.5. Promote use of existing forums to disseminate research results throughout the region.	<ul style="list-style-type: none"> <li>▪ National HIV monitoring &amp; evaluation plan linked to national strategic plan and addressing its objectives is developed.</li> </ul>
	ER 6.1.2. HIV surveillance system established.		
	ER 6.1.3. HIV data analysed and utilised to provide information for the management of programmes.		
	ER 6.1.4. Generation of reports and other products of use to stakeholders.		
SO 6.2. To develop appropriate evidence-based policies, practices, and interventions through the use of research findings and M&E data.	ER 6.2.1. Country policy making, programme design, and planning based on international best practices and research findings, including epidemiological, behavioural, economic, operational, and innovative research.		
	ER 6.2.2. Countries utilise research and programme data in their HIV advocacy efforts.		
	ER 6.2.3. Research results, lessons learned, and databases on HIV from Caribbean countries and other regions compiled and disseminated at the national level.		

## Annex 3. Explanatory Notes on the Estimated Cost of CRSF 2008-2012

Section 9 gives an estimated cost of US\$55.3 million for the operationalisation of the Caribbean Regional Strategic Framework 2008-2012 through the delivery of the regional public goods and services for the six Priority Areas and through the coordination and monitoring by the PANCAP bodies.

This annex provides a brief explanation on the assumptions made for the costing exercise. However, the lack of detailed expenditure data from the CRSF 2002-2006 limits this exercise.

1. The heading “**Delivery of Regional Public Goods and Services by Priority Areas**” groups the estimated costs for each of the six Priority Areas. These costs mainly reflect the costs of providing the regional public goods and services (e.g., research, consultancies, workshops, training, and dissemination of policy documents or best practice examples) and related costs such as translations, communication, and travel.

With regard to unit cost, the following assumptions have been made:

### Operational Costs:

- Translation: budgeted at US\$20 per page per language
- Interpretation: budgeted at US\$250 per day per language
- In general, 10% of the total activity costs (per “regional public good or service”) is added to cover other operational costs (e.g., copies, printing, and telephone calls).

### Activity Costs:

- Dissemination (manuals, guidelines): lump sum of US\$5,000 per year per set
- Exchange visits: lump sum of US\$30,000 per year per exchange
- Networking: lump sum of US\$20,000 per year
- Policy or guidelines development: US\$1,000 per working day, including travel and subsistence allowance; otherwise US\$500 per working day
- Research or best practices analysis: US\$1,000 per working day, including travel and subsistence allowance
- Support: lump sum budget of US\$15,000 per year
- Training/workshops: US\$1,500 per person for 3 days; US\$2,500 per person for 5 days; US\$4,000 per person for 2 weeks.

Since it is not possible to precisely define all regional public goods and services at the start of the Framework (more details will come from the preparation of the two-year work plans), assumptions regarding the priority areas were made as well:

- Priority Area 1: the establishment of the Regional Stigma & Discrimination Unit with 4 staff members at US\$35,000 per year per staff, on average;
- Priority Area 2 includes substantial amounts for country support related to the revision or planning of their national HIV programmes and to the network and capacity building of CSOs, NGOs, and FBOs involved in the HIV response;

- Priority Area 3: condom social marketing programme for a total value of US\$8,000,000 has been included (mainly financed by KfW for the second phase of the CARISMA project until the end of 2011), complemented with other targeted activities;
  - Priority Area 4 mainly takes into account the regional dissemination of guidelines and the monitoring of drug resistance;
  - Priority Area 5 includes the cost for all capacity development and strengthening interventions at the regional level (which means that countries will benefit from it by having their staff members trained or their health systems supported);
  - Priority Area 6: mainly based on a research proposal prepared by the Technical Working Group on Policy Research and Social Statistics (November 2007); specific research related to strategic objectives of the other priority areas have been budgeted under that particular priority area.
2. The heading “**PANCAP Coordinating and Monitoring bodies**” provides estimates of staff and operational costs for the coordination of the Pan Caribbean Partnership through its coordinating (PCU, PACC) and monitoring bodies (RCM, AGM).
- The salary cost for the PCU is based on October 2007 cost estimates and the number and categorisation of the PCU staff as they were in October 2007 have been kept fixed until 2012. These cost estimates may have to be revised in the light of the outcomes of the Organisational and Management review by Delta Partnerships, as this may come up with a new organisational structure for the PCU and consequently with a different cost and operational structure.
  - The costs for the organisation of the annual AGM, the bi-annual RCM, and the quarterly meetings of the PACC are based on the data available for the transition budget estimates for the period January 2008-June 2009.
  - Provision is made for two meetings for 2008 and 2009 for the Special Working Group on OCTs and for six meetings per year for the Technical Working Groups (on governance, on Monitoring and Evaluation).
  - Provisions have been made for a PANCAP delegation to the UNAIDS board meeting, the GFATM meeting in Geneva, the annual International AIDS Conference and other high-level missions.
3. The heading “**Information, Education, and Communication Strategy to Support CRSF Implementation**” provides support for the development and application of innovative approaches, design and execution of regional interventions, documentation and dissemination of best practices, and sharing of information among PANCAP partners.

Objective: to connect stakeholders at the national and regional levels and to project the CRSF as a mechanism for sustaining the PANCAP Network and ensuring its external legitimacy and internal visibility.

The expected outcomes would include:

- Establishing ongoing linkages between the Information and Communication Unit within the PCU and the expertise across the region to advance coherent IEC objectives.
  - Pursuing options to engage information and communications workers through access to specialised PANCAP partners, such as the Caribbean Broadcasting Media Corporation.
  - Producing regular publications (e.g., E-news, bulletins, promotional materials) on stigma and discrimination and other areas related to research and policies from the six priority programme areas.
  - Developing Web-based programmes to intensify dialogue among stakeholders and encourage greater interconnectivity among partners in real-time.
  - Utilising newer information technologies to engage in the promotion of results obtained from the CRSF element, especially the engagement of youth by creating access to *You Tube*, cell phone interaction, virtual reality, and others.
  - Projecting results of CRSF priorities through multimedia forums to reach a wide cross-section of stakeholders.
4. A **contingency** of 5% of total overall anticipated expenditures has been included.