



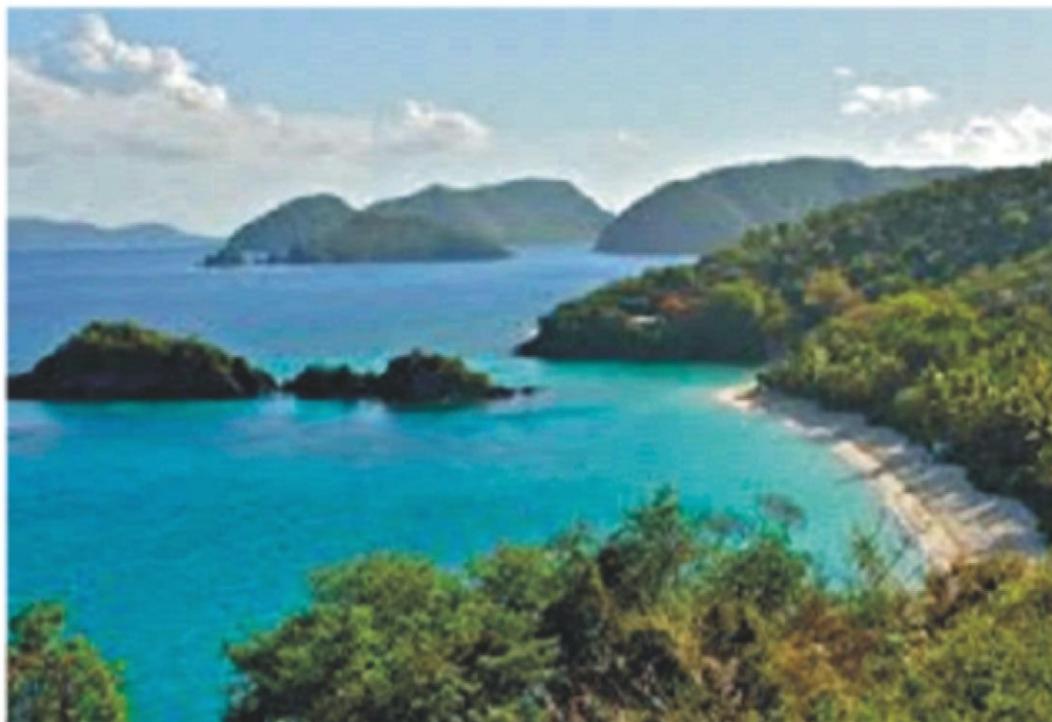
PAN CARIBBEAN PARTNERSHIP



AGAINST HIV/AIDS

An AIDS Free Caribbean

Caribbean Regional Strategic Framework on HIV and AIDS 2014-2018



**Caribbean Community (CARICOM)
Pan Caribbean Partnership against HIV and AIDS (PANCAP)**

ACRONYMS

AGM	Annual general meeting
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CARICOM	Caribbean Community
CARPHA	Caribbean Public Health Agency
CCNAPC	Caribbean Coalition of National AIDS Programme Coordinators
COHSOD	Council for Human and Social Development
COIN	Centre of Orientacion and Integrated Investigacion
CRN+	Caribbean Regional Network of People Living with HIV/AIDS
CRSF	Caribbean Regional Strategic Framework
CSO	Civil society organisation
CVC	Caribbean Vulnerable Communities Coalition
EMTCT	Elimination of mother-to-child transmission
FBO	Faith-based organisation
FSW	Female sex worker
GARPR	Global AIDS Response Progress Report
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
HSS	Health systems strengthening
KAP	Knowledge, attitude and practice
KfW	Kreditanstalt für Wiederaufbau (German Development Bank)
LGBT	Lesbian, gay, bisexual and transgender
MARP	Most at risk population
MCH	Maternal and child health
MDGs	Millennium Development Goals

M&E	Monitoring and evaluation
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NAP	National AIDS Programme
NCD	Noncommunicable disease
NGO	Non-governmental organisation
NHP	National HIV Programme
OECS	Organisation of Eastern Caribbean States
OI	Opportunistic infection
PACC	Priority Areas Coordinating Committee
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV and AIDS
PBOP	PANCAP Biennial Operational Plan
PCU	PANCAP Coordinating Unit
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHCO	PAHO HIV Caribbean Office
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PSM	Procurement and supply management
PR	Principal recipient
RPG	Regional public good
RSA	Regional support agency
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SW	Sex worker
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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PREFACE



I am very pleased to witness the production of yet another Caribbean Regional Strategic Framework on HIV and AIDS that establishes a cohesive response by the PANCAP Network to HIV and AIDS for the next five years. This essential tool not only provides the overarching goals and aspirations for approximately 29 countries and 70 partners, but also establishes concrete, expected outcomes that explicitly lead the way toward ending the AIDS epidemic by 2030. I commend PANCAP for the consultative process that produced this document. It engaged stakeholders across the various sectors and placed emphasis on programmes and policies designed to ensure that AIDS remains a priority in the Post-2015 Development Agenda.

The six priorities identified in this Framework are all relevant to the vision of PANCAP to substantially reduce the spread of HIV and AIDS ‘through sustainable systems of universal access to HIV prevention, treatment, care and support’. It is, however, the proposals for implementing these priorities that provide the essential ingredients of hope that the Caribbean, acting collectively, will achieve the goals of elimination. The elements of elimination correspond to major challenges of prevention, treatment, viable integrated health systems, sustainable financing, shared responsibility and the fostering of an enabling environment. Not only is each of the priorities linked to measureable targets, but they are also anchored in the realities of the Caribbean, especially norms and behaviour, that support, as well as undermine, healthy and equitable societies.

While access to treatment is highlighted, there is recognition that affordable medicines and universal health care are fundamental pillars of elimination. While prevention is targeted at multiple levels of reducing risk behaviours, the prerequisites for viable outcomes are based on engagement of the community and the education system, as well as the provision and monitoring of high-quality services and the participation of people living with HIV in the governance and oversight of the AIDS movement. While shared responsibility is adequately

referenced in the framework, it is important to note that the elements for achieving viable outcomes depend on “strong and mutually accountable partnerships...with more effective and sustainable investments in goods and services that translate to real benefits on the ground.” In this regard, the avenues are open for fostering global solidarity such as the proposed CARICOM - African Union partnership road maps for elimination through shared responsibility.

I note, with pleasure, that the Framework highlights *Justice for All*; It places emphasis essentially on the elimination of HIV-related discriminatory practices, especially as they related to key populations, such as men who have sex with men, commercial sex workers, gender-based violence and child abuse. In this regard, the Caribbean must continue the dialogue on HIV and human rights.

This Caribbean Regional Strategic Framework is being disseminated at a time of great optimism about the ending of the epidemic. This is based on momentous scientific advances. The advocacy for a *90-90-90 Treatment Agenda* by UNAIDS provides powerful momentum. It advocates for ambitious, but achievable, targets by 2020: 90 percent of all people living with HIV will know their HIV status, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90 percent of all people receiving antiretroviral therapy will have viral load suppression. Then there is the declaration from the 20th International AIDS Conference 2014 that affirms the important role of science and fast tracking treatment. At the same time, it cautions that without achieving elimination of HIV-related stigma and discrimination, we would have squandered the opportunity for ending the AIDS epidemic.

Indeed, the evidence shows that the Caribbean could be the first region in the world to eliminate mother-to-child transmission of HIV. Let us therefore use the Caribbean Regional Strategic Framework as a reference point for achieving this low-hanging fruit and move beyond. Let our aspirations translate into actions heralding the Caribbean as the first region in the world to eliminate AIDS.

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

EXECUTIVE SUMMARY

Since the inception of the Pan Caribbean Partnership Against HIV (PANCAP) in 2001, the Caribbean regional response to HIV has made significant strides. HIV prevalence has declined from 1.3 percent to one percent in 2012. New infections among children have been reduced by 52 percent over the same time period. Treatment coverage rates have dramatically improved with over 90 percent of HIV positive pregnant women receiving services to prevent mother-to-child-transmission and 70 percent of eligible people living with HIV receiving ARVs.

These successes rest on the combined efforts of regional public health agencies, donor partners, civil society and private sector agencies, which comprise PANCAP, in supporting national programmes to improve their capacity to implement prevention, treatment and care interventions. Substantial investments have been made in strengthening health systems and in scaling-up services for on-going care and support for the increasing numbers of people who are living longer with HIV. Regional public goods and services have lowered transaction costs by providing more affordable access to medicines and shared capacity in specialised services, information and advocacy.

Building on these achievements, the Caribbean Regional Strategic Framework 2014-2018 represents a commitment to inclusive and harmonised multisectoral action in order to achieve universal access to comprehensive, high-quality health services. As the epidemic remains entrenched in certain key populations, further reductions in AIDS-related mortality and transmission rates will only be possible with the removal of the legal, social and cultural obstacles which particularly affect these groups. This will require strengthened collaboration across sectors, including with Ministries of Legal Affairs, Home Affairs, Women and Gender, Planning and Social Development, parliamentarians, the judiciary, human rights and gender-equality advocates and the faith-based community, among others.

Achieving an AIDS-free Caribbean, even as resources for HIV are shrinking, requires strategic action at both the regional and national levels. The small island developing states of the Caribbean must find the resources to sustain prevention programmes, increase access to services for key populations, expand treatment programmes and meet the needs of an ageing population of PLHIV. To this end, the Caribbean Regional Strategic Framework 2014-2018 provides high level guidance to ensure that resources are directed towards effective interventions that maximise the impact of regional efforts, and provide good value for money, including by intensifying intervention efforts where HIV is most heavily concentrated.

Developed through a lengthy consultative process, the CRSF 2014-2018 articulates the vision and collective priorities of Caribbean states and regional-level partners. Six Strategic Priority Areas (SPAs) have been defined as key to achieving the vision of an AIDS-free Caribbean, while promoting sustainable health and development. These are:

1. An enabling environment
2. Shared responsibility
3. Prevention of HIV transmission
4. Care, treatment and support

5. Integration
6. Sustainability

Expected results defined within each SPA allow for partner countries to set national targets, bearing in mind variations in levels of country capacity and development. The CRSF 2014-2018 will be operationalised through two-year plans which will complement national strategies by focusing on regional actions and regional public goods and services. Operational plans will define priority actions, roles and responsibilities, timeframes and lines of accountability. A monitoring and evaluation framework, designed to minimise the reporting burden on countries, will ensure the region is progressing towards the achievement of expected results. Oversight of the implementation of operational plans will be the responsibility of the Priority Areas Coordinating Committee (PACC), which reports to the PANCAP Executive Board and to the Annual General Meeting.

1.0 INTRODUCTION

“We must remain strong and resolute as we continue on our path to HIV elimination and draw courage and motivation to carry on our efforts from the progress that we have been making in the Caribbean.”

The Right Honourable Dr. Denzil Douglas,
Prime Minister of St. Kitts and Nevis and Chair of PANCAP

The Caribbean Regional Strategic Framework 2014-2018 articulates the vision and collective priorities of Caribbean states and their partners through their membership in the Pan Caribbean Partnership Against HIV and AIDS (PANCAP). PANCAP is a multisectoral, multilevel partnership that brings together governments and national HIV programmes, civil society, including key populations, the private sector and regional and international organisations.

The strategic regional approach to HIV builds on a strong history of collaboration in public health to overcome the challenges inherent to the unique geography, economy and culture of the Caribbean. A key objective is to achieve value for money by promoting economies of scale, as the region’s small developing states may provide limited capacity for developing the complex programmes needed for a comprehensive response to HIV.

Since the inception of PANCAP, in 2001, notable successes have been achieved. HIV incidence and AIDS-related deaths have been reduced, and some countries have achieved virtual elimination of mother-to-child transmission. Strengthened national programmes have improved capacity to implement prevention, treatment and care interventions. Substantial investments have been made in strengthening health systems and in scaling-up services for increasing numbers of people who are living longer with HIV. Regional public goods and services have facilitated this by lowering costs and reducing inefficiencies inherent in building capacity in multiple countries. Countries contribute to, and benefit from, more affordable access to medicines and the sharing of technical skills, operational capacity, information, advocacy and specialised services. Technical support is sourced within the region, and is implemented through peer-learning methodologies.

In spite of these achievements, there remains much to be done to realise the goals and targets to which PANCAP countries have committed themselves and, ultimately, to get to zero discrimination, zero new infections and zero AIDS-related deaths.¹ As the Partnership sets its sights on an AIDS-free Caribbean, it does so within a rapidly changing global and regional context. HIV is losing ground as a priority for financing in the face of other competing health and social development issues, including the rising burden of chronic diseases in the Caribbean and

1. UNAIDS. Getting to zero: 2011-2015 strategy Joint United Nations Programme on HIV/AIDS (UNAIDS). 2010. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc2034_unaids_strategy_en.pdf

elsewhere in the world. The shrinking of resources for HIV globally is compounded by increasingly stringent eligibility requirements, which limit access to funding for those Caribbean states now classified as middle-income countries.

Against the backdrop of a worsening fiscal and economic environment, further progress towards ending the HIV epidemic requires the capacity to provide lifelong care and support for increasing numbers of people on treatment for longer periods. Maintaining lower transmission and mortality rates will only be possible if levels of investment are sustained, not only in treatment programmes, but also in effective and comprehensive prevention efforts. These must include the removal of legal, social and cultural obstacles which prevent key populations at higher risk from accessing comprehensive and high-quality health services. Issues of stigma and discrimination must be addressed. Ending HIV is not possible until the human rights of all people, and particularly those most vulnerable to HIV, are fully realised. PANCAP is in a unique position to drive this process, as leaders and policy makers show an increasing willingness to find pragmatic solutions to these difficult issues.

Structural drivers of the epidemic are deeply rooted in Caribbean societies and are reinforced by institutions including schools, workplaces and health systems. A broader and sustained commitment to the fight against HIV must, therefore, involve Ministries of Legal Affairs, Home Affairs, Women and Gender, Planning and Social Development, parliamentarians, the judiciary, human rights and gender-equality advocates and the faith-based community, among others. Coordinated, multisectoral efforts are required to systematically address policy and legislative issues; scale-up and invest in social and economic support programmes; and integrate HIV services with other health and social development programmes. The CARICOM Secretariat, with a longstanding role in canvassing regional leaders in key areas of health, social development, trade and economic development, provides an important mechanism for aligning the regional HIV response with other strategies, including in the areas of youth, adolescent pregnancy and reproductive health.

Looking forward, the Caribbean is playing a leadership role in ensuring that HIV and AIDS are retained as key issues on the Post-2015 Development Agenda and in raising awareness of the importance of a holistic, comprehensive approach to health. In addition to addressing the social determinants of health, and, of HIV in particular, the critical policy and programmatic nexus between HIV and non-communicable diseases is a growing concern. This is particularly salient in light of the demographic transition facing countries, which is evident in the growing number of PLHIV, who also have chronic diseases, and in young adults who have been living with HIV since birth and who must now navigate the dual challenges of adolescence and HIV.

Through CARICOM, the region has articulated the importance of an open, transparent and inclusive process to shape a Post-2015 Development Agenda that is directed towards:

- A people-centred approach that promotes the welfare and well-being of people that contributes to poverty reduction, social inclusion, equity and the empowerment of women
- An integrated and holistic development agenda that accommodates the diverse development realities of countries and regions

- The primacy of sustainable development that promotes the balanced integration of the economic, social and environmental dimensions at all levels
- The importance of accountability to promote and monitor the implementation of commitments and the contribution of stakeholder partnerships including public-private partnerships in shaping and advancing the Post-2015 Development Agenda.²

1.1 Developing the Caribbean Regional Strategic Framework 2014-2018

The Caribbean Regional Strategic Framework defines the links and interface between PANCAP partners. It represents a consensus to strategically align efforts in the fight against HIV through joint decision making in setting programmatic priorities and in harmonising partner contributions. A core premise is the leadership of national programmes within an inclusive multisectoral response.

The CRSF 2014-2018 was developed through widespread consultations with stakeholders at all levels:

- In 2012, the United Nations Secretary General Special Envoy for HIV in the Caribbean reported to the PANCAP Executive Board on consultations with a cross section of government officials, including Prime Ministers, leaders of nongovernmental organisations, representatives of faith-based organisations, youth movements, the media, universities and development partners throughout the Caribbean.
- A PANCAP Executive Board meeting in July 2013 engaged 32 representatives of stakeholder constituencies in a strategic planning exercise.
- A strategic planning meeting hosted by the Caribbean Public Health Agency (CARPHA) in September 2013 provided an opportunity for wider input of 61 stakeholders.
- Ministers of Health at the 25th Meeting of the Council on Human and Social Development (COHSOD) of CARICOM, in September 2013 in Washington, D.C. provided high-level, political input on the direction of PANCAP, regional priorities for health and the HIV response.
- A meeting of 51 NAP managers and key partners, including chief medical officers, was held in Trinidad and Tobago in October 2013, and allowed for in-depth discussion of the status of the epidemic and country needs.

2. CARICOM Secretariat. CARICOM Statement on a Post 2015 Development Agenda. Available at <http://www.caricom.org/Final%20-%20Statement%20on%20Post-2015%20Dev%20Agenda%20at%2010%20December.pdf>.

- Representatives of civil society, including people living with HIV and key populations, were engaged through the Strategic Planning Retreat of the PANCAP Executive Board and National AIDS Programme (NAP) Managers and Key Partners Meeting.

Throughout the process, technical guidance and oversight were provided by the PACC. International-, regional- and national-level reports along with an independent evaluation of the CRSF 2008-2012 were key inputs.

This document describes the Caribbean Regional Strategic Framework 2014-2018. Section Two describes the PANCAP regional response to date, highlighting key achievements, challenges and gaps. Section Three presents an updated epidemiological profile and a discussion of the particular economic, social and cultural factors which impact on the regional response. Section Four describes the vision and goals of the CRSF, the strategic objectives and expected results. Section Five presents an overview of institutional arrangements, and Section Six describes how the impact of national and regional responses will be measured, monitored and evaluated.



Participants at the PANCAP Regional Consultation on Justice for All and Human Rights Agenda

2.0 The Pan Caribbean Partnership HIV response

“The creation of PANCAP was possible because AIDS was seized as a political priority, and because it had political leadership and support. This was the single most important factor in the emergence of decisive intersectoral action on AIDS in the Caribbean region.”³

The Pan Caribbean Partnership against HIV and AIDS strategic regional approach to HIV builds on a strong history of collaboration in public health to overcome the challenges inherent in the diversity of the Caribbean region. It builds on and supports a unique, longstanding and deepening regional integration process of over 30 countries and four continental entities of varying population size, social and economic development, language and culture. There are also vast disparities in health system capabilities among partner countries with HIV programmes relatively well-developed in some larger countries, while others are unable to support a comprehensive response. The collective efforts of the PANCAP membership seek to mitigate these challenges by promoting economies of scale, shared capacity and regional-level action to address common opportunities and challenges, particularly in the areas of policy and legislation, resource mobilisation and health systems strengthening. To this end, PANCAP’s mandate spans three key areas:

- Coordination
- Provision of regional public goods and services
- Resource mobilisation.

2.1 Evolution of the response

Since the establishment of PANCAP, high-level political commitment for AIDS in the Caribbean has been strengthened through a number of international and regional mechanisms:

1. The United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration targets have been integrated into the Nassau Declaration on Health: *The Health of the Region is the Wealth of the Region*.
2. HIV is identified as a priority area within the Caribbean Cooperation in Health Initiative (CCH) III, the mechanism for health development through increasing collaboration and promoting technical cooperation among countries in the Caribbean.
3. In 2010, PANCAP, through its 10th AGM, committed the region to working towards the following targets by 2015:
 - Elimination of mother-to-child transmission
 - Elimination of travel restrictions for people living with HIV
 - An 80 percent increase in access to treatment
 - A 50 percent reduction in infections

3. CARICOM Secretariat and UNAIDS. A Study of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP) Common goals, shared responses. 2004. Available at http://data.unaids.org/Publications/IRC-pub06/jc1089-pancap_en.pdf

- Acceleration of the agenda to address prevention, care and treatment.
- The 10th AGM targets are aligned with the Millennium Development Goals and precede the targets agreed at the 2011 United Nations High-level Meeting (HLM) on AIDS, which also guide the work of PANCAP:
 - A 50 percent reduction in sexual transmission of HIV
 - A 50 percent reduction of HIV among people who inject drugs
 - A 50 percent reduction of tuberculosis (TB) deaths in people living with HIV
 - Ensure no children are born with HIV and reduction of AIDS-related maternal deaths
 - 15x15 (15 million people on antiretroviral treatment by 2015).

Against this backdrop, the CRSF has evolved in line with international thinking and reflects the changing epidemiology of the epidemic; progress in the development of national programmes; and the emerging needs of countries. Over the period 2002-2006, the first iteration of the CRSF focused on institutional strengthening of core PANCAP partners to be able to provide technical assistance to countries and to build regional capacity. The CRSF 2008-2012 emphasised the provision of regional public goods and services to meet the needs articulated by countries in their national strategic plans.

2.2 Achievements and challenges: an assessment of the response

The collective efforts of Partners have resulted in the realisation of the three core goals established by the Caribbean Regional Strategic Framework 2008-2012:

- To reduce the estimated number of new HIV infections
- To reduce mortality due to HIV, and
- To reduce the social and economic impact of HIV and AIDS on households.

By the close of the 2008-2012 period, the rate of new HIV infections in the region had declined by almost 50 percent; the number of people dying from AIDS had rapidly declined; and increasing numbers of people were receiving treatment, care and support free of cost. There is much to be proud of, but also much that remains to be done to further reduce HIV infections and to ensure that all in need are receiving and fully adhering to treatment. A strategic approach is required to build on successes, learn from failures and strengthen efforts in areas which have lagged if progress is to be accelerated within a context of diminishing resources.

The successful implementation of the CRSF 2008-2012 provides a strong foundation for moving forward with a more effective and focused response that builds on high-impact and well-performing interventions, and learns from those which have not worked as well. PANCAP has successfully demonstrated the added value of a strategic regional approach in:

- Providing regional public goods and services to support national-level efforts against HIV
- Developing and rolling out high-quality pilot interventions

- Achieving economies of scale in the procurement of ARVs for OECS countries and in the establishment of regional laboratory capacity
- Mobilising resources in ways unavailable to individual countries
- Addressing human rights issues with advocacy through regional governmental agencies.

Additional key findings from the independent evaluation of CRSF 2008-2012 and PANCAP Strategic Planning Meeting are highlighted below.

An enabling environment that fosters universal access to HIV prevention, treatment, care and support

- PANCAP has led and coordinated advocacy efforts to accelerate the human rights agenda and to eliminate stigma and discrimination. Key initiatives have included the establishment of a regional stigma and discrimination unit, a regional policy on HIV-related stigma and discrimination, model anti-discrimination legislation and national human rights dialogues in several countries. Policies to ensure universal access to HIV services are in place in eight countries.
- Although all countries have integrated some elements of human rights in their national response to HIV, in many instances, new policies are not being implemented.⁴
- In spite of these efforts, stigma and discrimination persist. Recent surveys of health facilities on three islands have found stigma and discriminatory practices present across all levels of staff.^{5,6}
- The legislative framework within the region continues to be at odds with the inclusive rights-based approach necessary for a successful public health response. A positive development is the increasing use of Caribbean courts for legal challenges, although the practice of public interest litigation remains limited.
- Other challenges in the legal and policy environment include:

4. UNAIDS. Keeping Score III: The Voice of the Caribbean People. 2011.

5. The Health Policy Project. Getting to “Stigma-Free” HIV Services in Dominica. Testing and Rolling-out an Intervention Package for Health Facilities. 2013.

6. The Health Policy Project. Getting to “Stigma-Free” HIV Services in St. Kitts and Nevis. Testing and Rolling-out an Intervention Package for Health Facilities. 2013.

7. UNAIDS. Keeping Score III: The Voice of the Caribbean People. 2011.

- Laws which prohibit young people under 18 years old from accessing HIV testing or health services without parental consent, even where the age of consent is set at 16 years
- Lack of redress for people who experience discrimination on the grounds of race, gender, disability and sexual orientation
- Absence of Caribbean Commission for Human Rights as a monitoring and sanctioning body.⁷

Box 1. The legislative environment

- The constitutions of the majority of Caribbean countries lack reference to non-discrimination on the basis of HIV status or sexual orientation. Ordinary laws do not cater for non-discrimination on the basis of sexual orientation or HIV status. Broad-based non-discrimination and equality legislation exists only in relation to employment in certain countries. The Bahamas is the only CARICOM country where antidiscrimination provisions in the employment act make reference to HIV as a basis for non-discrimination.
- The Bahamas restricts entry, stay and residence for HIV positive people while Belize, Saint Lucia and Trinidad and Tobago have specific laws criminalising HIV transmission.
- The Anglophone Caribbean maintains some of the most regressive anti-gay laws in the world. Same-gender intimacy, regardless of consent or physical location, is criminalised in 11 CARICOM states. Sentences range from life imprisonment in Barbados and Guyana to 10 years in Belize, Dominica, Grenada, St. Kitts and Nevis, and St Vincent and the Grenadines. There are also laws against cross-dressing and constitutional bans on legal recognition of same-sex relationships. Trinidad and Tobago prohibits entry for homosexuals.
- With the exception of Suriname, PANCAP member countries prohibit activities related to sex work, including soliciting, living off earnings, loitering and wandering in public places, procuring for the purpose of prostitution and using a premises as a brothel.

Source: PANCAP. Justice for All: Creating a Facilitating Environment to Reduce HIV Related Stigma and Discrimination in the Caribbean. 2014.

An expanded and coordinated multisectoral response to the HIV epidemic

- PANCAP's achievements rest on the combined efforts of a broad-based multisectoral partnership of over 62 countries and organisations. A key feature of success has been the high-level political leadership driving decision making, partnership and resource allocation. PANCAP has been particularly effective in engaging people living with HIV and key populations, and in supporting institutional capacity building for regional and national networks. Regional collaboration has been strengthened through such mechanisms as the PANCAP multi-country grant from the Global Fund, and the establishment of the Caribbean Public Health Agency (CARPHA). Efforts are needed to ensure similar sustained levels of engagement and broad-based partnership at the national level.
- Resource mobilisation has been a particular strength of the partnership; PANCAP has successfully managed a number of multi-country grants from a range of donor partners. In 2010, 64 percent of AIDS spending in the region came from international donors such as the Global Fund, PEPFAR and the World Bank.⁸ Changes in the global and regional landscape have seen a recent de-prioritisation of the region by international funders and concomitant shrinking of budgets for HIV. This has taken place in tandem with a worsening of the fiscal and economic environment in the Caribbean. Mitigating the impact of these changes and closing the resource gap while continuing to expand treatment programmes, requires strategic action at both the regional and national levels. While domestic investment for HIV is increasing, it continues to be low in comparison with other regions. The latest available data showing domestic public spending levels at 24 percent of total domestic public and international spending in 2013.

Prevention of HIV transmission

- While HIV incidence is declining, due especially to the reduction of mother-to-child transmission, the rate of decline is still too slow. AIDS remains a leading cause of death among the 15 to 44 year-old population, and the Caribbean is still the second most affected region in the world behind sub-Saharan Africa. Social and cultural factors, including gender norms and stigma associated with HIV and homosexuality, contribute to the continued spread of HIV.⁹
- Condom use has increased for some groups and in some settings, including among people with two or more sexual partners in Jamaica.¹⁰ However, usage rates are below 50 percent among similar populations in Barbados, Dominican Republic, Haiti, Suriname

8. UNAIDS. Global Report: UNAIDS report on the global AIDS epidemic 2013. 2013. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

9. Figueroa, P. Review of HIV in the Caribbean: Significant Progress and Outstanding Challenges. *Current HIV/AIDS Reports*. 2014 Jun;11(2):158-67.

¹⁰ Ibid

and Trinidad and Tobago. Usage is higher among MSM at than 50 percent in 16 reporting countries and for female sex workers, at 85.2 percent in Jamaica, 94.2 percent in Guyana and 98.4 percent in Suriname.¹¹

- While countries have improved the provision of testing services for the general population through such initiatives as national days of testing, low levels of HIV testing continue to be reported among sexually experienced youth in Guyana, Haiti and the Dominican Republic (from 17 percent in Haiti to 48 percent in the Dominican Republic).¹² Access to HIV testing is inadequate for MSM in Saint Lucia and Dominica where less than 40 percent are reached.¹³ The percentages of sex workers tested were higher in Saint Lucia (51 percent), Jamaica (59.2 percent), Belize (66.3 percent) and Guyana (83.9 percent).¹⁴
- These findings underscore persistent concerns about inadequate access to prevention services for key populations and vulnerable groups. Only five countries reported prevention programmes for MSM in 2012 -- up from three in 2009. The capacity to reach sex workers is best in Haiti and Jamaica (80 percent) and low in the Dominican Republic, Suriname and Guyana where less than 50 percent of this population is reached. Many national programmes do not adequately address the needs of youth, and only Jamaica defines and targets subpopulations of marginalised youth.¹⁵

Treatment, Care and Support

- Providing regional public goods and services in these areas has been a strength of the PANCAP response. Good examples are the dissemination of treatment guidelines, training of health care workers, and regional procurement and advocacy processes to improve access to antiretrovirals (ARVs).
- A key result has been the advancement of antiretroviral therapy (ART) coverage since 2009, although there continue to be serious concerns about equitable access and the quality of service provision. Weaknesses in procurement and supply chain management capacity impact the availability of medication and other supplies, and stigma and discrimination continue to constrain access, particularly for key populations. Countries report the need to strengthen linkages to treatment, care and support and to improve retention of patients on treatment. The 12-month retention rate for adults and children is as low as 33 percent in St. Kitts and Nevis.¹⁶

¹¹ Ibid

¹² PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2012.

¹³ Andrews, BE. Prevalence and correlates of HIV testing among Caribbean youth. *Int J STD AIDS*. 2011 Dec;22(12):722-6.

¹⁴ PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2012.

¹⁵ Ibid

¹⁶ PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2012.

- Financing of treatment programmes continues to be a major concern for the region. Nine of 16 reporting countries are still considered highly dependent on external funding for ART costs and there are large differences, between countries, in the per-patient cost of treatment.¹⁷

Table 1. Dependency on external resources for ART financing

	2007-2008	2013
High 75-100 percent external funding of ARV	Antigua and Barbuda Dominica Grenada Guyana Haiti Jamaica St. Kitts and Nevis St. Vincent and the Grenadines Dominican Republic Saint Lucia Suriname	Antigua and Barbuda Dominica Grenada Guyana Haiti Jamaica St. Kitts and Nevis St. Vincent and the Grenadines
Medium 20-75 percent external funding of ARV	Cuba Anguilla Belize Montserrat	Cuba Dominican Republic Saint Lucia
No Dependency 0-5 percent external funding of ARV	Bahamas Barbados Trinidad and Tobago	Anguilla Bahamas Barbados Belize Montserrat Suriname Trinidad and Tobago

Source: WHO Antiretroviral Use Survey, 2013; PAHO. Antiretroviral therapy under the spotlight: a public health analysis in Latin America and the Caribbean 2012

Capacity development for HIV and AIDS services

- Capacity building has focused on human resources, laboratory services and monitoring and evaluation and has been achieved through technical assistance, needs-based training and sharing of information, skills and regional service providers.
- Weaknesses in health systems continue to present barriers to access and sustainability of services, particularly where parallel service delivery systems for HIV have been established. Vertical systems are inefficient, costly and perpetuate stigma and discrimination, resulting in low rates of entry and retention in treatment. Of major

17. UNAIDS. Global Report: UNAIDS report on the global AIDS epidemic 2013. 2013. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

concern is the loss of patients at various stages along the HIV treatment continuum, as this reduces the proportion achieving viral suppression.

Monitoring, evaluation and research

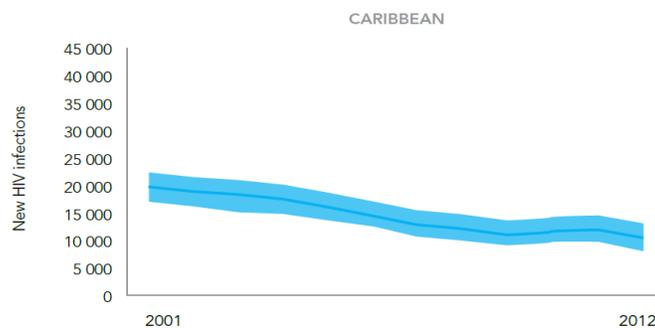
- PANCAP has worked to strengthen national monitoring and evaluation systems in a number of key areas, including evaluation of national AIDS programmes; implementation of special studies among key populations; development of monitoring and evaluation (M&E) plans; and training in results-based management.
- Countries continue to face deficiencies in research capacity and in translating findings into actionable recommendations for policy and programme development.

3.0 EPIDEMIOLOGIC PROFILE

The Caribbean has made significant progress in stemming the HIV epidemic. This is evident in data which show:

- **HIV prevalence in the Caribbean has declined over the period 2001 to 2012 from 1.3 to 1 percent** (95percentConfidence Interval 0.9percent- 1.1 percent). The Bahamas (3.3 percent), Haiti (2.1 percent), Belize, Guyana, Jamaica, Suriname and Trinidad and Tobago have rates over 1.0 percent. Prevalence is estimated at below 1.0 percent in Barbados, Cuba and the Dominican Republic (0.9%, 0.1percent and 0.7 percent respectively).
- **HIV incidence in the Caribbean has decreased by 49 percent between 2001 and 2012, with 12,000 new infections reported in 2012.**¹⁸ The rate of new infections is declining faster than in any other region.

Figure 1. Trends in HIV Incidence in the Caribbean 2001-2012



Source: Global report: UNAIDS. Global Report: UNAIDS report on the global AIDS epidemic 2013. 2013.

- **An overwhelming majority of new infections occur in four of the larger countries: Haiti, Dominican Republic, Jamaica and Trinidad and Tobago.** Haiti alone accounted for approximately 71 percent of the new infections recorded in 2012.
- **Many countries have features of both a generalised and a concentrated epidemic. While heterosexual transmission is the predominant mode of transmission of HIV in the Caribbean, MSM represent a significant proportion of HIV cases.**^{19,20} Data show nearly equal numbers of men and women living with HIV although there are

18. UNAIDS. Global Report: UNAIDS report on the global AIDS epidemic 2013. 2013. Available at http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf

19 Figueroa, P. Review of HIV in the Caribbean: Significant Progress and Outstanding Challenges. *Current HIV/AIDS Reports*. 2014 Jun;11(2):158-67.

20. PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2012.

significant differences between the proportions of women living with HIV across countries—from 19 percent in Cuba to approximately 60 percent in the Bahamas.²¹ These figures may reflect a cultural context in which more women than men choose to be tested, including through well-developed prevention of mother-to-child transmission (PMTCT) programmes, and in which men who have sex with men may choose not to report same-sex activity.

- **The Caribbean is poised to be the first region to eliminate the transmission of HIV from mother to child.** New cases of HIV infection among children declined by 32 percent between 2009 and 2011, and the estimated number of new infections in children declined from 3,500 in 2001 to fewer than 55 in 2012. There is high variability in transmission rates across countries, and the vast majority of new infections continue to occur in Haiti.²²

Table 2. Mother-to-child transmission and testing rates in selected countries

Country	Transmission Rate	Percentage of pregnant women tested who received results (2011)
Antigua and Barbuda	20.0 (2011)	55
Bahamas	5.0-7.0 (2010)	73
Barbados	0.0 (2011)	63
Belize		87
Cuba	1.1 (2011)	>95
Dominica	0.0	64
Dominican Republic	4.0 – 8.0	46
Grenada	0.0 (2011)	>95
Guyana	4.6 (3.0-7.0) (2011)	>95
Haiti	11.1 (2011)	
Jamaica	7.6 (2011)	55
Saint Lucia	0.0 (2011)	65
St Vincent and the Grenadines		>95
Suriname	5.5 (5.0-17.0) (2011)	84

21. Figueroa, P. Review of HIV in the Caribbean: Significant Progress and Outstanding Challenges. *Current HIV/AIDS Reports*. 2014 Jun;11(2):158-67.

22 PAHO. 52nd Directing Council, 65th Session of the Regional Committee. Strategy and Plan of Actions for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis: Mid Term Evaluation. 2013.

Trinidad and Tobago		70
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Source: PAHO. 2012 Progress Report: Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis in the Americas. 2013.

- **AIDS-related mortality has declined by 52 percent from 24,000 deaths in 2001 to 11,000 deaths in 2012.** The number of deaths is highest in Haiti (7,500 or 68 percent of the regional estimate), followed by the Dominican Republic (17 percent) and Jamaica (12percent).
- **The number of people living with HIV is estimated to be 250,000 (2012)** and of these, 60 percent live in Haiti.
- **Coverage with antiretroviral therapy has increased from less than five to 70 percent of the eligible population between 2001 and 2010.**²³ Significantly, coverage of pregnant women living with HIV increased from approximately 55 to greater than 95 percent between 2008 and 2013. Of the estimated 5,700 women whose need for ART is unmet, 4,200, or 74 percent, are in Haiti.

Table 3. ART coverage in selected countries

Country	No. PLHIV	% Adult HIV prevalence	No. Deaths	% ART coverage
Bahamas	700	3.3	500	71
Barbados	1,550	1.0	<100	90
Belize	3,100	1.4	<200	91
Cuba	4,700	<0.1	<100	99
Dominican Republic	45,000	0.7	1900	92
Guyana	7,200	1.3	<100	77
Haiti	150,000	2.1	7500	58
Jamaica	28,000	1.7	1300	58
Suriname	4,000	1.1	<200	67
Trinidad & Tobago	14,000	1.6	750	73
Caribbean	250,000	1.0	11,000	70

23. PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2012.

3.1 Key populations at higher risk of HIV exposure in the Caribbean

The term ‘key populations’ or ‘key populations at higher risk of HIV exposure’ refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response.

UNAIDS Terminology Guidelines. 2011.

The conservative and close-knit nature of Caribbean societies makes it difficult to identify, define and reach key population groups. This is compounded by the limited availability of disaggregated data, particularly in smaller countries where information systems are not well developed. In 2012, for example, only six countries reported data on men who have sex with men, and despite high rates of population mobility in the region, there is very little data on HIV prevalence among migrant and mobile populations. Further, the vast majority of countries do not collect or report data for subgroups of stigmatised and isolated populations who often face multiple and overlapping vulnerabilities and risks. These include non-identifying MSM, transsexuals, non-identifying sex workers, MSM sex workers who do and do not identify as gay, mobile sex workers, transgender sex workers, youth involved in transactional sex and drug users.

Recent modes of transmission studies, surveys and participatory research have contributed to a better understanding of the dynamics of the epidemic in the following key populations at higher risk of HIV exposure:

- Men who have sex with men
- Heterosexuals at high risk
- Sex workers and their clients
- Adolescents and youth
- People who use drugs
- People living with HIV.

Men who have sex with men. In the Caribbean MSM are five to ten times more likely than the general population to be living with HIV. In the Dominican Republic, prevalence is 11 percent among MSM in contrast to less than one percent for the general population. In Jamaica, prevalence among MSM may be as much as ten times higher than for the general population, at an estimated 32 percent in 2012. Prevalence among MSM is similarly high in Guyana (19 percent), Trinidad and Tobago (19 percent) and Haiti (18 percent).²⁴ Because of high levels of stigma, however, survey data may not be representative of the entire MSM population.²⁵

Heterosexuals at high risk for HIV infection. In the Caribbean, this group includes those with multiple and/or casual partners; those who are clients of sex workers or who participate in transactional sex; those who are in the military; and those who abuse alcohol. In Jamaica, this

24. PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2012.

25. Figueroa, P. Review of HIV in the Caribbean: Significant Progress and Outstanding Challenges. *Current HIV/AIDS Reports*. 2014 Jun;11(2):158-67.

risk group, their partners and low-risk heterosexuals, account for approximately 50 percent of new infections.²⁶ In the Dominican Republic, studies show high-risk behaviour among heterosexual men stationed at military border-crossing zones: condom use is inconsistent; 41 percent report having casual sex during the past 12 months; 37 percent have had sex with a sex worker; and 15 percent report using sexual coercion in the past 12 months.²⁷ Over the period 2010 to 2012 in Saint Lucia, high-risk behaviour among sexually active men aged 25 to 49 years old worsened. Condom use declined from 61.8 to 47.9 percent; the number receiving an HIV test in the past 12 months declined from 62.7 to 35.4 percent; the number receiving an STI screening in the past 12 months fell from 37.3 to 29.1 percent; and the average number of casual partners increased from 1.87 to 2.41.²⁸

Sex workers in the Caribbean show persistent high levels of HIV prevalence, even where reductions have been achieved among female, establishment-based and self-identifying sex workers. This is the case in Guyana, Jamaica and the Dominican Republic where, in 2012, HIV prevalence among sex workers in was estimated to be 16.6, 4.6 and 3.7 percent respectively—higher than overall adult prevalence which ranges from 0.7 percent in the Dominican Republic to 1.7 percent in Jamaica. Elsewhere in the region, prevalence among female sex workers ranges from approximately 5 percent in Haiti to 24 percent in Suriname. Clients of sex workers are also significant contributors to new infections.

Adolescents and youth show mixed trends in HIV prevalence. While less than 1.0 percent of young people aged 15-24 in the Caribbean are living with HIV, there are indications that prevalence is increasing in some countries. In Guyana, for example, the population aged 15-24 accounts for 17.69 percent of cases. This is up from 15.6 percent in 2006. Strong indications that young people are at higher risk for HIV include high rates of early initiation of sex (before the age of 15) in most Caribbean countries. This is higher than 30 percent in The Bahamas, Haiti and Jamaica, and at 20 percent in Barbados, Cuba, Dominica, the Dominican Republic, Guyana, St. Kitts and Nevis and St. Vincent and the Grenadines.²⁹

26. Jamaica Modes of Transmission Study

27. Figueroa, P. Review of HIV in the Caribbean: Significant Progress and Outstanding Challenges. *Current HIV/AIDS Reports*. 2014 Jun;11(2):158-67.

28. PSI Research & Metrics, "HIV/AIDS TRaC Study Evaluating Condom Use among Sexually Active Youth 16-24 years in St. Lucia," TRaC Summary Report, (2012). Available at <http://www.psi.org/resources/publications>

29 PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2012.

Box 2. Health behaviours among sexually active youth 16 to 24 years old

- **Low HIV and STI testing rates.** In Suriname rates were 27.5 percent for HIV and 19.9 percent for STIs, and in Belize 3 percent for HIV and 30.6 percent for STIs. In Saint Lucia, the proportion receiving an HIV test in the past 12 months declined from 52.2 to 36.7 between 2010 and 2012, and the proportion screened for an STI also decreased from 32.2 to 25 percent in the same period.
- **Good access to condoms.** Over 90 percent of respondents in Belize and Suriname reported that they can get a condom when they need one, but only 77.3 percent in Belize and 64.6 percent in Suriname said that it is easy to purchase a condom.
- **Limited ability to use condoms correctly.** Correct condom use was demonstrated by only 26.5 percent of surveyed youth in Suriname and 32.5 percent in Belize.
- **Self-efficacy variables are mixed.** In Saint Lucia, only 11 percent of respondents feel able to convince their partners to use a condom, while in Belize this rises to 91 percent.
- **Consistent condom use varies according to partner type.** With regular partners, condom use is reported at 45.9 percent in Suriname and 45.3 percent in Belize. Rates are higher for non-regular partners, at 72.7 percent for Suriname and 69.1 percent for Belize. In Saint Lucia, there was a dramatic decline in reported condom use with regular partners, from 33.3 percent in 2010 to 1.7 percent in 2012. Consistent condom use with non-regular or commercial partners increased from 52 to 70.7 percent over the same period.
- **Fewer partners, but increased sexual activity.** The proportion of young people who report having sexual partners declined in Saint Lucia from 4.73 to 2.83 percent between 2010 and 2012. At the same time, findings show an increase from 18.59 to 31.06 in the number of sex acts in the last month, suggesting that sexually active youth have fewer partners but more sexual encounters.

Source: *PSI Research & Metrics, "Saint Lucia (2012): HIV/AIDS TRaC Study Evaluating Condom Use among Sexually Active Youth 16-24 years. Round 2" TRaC Summary Report, (2012)* <<http://www.psi.org/resources/publications>>.

People who use crack cocaine in Caribbean countries are at higher risk of becoming infected with HIV, perhaps because of the association between drug use and transactional sex and risky sex.³⁰ In Trinidad and Tobago, a significant number of people living with HIV report a history of crack use,³¹ and similar evidence exists from the Dominican Republic and Jamaica, particularly among people who have been deported from the United States of America.³²

People living with HIV. The region faces the challenge of expanding treatment, care and support services to meet the needs of increasing numbers of people who are living longer with

30. UNAIDS. Keeping Score III: The Voice of the Caribbean People. 2011.

31. http://data.unaids.org/Publications/Fact-Sheets01/trinidad-tobago_en.pdf

32. Figueroa, J.P. The HIV epidemic in the Caribbean: meeting the challenges of achieving universal access to prevention, treatment and care. *West Indian Medical Journal* 2008; 57 (3): 195-203.

HIV - many of whom are also coping with chronic diseases. National programmes report that linkage to care and retention in care are areas of particular concern. Stigma and discrimination continue to be obstacles to testing, disclosure, condom use and access to treatment.

Box 3. Modes of HIV transmission studies

- In the Dominican Republic, evidence suggests the coexistence of generalised and concentrated epidemics. Most new infections are estimated to have occurred in two key population groups: 31.9 percent in a segment of the general population who engage in sex with a steady partner (low-risk heterosexuals) and 33 percent in gays, transsexuals and other men who have sex with men (GTMSM). Other key populations at higher risk of exposure include residents of 'bateyes' or communities located on or near sugar cane plantations (9.1 percent), clients of sex workers (5.6 percent) and people having casual sex (8.3 percent).³³
- In Jamaica, the HIV epidemic has become increasingly concentrated among high-risk groups with 32 percent of new infections occurring in the MSM group and 7.2 percent among their female partners. The self-identified casual heterosexual sex risk group, their partners and low-risk heterosexuals account for approximately 50 percent of new infections. Sex workers, their clients and the partners of sex worker clients contribute 10 percent of new infections.³⁴

3.2 Social and cultural factors

A fundamental rationale for the regional response has been the need to confront deeply ingrained social and cultural norms and beliefs, particularly around gender roles, that drive the epidemic in the Caribbean by increasing vulnerability and creating barriers to services for key populations at higher risk. These cultural norms and beliefs also impact more widely on infected and affected persons, including partners and children of people who are HIV positive. Gender norms increase the vulnerability of women and girls, as well as men and boys, to risky behaviours.

Early initiation of sex. This typically occurs before the age of 15 in most Caribbean countries. In The Bahamas, Haiti and Jamaica, almost a third of teenagers have initiated sex by age 15, while almost a fifth report having done so in Barbados, Cuba, Dominica, the Dominican Republic, Guyana, St. Kitts and Nevis and St. Vincent and the Grenadines.³⁵ It is estimated that most infections occur when individuals are in their teens and early twenties,³⁶ and there is evidence of increasing HIV prevalence among youth in many countries, including Trinidad and Tobago and Guyana.

33. UNAIDS and COPRESIDA. HIV Modes of Transmission Model. Analysis of the distribution of new HIV infections in the Dominican Republic and recommendations for prevention. Final Report. 2010. Available at

http://www.unaids.org/en/media/unaids/contentassets/documents/countryreport/2010/201011_MOT_DominicanRepublic_en.pdf

34. UNAIDS and the National HIV/STI Programme, Jamaica Ministry of Health. HIV Modes of Transmission Model Distribution of new HIV infections in Jamaica for 2012: Recommendations for efficient resource allocation and prevention strategies. Available at www.academic.edu

35. PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2012.

36. Interagency Coalition on AIDS and Development One Blood: Youth & HIV in the Caribbean and Caribbean Diaspora in Canada. 2011

Age mixing in sexual relationships usually involves young women participating in a complex web of concurrent sexual relationships, including with significantly older men. The scale of this problem and the blurred boundary between transactional sex and sex work present a major challenge for developing effective interventions.

High rates of multiple partnering among the general population aged 15 to 49. Almost 50 percent of this population in Trinidad and Tobago have had more than one partner in the previous 12 months. In Jamaica, almost a third of the population report multiple partners, and in other countries this proportion ranges from 15 to 23 percent.³⁷

High prevalence of transactional sex. Commercial sex is readily available and not regulated in most Caribbean countries. Throughout the region, this, coupled with the phenomenon of hidden bisexuality, is a significant driver of the epidemic and likely contributes to what has been termed a ‘feminisation’ of the epidemic.

Hidden homosexuality and bisexuality resulting from homophobia in conservative Caribbean societies. Gay, transsexual and other men who have sex with men may be reluctant to disclose their sexual orientation because of stigma and discrimination that is legitimised by archaic punitive laws. This drives the epidemic underground by preventing testing, treatment adherence and disclosure of HIV status.

Increasing levels of gender-based violence in the region increases vulnerability to HIV by constraining women’s and men’s control over sexual activity, including condom use. The 2013 World Health Organization (WHO) Report on Violence Against Women ranks the Caribbean as having three of the top ten recorded rape rates the world.³⁸ The Caribbean countries for which there are available and comparable data, each have a rape rate higher than the average for the 102 countries studied in the report. Violence against MSM and transgender people has been documented extensively in a nine-country study by the Caribbean Epidemiology Centre (CAREC). Data from CVC/COIN qualitative surveys show high numbers of youth regularly experiencing forced sex or threats of violence, particularly youth involved in transactional sex and LGBT youth.³⁹

Stigma associated with HIV continues to be prevalent in the Caribbean, and prevents people from getting tested, disclosing their HIV status and accessing HIV and other health

37. PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2012.

38. WHO, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council. Global and regional estimates of violence against women. Prevalence and health effects of intimate partner violence and non-partner sexual violence. 2013. Available at <http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/>

39. PANCAP Coordinating Unit. Analysis of 2012 Country Progress Reports. 2014.

40. Figueroa, P. Review of HIV in the Caribbean: Significant Progress and Outstanding Challenges. *Current HIV/AIDS Reports*. 2014 Jun;11(2):158-67.

41. This refers to Caribbean people maintaining a home in two countries between which they move with varying frequency.

42. <http://www.iom.int/cms/en/sites/iom/home/what-we-do/migration-health-2/hiv-and-population-mobility.html>

services. An estimated 50 percent of HIV positive people do not disclose their status and, among MSM, the proportion who do not disclose is even higher at 60 percent.⁴⁰

Intra-Caribbean migration, including high levels of transnational mobility⁴¹ and return migration, may increase the vulnerability of certain migrant subpopulations who face a range of barriers to accessing health services.⁴² Because countries do not collect, publish or standardise detailed data on migrants, it is difficult to understand the scope of challenges related to migration in the region, including HIV prevalence. There is an immediate need to improve data, both within and across countries, on who migrants are; where they are; where they came from; why and when they move; and the circumstances in which they live in their destinations. Migrants who may be at higher risk of HIV transmission include those who are undocumented; irregular migrant workers across a range of sectors (including agriculture, construction, tourism, sex work); families and partners of migrants (including sex workers); as well as victims of sexual and gender-based violence and trafficked persons (or victims of trafficking or persons who have been trafficked).

3.3 The economic context

The Caribbean region is characterised by a wide range of economic and human development levels. Three countries -- The Bahamas, Barbados and Trinidad and Tobago -- have developed-country status while at the other end of the spectrum, Guyana is considered to be lower middle-income and Haiti to be low-income. In between these extremes, countries as diverse as Antigua and Barbuda, Belize, Cuba, Dominican Republic, Grenada, Jamaica, Saint Lucia, St Kitts and Nevis, St Vincent and the Grenadines and Suriname are all classified as middle-income, in spite of their vastly different economic and social environments.⁴³ Gross domestic product levels range from a high of US\$32,000 in The Bahamas to US\$8,000 in Guyana.⁴⁴

At the same time, Caribbean countries share special vulnerabilities common to small island developing states (SIDS), which constitute severe and complex challenges to sustainable development. These include:

- **High dependence on a narrow range of resources.** Caribbean states are highly dependent on the agriculture and tourism sectors for economic growth, and can be

43. According to World Bank income classifications.

44. International Monetary Fund. Regional Economic Outlook Update. October 2012.

grouped as commodity exporters or service-based economies with mainly tourism and financial services.

- **High levels of vulnerability to external shocks.** Vulnerability resulting from the lack of economic diversity and heavy reliance on international trade and tourism in-flows is compounded by limited institutional capacities and small domestic markets.
- **High levels of exposure to frequent and devastating natural disasters.** Because of the small land mass, high population density and limited resources for disaster preparation and recovery, natural disasters often have disproportionate and long-lasting economic, social and environmental consequences. The six countries of the Eastern Caribbean rank among the top ten most disaster prone countries in the world, measured in terms of disasters per land area or population. All Caribbean countries are listed among the top 50 hot spots for natural disasters.
- **Vulnerability to climate change and sea-level rise.** The Caribbean islands and low-lying continental entities are vulnerable to the adverse effects of climate change and sea-level rise, which are expected to worsen and, therefore, present a serious risk to the sustainable development of the region.

The special vulnerabilities of small island developing states coexist with the economic and fiscal challenges which result, in large part, from the detrimental effects of trade liberalisation and globalisation. For decades, this has included high rates of migration of professionals and skilled workers to Europe and North America, seriously depleting the region's reserves of human resources, particularly in the areas of education and health. The adverse consequences of migration losses on the region's economic development are significant, including the loss of the person's contribution to the country's economic activity; the high cost of skill replacement; and opportunities lost for capacity building based on human resources, particularly since the education level of the average Caribbean emigrant is higher than the average for remaining nationals.⁴⁵ While the entire Caribbean region is affected by losses in human resources, losses in the health and education sectors have a disproportionately negative impact on poorer countries.

The small economies of the Caribbean are very open to international trade. Weak external demand, including erratic tourism growth, unfavourable terms of trade and high dependence on oil imports have contributed to sizable external current account deficits. By some assessments, the Caribbean has been getting poorer over recent decades; GDP has been declining as growth and competitiveness have deteriorated as a result of low productivity and high costs. Further, many Caribbean economies face high and rising debt-to-GDP ratios that jeopardise prospects for medium-term debt sustainability and growth. Average debt exceeded 76 percent of GDP in 2013 with rates of over 100 percent in Jamaica and St Kitts and Nevis.⁴⁶ A number of Caribbean states are unable to finance their high debt, while Antigua and Barbuda, Jamaica and St. Kitts and Nevis have moved ahead with debt restructuring.

45. International Monetary Fund. Regional Economic Outlook Update. October 2012.

46. Ibid.

Poverty in the Caribbean is expressed in many ways, for example, in the weak status of the labour market, the status of vulnerable groups in society, poor health facilities for large portions of the population, poor efficiency and quality of social services (safe water supply, electricity, adequate housing), high income disparities, poor infrastructure in many countries and inadequate maintenance of same, crime and violence, shortcomings in matters of governance and social well-being, generally.

UNDP. 2012 Caribbean Human Development Report

There is consensus that the global financial crisis of 2008-09 hit the region hard, and that service-based economies have particularly suffered because of reduced tourism arrivals. As exports have also decreased, GDP growth has been sluggish for the region as a whole. Goods producing economies have responded to the crisis in a somewhat better way than service producing economies. Guyana and Haiti, for example, saw their economies grow while the Jamaican economy was at a standstill, and Barbados and Dominica experienced contraction. Low overall regional growth of less than one percent in 2012 was driven by the commodity producing countries, while those reliant on tourism and the financial sector experienced an overall decline. Weak growth has, in turn, negatively impacted unemployment. Rates are high across the region (4.9 percent to 21.4 percent) and have increased in countries like Barbados and Jamaica.⁴⁷

At the same time, the global financial crisis has resulted in official development assistance to the region becoming much more limited. Aid inflows to the region are declining both as a percentage of gross national income (GNI), and in comparison with other developing regions in spite of the vulnerability of the small island states, whose traditional economies are being undermined by globalisation. A major contributing factor is the classification of a larger number of Caribbean countries as 'middle-income', disqualifying them from the per capita income-based criteria on which official development assistance is allocated. This criteria reflects the assumption that increasing per capita incomes will translate into increasing resources and capacity to finance development, and that this measure is adequate for capturing the range of needs and vulnerabilities of the middle income countries in the region. This is not the case however, as these countries continue to face a range of structural gaps, which include differing poverty rates, levels of social inclusion and institutional financial capacity. Middle-income countries need support to be able to overcome the range of obstacles to addressing poverty and inequality, and to overcome vulnerabilities in order to develop viable economies.⁴⁸

Specific to HIV, global funding has not increased significantly since 2008, a flattening that mirrors trends in development assistance more generally. In 2012, donor governments disbursed US\$7.86 billion toward the AIDS response in low-and middle-income countries, essentially unchanged from the US\$7.63 billion level in 2011 (after adjusting for inflation). Many countries in the region have become, and continue to be, highly dependent on external financing for a significant proportion of HIV investment and for ARVs in particular. As financing

⁴⁷ United Nations. ECLAC. Economic Survey of the Caribbean 2013.

⁴⁸ United Nations. ECLAC. Middle-income countries: A structural-gap approach. 2012.

declines and numbers of people requiring treatment increase, governments will be challenged to identify budgetary flexibility for additional investments in HIV without compromising fiscal stability. The financing needs of the HIV response will remain substantial for many years to come as few countries will be able to fully fund their HIV response without international assistance. To sustain advancements, the results of the AIDS response must be an impetus for increasing investments, not decreasing them.

Box 3. Investing in HIV and health brings returns that are not exclusive to HIV.

Investments funded as part of HIV programmes are an important contributor to a functioning health system, and have positive externalities beyond health, as they affect the capacity of societies to address key social issues, for example, gender-based violence, social and family life education, and human rights. The recent Lancet Commission on Investment in Health estimates that up to 24 percent of economic growth in low and middle income countries was due to better health outcomes. While the payoffs are immense – investing in health yields a 9 to 20-fold return on investment - the case for investing in health is also about equity. Investing in HIV is an investment in Universal Health Coverage.

Source: UNAIDS Regional Support Team



Participants of key partners Meeting to develop the CRSF Operational Plan

4.0 CARIBBEAN REGIONAL STRATEGIC FRAMEWORK 2014-2018

Aligned with the epidemiological context and needs of national programmes, the CRSF 2014-2018 is a strategic investment approach that represents consensus among partners to guide regional efforts for sustainable health and development. Strategic priority areas and objectives are intended to strengthen and supplement national- and community-level programmes by focusing on issues best addressed through collaboration and with regional public goods and services. Within each strategic objective, expected results will be reinforced with national targets set by individual countries to promote national ownership, and to allow for variations in country capacity and rates of progress. While this flexibility is necessary to respond to the needs of different countries, a better understanding of the epidemic and mounting evidence about what works ensures that the CRSF 2014-2018 directs resources towards effective interventions that maximise the impact of regional efforts, and provide good value for money, including by intensifying efforts where HIV is most heavily concentrated.

4.1 Vision

An AIDS-free Caribbean

4.2 Goal

To halt the spread and reduce the impact of HIV in the Caribbean, while promoting sustainable health and development.

4.3 Strategic Priority Areas

The Strategic Priority Areas (SPAs) of the CRSF 2014-2018 build on previous iterations of the Framework to move the regional response closer to realising the vision of an AIDS-free Caribbean. Progress towards sustainable health and the elimination of HIV transmission requires an accelerated and systematic approach to confronting the breadth of issues across the human rights, social, economic and political dimensions of the epidemic. The SPAs are interlinked and overlapping, together constituting a holistic and comprehensive approach to addressing complex social and structural challenges. Progress is interdependent; results are required in all areas if the elimination of AIDS is to be achieved.

The six strategic priority areas are:

1. An enabling environment
2. Shared responsibility
3. Prevention of HIV transmission
4. Care, treatment and support
5. Integration
6. Sustainability

Although research is not defined as a stand-alone priority, it is cross-cutting and fundamental to all six Strategic Priority Areas. A guiding principal of the regional response is that efforts must

be evidence informed and national programmes must be supported to conduct research, surveillance and M&E.

4.4 Strategic objectives and expected results

STRATEGIC PRIORITY AREA 1: AN ENABLING ENVIRONMENT

An 'enabling environment' establishes and sustains equal opportunities for health and well-being regardless of race, class, religion, gender, sexual orientation, age, disability or country of citizenship. It refers to the responsibilities of governments with respect to the rights enshrined in the Universal Declaration of Human Rights and the constitutions of all Caribbean States. Specific to HIV, these rights underpin the MDGs, UNAIDS *Getting to Zero*, the PANCAP 10th Annual General Meeting and the 2011 United Nations High Level Meeting Declaration. PANCAP's *Justice for All* programme establishes human rights as a priority of the regional response through a Pan Caribbean Declaration and Roadmap aimed at reducing stigma, eliminating discrimination and strengthening rights-based legislative frameworks by reforming laws that are incompatible with these international commitments.

The rights of all residents are also accompanied by the responsibility to lead, participate in and support processes to change harmful social norms that sanction gender inequality and stereotypes, interpersonal and gender-based violence, child abuse, discrimination and stigma associated with HIV and against homosexuals and other marginalised groups, including the differently abled. This will require widespread education, advocacy and a more open approach to human sexuality, as well as pragmatic responses to overcoming everyday manifestations of stigma, discrimination and social exclusion. Evidence-informed strategies to address gender-related risks and vulnerabilities to HIV and AIDS will be incorporated in each of the CRSF Strategic Priority Areas and will be a particular area of focus in working towards an enabling environment. Barriers to prevention and treatment programmes will be targeted at multiple levels to mitigate individual risk behaviours and to promote community engagement, including in advocacy, provision and monitoring of high quality services and in governance and oversight of the regional response.

Strategic objectives:

- 1.1 Increase access to justice for all in the Caribbean.
- 1.2 Promote the development and acceptance of positive social norms and behaviours that support healthy and equitable societies.

Strategic objective 1.1: Increase access to justice for all in the Caribbean.

Expected results:

- 1.1.1 Understanding of the roles and responsibilities of governments and residents of the region in enforcing rights-based laws and policies is increased.

- 1.1.2 Sector-specific policies and programmes are implemented to eliminate discriminatory practices.
- 1.1.3 Rights-based policies and laws are enacted with the appropriate regulations and training to enable enforcement.
- 1.1.4 Litigation is used strategically to establish precedents which advance social justice and constitutional rights.

Strategic Objective 1.2: Promote the development and acceptance of positive social norms and behaviours that support healthy and equitable societies.

Expected results:

- 1.2.1 Understanding of human sexuality, sexual health and responsible sexual behaviour is increased.
- 1.2.2 Positive norms and behaviours that support gender equality and reduce gender-role stereotypes, gender-based violence, violence against children and child abuse are promoted.
- 1.2.3 High-quality, accessible and acceptable sexual and reproductive health services are available to meet the needs of adolescents, women and men regardless of disability, age, citizenship status, gender identity or sexual orientation.
- 1.2.4 Multisectoral interventions that promote gender equality, and prevent and respond to gender-based violence, violence against children and child abuse are implemented.

STRATEGIC PRIORITY AREA 2: SHARED RESPONSIBILITY

“Shared responsibility is not an option for small states. It is our reality. We have no choice in the Caribbean but to develop shared approaches in all sectors.”

Honourable Denzil Llewellyn Douglas, Prime Minister of the Federation of St Kitts and Nevis

The principle of shared responsibility is at the core of the PANCAP model and of a broader, more inclusive vision of health and sustainable development in the region. Harnessing the comparative advantages of all partners, in multiple sectors, increases the availability of resources, improves efficiency and creates synergies for sustainable long-term solutions to common problems. Shared responsibility in the regional response to HIV underscores a commitment to an enabling environment (SPA 1) and sustainability (SPA 6) by ensuring voice and participation in decision making and diversifying funding sources. It expresses the importance of good governance at all levels of the response, including active and sustained

political leadership, efficient regional coordination and people empowered to hold governments accountable for how resources are used and results are achieved. Country ownership will continue to be central to a strong and mutually accountable partnership. More effective and sustainable investments that reflect country priorities will ensure that regional public goods and services translate to real benefits on the ground. Sharpening the focus on connectivity at the regional, national and community levels through information sharing, technical support and multisectoral and public-private partnerships will reinforce the leadership role of country partners in setting priorities, implementing programmes and achieving results. Community systems strengthening to develop the capacity of key populations to engage as full partners in the regional response is a cross-cutting area of focus for PANCAP.

Strategic objectives:

- 2.1 Strengthen country ownership through multisectoral approaches and by increasing the use of modalities such as horizontal cooperation.
- 2.2 Strengthen accountability and transparency mechanisms to promote good governance.

Strategic objective 2.1: Strengthen country ownership through multisectoral approaches and by increasing the use of modalities such as horizontal cooperation.

Expected results:

- 2.1.1 Reporting and information sharing is strengthened and streamlined at all levels to promote evidence-informed decision making within the partnership.
- 2.1.2 Regional technical leadership is coordinated to provide coherent, consistent and creative strategic guidance to national programmes.
- 2.1.3 Technical support is tailored to country needs, including laboratory capacity and strategic information (research, surveillance, data management and M&E).
- 2.1.4 The private sector is a partner in strengthening national systems through the application of its competencies, infrastructure and resources.
- 2.1.5 Civil society, people living with HIV and key populations are empowered to engage in all facets of the response.
- 2.1.6 Civil society, people living with HIV and key populations are partners in planning, delivery and evaluation of quality-assured, rights-based prevention, care and treatment programmes.

Strategic objective 2.2: Strengthen accountability and transparency mechanisms to promote good governance.

Expected results:

- 2.2.1 Systems are strengthened to measure, track, document and report on funding flows in order to better understand the response and for greater transparency and accountability in the deployment of resources.
- 2.2.2 At all levels of the partnership, procedures, policies and agreements that facilitate accountability and transparency are in place.
- 2.2.3 Improved harmonisation of international and regional partners to support more effective and efficient regional and country responses is achieved.

STRATEGIC PRIORITY AREA 3: PREVENTION OF HIV TRANSMISSION

Preventing new infections continues to be the cornerstone of a sustainable and successful regional response. While results have been achieved, most notably in preventing mother-to-child transmission, accelerating prevention efforts is an imperative in the context of diminishing financial resources for HIV. The goal of eliminating transmission to children is within reach, and can be achieved by simplifying and expanding ART for all pregnant women, and by ensuring continuity of treatment to lower lifetime transmission rates. Treatment programmes are also faced with the long-term prospect of supporting increasing numbers of people on ART for longer periods, as AIDS-related mortality declines and countries move towards implementing the 2013 WHO Treatment Guidelines. Small declines in infection rates will not be enough to off-set these costs, and maximizing impact and value for-money requires a combination prevention approach with a range of evidence-based behavioural and biological interventions appropriate to the country context and to the needs of key populations at higher risk. Resources must be targeted to where the epidemic is at the country, community and individual levels. Doing so effectively will require establishing and sustaining an enabling environment (SPA 1) by addressing social and cultural drivers of the epidemic and by removing barriers to service access. In particular, more conscious efforts to address human sexuality are needed in order to equip young people with the knowledge and tools they need for healthy development. In many countries, economic and social support programmes, including the use of community platforms for service delivery, the provision of incentives to promote health seeking behaviours, and food and nutrition support, show promise in reducing vulnerability to HIV infection. These can be built upon, supported by the requisite research and M&E, for more holistic and integrated prevention approaches.

Strategic objectives:

- 3.1 Expand access to high-quality, evidence-based and appropriately targeted packages of prevention services (combination prevention).
- 3.2 Scale-up access to high-quality interventions for the elimination of mother-to-child transmission.

Strategic objective 3.1: Universal access to high-quality, evidence-based and appropriately targeted packages of prevention services.

Expected results:

- 3.1.1 Country-appropriate prevention strategies include high-impact interventions, such as increased coverage of HIV testing, counselling and treatment; widespread accessibility and use of condoms; and expanded access to STI testing and treatment.
- 3.1.2 Interventions are tailored to meet the needs of key populations, and uptake of services is increased.
- 3.1.3 Age-appropriate, gender-sensitive, evidence-informed programmes that provide comprehensive sexual and reproductive health education are being delivered throughout the education sector and in community settings.
- 3.1.4 Male and female condoms and lubricants are consistently available through appropriate distribution channels.
- 3.1.5 Comprehensive and integrated SRH services are being delivered.
- 3.1.6 Technical guidance and support is provided to establish and maintain high-quality standards for safe and effective prevention programmes.
- 3.1.7 Operational research is conducted to identify best practices and to inform the applicability of evidence-informed practices such as voluntary medical male circumcision and post-exposure prophylaxis (PEP).

Strategic objective 3.2: Scale-up access to high-quality interventions for the elimination of mother-to-child transmission

Expected results:

- 3.2.1 EMTCT interventions are integrated into MCH and SRH programmes.
- 3.2.2 Lifelong ART treatment is offered to all HIV positive pregnant women, regardless of CD4 count.
- 3.2.3 The 2013 WHO Treatment Guidelines are adapted for national use.
- 3.2.4 Linkages to ART are strengthened to improve retention in treatment post-delivery to ensure continuity if subsequent pregnancies occur.
- 3.2.5 Early infant diagnosis is provided for all HIV-exposed infants.

STRATEGIC PRIORITY AREA 4: CARE, TREATMENT AND SUPPORT

Throughout the region, countries are faced with the challenge of absorbing the full costs of treatment programmes. At the same time, the number of people on treatment will steadily increase as programmes move towards earlier initiation of treatment, provision of lifelong ART for pregnant women and ultimately, to a ‘test-and-treat’ approach. The scale of this challenge is evident in *Table 4* below which shows how coverage rates drop sharply with the application of the 2013 WHO Treatment Guidelines of initiation at a CD4 count of 500 or lower. The region as a whole falls below 50 percent, and it is estimated that full implementation of guidelines for pregnant women (Option B Plus) would amount to initiating lifelong treatment for an additional 75 percent of HIV positive pregnant women.⁴⁹ Further, moving towards universal access to treatment will require developing and implementing targeted programmes to better reach underserved key populations. This will add to the immediate and significant increases in treatment costs.

In this context, the expansion of treatment programmes must be strategic, driven by national priorities and with capacity constraints taken into account. Stepping-up regional efforts to mobilise resources and to implement measures to reduce the cost of ART will be essential. National programmes must also reduce inefficiencies associated with vertical procurement and delivery systems (SPA 5), and remove structural barriers which contribute to low rates of entry and retention (SPA 1). Adherence is a key issue for the region, as the numbers of people on second- and third-line regimens contribute to high costs and increased potential for drug resistance. With more people on treatment for longer periods, provision of a continuum of care and effective co-management of STIs, TB and NCDs, including mental illness, is increasingly important. Expanding treatment and increasing the proportion of PLHIV who achieve viral suppression, at a pace that countries can sustain, are critical for achieving the goal of an AIDS-free Caribbean. In the long term, the benefits to countries will be reduced transmission rates and fewer people entering treatment programmes.

⁴⁹ PHCO Presentation to 25 COHSOD. *The Rationale for Implementing the WHO Option B+ Treatment Approach in the Caribbean*, Sept 2013

Table 4. Comparison of current coverage with coverage under the 2013 WHO Guidelines

Country	Coverage Rate (2010)	Coverage Rate (2013 WHO Guidelines applied)
Haiti	60%	36%
Dominican Republic	77%	58%
Jamaica	69%	44%
Trinidad and Tobago	74%	46%
Guyana	93%	60%
Bahamas	73%	47%
Cuba	206%	140%
Suriname	66%	42%
Belize	71%	50%
OECS (Organisation of Eastern Caribbean States)	67%	45%
Barbados	105%	84%
Total	71%	45%

Source: PAHO Reports. ART Coverage in the Caribbean. 2013.

Strategic objectives:

- 4.1 Expand and sustain access to high-quality care, treatment and support, including management of STIs and co-morbidities.
- 4.2 Improve linkage, adherence and retention in care, treatment and support.

Strategic objective 4.1: Expand and sustain access to high-quality care, treatment and support, including management of STIs and comorbidities.

Expected results:

- 4.1.1 Access to ART is expanded, in a way that is sustainable and in keeping with national priorities and capacity, including increasing the treatment threshold.
- 4.1.2 Early identification and treatment of STIs and contact-tracing is strengthened.
- 4.1.3 Comprehensive clinical care and treatment which integrates preventive services and strategies for positive health and living across the life course, including for NCDs, mental health and psychosocial support, is provided.

- 4.1.4 Efficiency of procurement and access to ARVs and other supplies is improved, including through integration of service delivery.

Strategic objective 4.2: Improve linkage, adherence and retention in care, treatment and support.

Expected results:

- 4.2.1 The continuum of care is strengthened to improve service uptake, adherence and retention, including by optimising ART drug regimens, strengthening linkages, referral and counter-referral and integrating essential health services.
- 4.2.2 Access to CD4 and viral load testing and other technologies is increased to better monitor people on ART, and to support retention in treatment.
- 4.2.3 Prevention and monitoring of HIV drug resistance is conducted utilising a public health approach that includes appropriate operational/implementation research and strengthening of surveillance systems.
- 4.2.4 Quality of care, treatment and support, including home- and community-based care, is improved.
- 4.2.5 Paediatric care, treatment and support are strengthened for all infants who are exposed to HIV.

STRATEGIC PRIORITY AREA 5: INTEGRATE HIV INTO HEALTH AND SOCIO-ECONOMIC DEVELOPMENT

Integration refers to rationalising health sector and social development resources, systems and processes in order to improve impact, efficiency and sustainability. In many countries, HIV services have been delivered through vertical or stand-alone programmes with parallel human resource, procurement and service delivery systems. There have been advantages and disadvantages to this approach. Strong central management structures have successfully mobilised significant external funding, and have delivered services effectively. In some instances, external funding earmarked for HIV has been used strategically to benefit the wider health system and to strengthen the capacity of civil society partners. In others, investment in HIV programmes has reduced the resources available for other health and social development programmes.

As donor funds for HIV diminish, there is widespread agreement on the need to improve efficiency in order to sustain quality HIV services. Many countries have made significant progress towards this by integrating HIV and other health platforms to reduce costs, improve planning and resource allocation and maximise return on investments. Weaknesses or gaps in the national health systems can hinder these efforts, however, and shared needs in this area

can benefit from regional support. Immediate challenges include maintaining strong, central HIV programme leadership and ensuring that innovations developed by HIV programmes -- including in the areas of outreach, social marketing, multisectoral and civil society partnerships, human rights promotion, stigma reduction and training -- are adapted by chronic disease and other programmes. Outside of the health sector, the challenge is for countries to capitalise on investments already made in support of other development priorities. Integration with social development efforts will broaden the focus of the HIV response from individual risk behaviours to the social and structural factors that influence the health of populations. Improving the conditions in which people live will reduce health disparities, sustain and accelerate progress towards elimination. This requires a proactive and deliberate process of collaboration with the planning, education, labour, social security, culture, youth and community development sectors playing more meaningful roles in changing social and gender norms.

Box 4. Integration

Eliminating parallel systems and usefully integrating programmes and services require three different sets of action:

- **The national-level policy and planning perspective.** Joint budgeting is needed for HIV and other disease programmes or overall health sectors, and health planning should be informed by, and linked to, other sectoral planning (e.g. finance, education, labour, human rights, gender). HIV monitoring should be embedded in broader health information systems.
- **The management perspective.** Donor approaches should support, rather than undermine, integrated planning and programme management, while governance structures should be strengthened and adapted to support integration. Human resources for health will need to be rigorously analysed to ensure sufficient numbers of workers and the right distribution of skills to deliver integrated health care.
- **The point of service delivery perspective.** At the point of delivery, HIV services should be integrated with health and other services as appropriate. Quality of service delivery should be closely monitored and improved where necessary.

Source: UNAIDS. Global Report: UNAIDS report on the global AIDS epidemic 2013. 2013.

Strategic objectives:

5.1 Integrate HIV services into national health systems.

5.2 Integrate HIV prevention into social and economic development efforts.

Strategic objective 5.1: Integrate HIV into national health systems

Expected results:

5.1.1 National capabilities are strengthened to move towards more integrated service delivery.

5.1.2 Targeted technical support is provided to strengthen national health systems in the areas of:

- *Leadership and governance*: Legislation, policies and guidelines are in place for the integration and decentralisation of HIV and STI services in primary health care and SRH programmes, depending on the national context.
- *Financing*: National health accounts are developed.
- *Service delivery*: Countries are supported to transition from vertical services to integrated prevention, care, treatment and support.
- *Human resources for health*: National human resources for health (HRH) policies and plans covering training, retention, tracking and quality improvement are formulated and activated, including strategies for task-shifting.
- *Medical products and technology*: Laboratory services are continuously improved. Supply chain management and pharmacovigilance are strengthened.
- *Strategic information*: Comprehensive M&E plans are operationalised; health information systems are developed; and surveillance systems, research capacity and information sharing are strengthened.

Strategic objective 5.2: Integrate HIV into social and economic development efforts

Expected results:

5.2.1 Priorities are identified for addressing social determinants of health and HIV, and strategies are developed to guide partnerships, research, and policy interventions for innovative and long-term action to address these.

5.2.2 Collaboration with non-health partners is strengthened to mobilise multisectoral action, including at the community level, to achieve health goals.

5.2.3 Social protection programmes, including economic interventions, are implemented to mitigate the impact of HIV in communities.

STRATEGIC PRIORITY AREA 6: SUSTAINABILITY

Key to sustainable HIV programming is the capacity of countries to invest to meet nationally-determined priorities and to provide uninterrupted high-quality services. On average, 45 percent of HIV expenditure is currently used for ARVs, resulting in significantly reduced AIDS-related mortality and contributing to declining incidence rates. Reductions in funding would place the lives of an estimated 167,500 people living with HIV and currently on treatment at risk, and could see the Caribbean revert to mortality levels not experienced since the early 1990s. While a few countries have made good progress in reducing their dependency on external funding of ARVs, 11 countries must still address the challenges of maintaining treatment programmes in the face of looming reductions in donor support, while all must contend with expanding access

in line with the 2013 WHO Treatment Guidelines. In the long term, strategic expansion of treatment programmes is an important tool for promoting sustainability, as reducing incidence and controlling the epidemic will ultimately result in cost-savings. In the short term, the cost implications will be that significant and increased funding will be needed. A continued focus on securing reductions in the prices of ARVs by employing a range of mechanisms, including maximising the use of Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities and cost-pooling facilities is critical. This must take place alongside country efforts to develop and implement innovative financing methods, which can support Universal Health Coverage, including dedicated tax levies, visitor health fees, regional health insurance and new private-public partnerships. Financing mechanisms must be matched with policies and strategies which leverage investments for maximum value for money. Programmes must be targeted at key populations and efficiency measures instituted to increase coverage and impact. An important first step is for countries to develop sustainability plans grounded in the principles of equitable access to quality health services for all people without the risk of financial hardship. In some countries, sustainability planning is well underway and steps have already been taken to increase domestic funding and integrate HIV with other health services.

Box 5. Sustainability Framework for the Jamaica National HIV/AIDS Programme 2013-2030

The Sustainability Framework for the Jamaica National HIV/AIDS Programme defines the policies, strategic approaches and management changes that the Government of Jamaica will adopt in ensuring uninterrupted provision of high-quality HIV and AIDS services in the face of financial constraints. A key goal is for 80-90 percent of programme costs to be met from national sources by 2020. A range of mechanisms are proposed for mobilizing resources to address a financing gap:

- Increasing government budgetary contributions, including the possibility of an earmarked human resource protection tax
- Mobilising resources via the private sector
- Institutionalising price benchmarking for antiretroviral drugs
- Developing more robust partnerships with civil society organisations
- Continuing efforts to access technical and financial resources through partnerships with bilateral and multilateral agencies, philanthropic institutions and international non-governmental organisations.

Source: Browne, Carl F. Sustainability Framework. Jamaica National HIV/AIDS Programme 2013-2030.

Strategic objectives:

6.1 Sustainable financing of national responses.

6.2 Policy, planning and evaluation for sustainable high-impact programmes.

Strategic objective 6.1: Sustainable financing of national responses

Expected results:

- 6.1.1 National investment frameworks are developed to achieve universal health coverage with no financial risk to citizens.
- 6.1.2 Sustainable HIV financing plans that increase the share of national funding of programmes in keeping with country capacity are developed.
- 6.1.3 Reductions in the price of ARVs and other medical products and technologies (medication for comorbidities, kits for rapid testing, CD4 and viral load, etc.) are pursued through regional negotiating mechanisms, including pooled procurement and the PAHO Strategic Fund.

Strategic objective 6.2: Policy, planning and evaluation for sustainable high-impact programmes

Expected results:

- 6.2.1 Policies for the sustainability of national programmes are developed.
- 6.2.2 Multiyear sustainability plans, including for human resources, to develop capacity for and transition to full national management and financing of high-quality programming are implemented.
- 6.2.3 Evaluations, including expenditure and costing analysis, of programmes for evidence-informed planning and priority setting are conducted.

5.0 INSTITUTIONAL ARRANGEMENTS

PANCAP was created by the Caribbean Heads of Government in 2001 to facilitate a coordinated regional response to reduce the spread and mitigate the impact of HIV in the Caribbean. With a membership of 62 countries and organisations and 50 affiliates, PANCAP is characterised by a strong culture of partnership and inclusiveness and is internationally recognised as a best practice. The Pan Caribbean Partnership Against HIV and AIDS approach is premised on the application of UNAIDS 'Three Ones' principles at the regional level: one agreed strategic framework developed through an inclusive consensus-building process (the Caribbean Regional Strategic Framework); one multisectoral governance body for mutual accountability (the PANCAP Executive Board); and one mechanism for monitoring and coordination (the Priority Areas Coordinating Committee (PACC) of the Executive Board).

The Caribbean Regional Strategic Framework (CRSF) establishes consensus on priority areas for regional collaboration, and defines regional public goods and services to be provided through the work of regional support agencies. Implementation of activities in support of the CRSF is executed by way of a PANCAP Biennial Operation Plan (PBOP). The execution is a collaborative effort coordinated by the PANCAP Coordinating Unit with oversight provided by the PACC on behalf of the Executive Board.

The PANCAP Executive Board provides policy guidance and oversees implementation of the CRSF. As the recognised regional governing body for HIV, the Executive Board enjoys a high level of engagement and support from national governments, civil society and donor partners. It brings together diverse regional and national perspectives to improve harmonisation of efforts.

The Priority Areas Coordinating Committee (PACC) provides strategic management and technical oversight in the planning, monitoring and evaluation of projects and programmes in support of the Caribbean Regional Strategic Framework. It coordinates the development of operational plans for each Strategic Priority Area and facilitates collaboration between regional support agencies working to implement these plans. These responsibilities are carried out through quarterly planning and monitoring meetings and biannual reports.

Harmonisation and alignment

PANCAP is the primary mechanism for ensuring harmonisation and coordination of the Caribbean HIV response. This takes place at two levels: at the country level, led by the national authorities; and at the regional level, led by regional support agencies and donor partners. The involvement of the spectrum of stakeholders constituting the PANCAP Executive Board in oversight ensures that all aspects of the regional response are efficiently addressed, the risk of duplication is minimised and that national health systems are strengthened. Coordinated annual plans developed for each Strategic Priority Area of the CRSF include all regional support agencies (RSAs) working in that area.

National programmes are involved in decision making through their representation on the Executive Board, and through regional meetings of NAP Managers. Ministers of Health, by way of the Council for Human and Social Development (COHSOD), receive regular reports from

PANCAP and are involved in policy decisions and strategic planning. Heads of Government also receive reports on the work of PANCAP at their Inter-sessional Meeting and Conference. Through the CARICOM Secretariat, regional governance mechanisms, including the COHSOD, provide the opportunity to ensure alignment with wider development and public health initiatives and systems not specifically focused on HIV.

Mutual accountability

PANCAP ensures accountability for the delivery of agreed interventions through the following defined lines:

- National authorities are responsible to their national governments for the performance of the national HIV programmes and to PANCAP for agreed goals and indicators defined in the CRSF.
- Regional Support Agencies (RSAs) are accountable to countries and to PANCAP for providing the regional public goods and services agreed in annual work plans and the CRSF.
- The PACC is accountable to the Executive Board for coordinating the planning and implementation of all regional interventions in the six Strategic Priority Areas of the CRSF.
- The PANCAP Coordinating Unit (PCU) is accountable to the Executive Board for reporting on the deliverables and outputs described in the annual work plans.
- The Executive Board is accountable to PANCAP members for timely reporting on the progress and performance of the implementation of CRSF and progress made towards achieving goals and indicators. The Executive Board presents reports to the PANCAP Annual General Meeting.
- Periodic external technical audits, undertaken by independent technical experts, are carried out in each Strategic Priority Area.

6.0 IMPLEMENTATION AND MONITORING AND EVALUATION

Operationalising the CRSF

The CRSF 2014-2018 sets high-level direction for action at all levels of the partnership through the articulation of strategic priority areas, strategic objectives and expected results. Achieving these by the end of 2018 requires a coordinated effort on the part of Caribbean states, regional support agencies, community organisations, service delivery organisations and institutions working in a broad range of sectors. National partners and key populations are at the heart of the response, and will be involved in planning, designing, implementing, monitoring and evaluating activities. National strategic plans will be expected to align with the CRSF 2014-2018, while providing for country-specific approaches. Results will be measured and reported through existing mechanisms, including annual UNGASS Country Progress Reports, Global AIDS Response Progress Reporting and national programme evaluations coordinated by the Caribbean Public Health Agency (CARPHA).

The CRSF 2014-2018 will be operationalised through two-year plans, which will complement national strategies by focusing on regional actions and the delivery of regional public goods and services. Operational plans will be developed through consultations with key technical partners and will detail how priority actions will be implemented, including defining roles and responsibilities, timeframes, lines of accountability and process monitoring indicators. Within each strategic priority area, a lead agency will assume priority responsible for coordinating implementation, monitoring and reporting.

Oversight of the implementation of operational plans will be the responsibility of the PACC with support from the PANCAP Coordinating Unit. In addition to the PANCAP governance mechanisms described in Section Five, regular meetings of lead agencies and an annual meeting of National AIDS Programme managers will facilitate tracking of implementation progress.

Monitoring and evaluation

Monitoring and evaluating the implementation of priority actions at the national and regional levels will ensure the region is progressing towards achieving the expected results outlined in this framework.

The monitoring and evaluation framework for the CRSF 2014-2018 is designed to minimise additional reporting requirements for national programmes:

- Each two-year operational plan will identify process indicators to be used to track implementation progress. Lead agencies will report against these indicators to the PACC.

- The eighteen output level indicators listed in the matrix below will be used to track progress achieved through the combined efforts of national and regional partners, and will inform changes in the regional response as required. To the extent possible, these include UNAIDS Global AIDS Response Progress Report (GARPR) already being reported on, although some countries still face limitations in the ability to generate robust and timely data. CARPHA and the PCU will take the lead in facilitating reporting against new indicators which can be tracked at a regional level.

Monitoring and Evaluation Framework

Strategic Objective	Revised Indicator	Lead & Support Agencies	Reference
GOAL: To halt the spread and reduce the impact of HIV in the Caribbean while promoting sustainable health and development			
	1. Percentage of persons aged 15 – 49 years newly infected with HIV in the last year 2. Percentage of children born to HIV-infected mothers who are infected		CRSF 2008-2012 (revised) CRSF 2014 (new indicator) Revised from PEPFAR, UA, UNGASS Core Indicator
	3. Percentage of eligible people in ART by treatment line (first, second, third) disaggregated by sex and age group (< 15 and >15) 4. Domestic and International AIDS spending by category and funding sources		GARPR (2013, 2014 & 2015), PEPFAR, UA GARPR 2012, 2013, 2014 & 2015
Strategic Objective 1.1 Increase access to justice for all in the Caribbean Zero Discrimination Targets:	5. # of countries achieving legislative reform for modifying and repealing discriminatory laws that infringe on human rights	PCU, UNAIDS, CRN+, CVC, UNDP, UWI	PANCAP Justice for All Roadmap 2014

<p>80% of countries that have laws and policies that discriminate against PLHIV, key and vulnerable populations (MSM, trans, SW, people who use drugs, mobile populations and others) or that criminalize the transmission of HIV or non-disclosure of HIV statues have repealed and/or reformed them</p> <p>80% of countries have approved at least one protective law that safeguards the human rights of people most vulnerable to HIV</p> <p>All countries have a monitoring system to address discrimination by health providers against MSM, Trans, FSW, people who use drugs, PLHIV and other vulnerable populations</p> <p>In 20 countries of LAC, there has been a reduction of at least 15% in PLHIV and key populations who experience discrimination in health services</p> <p>80% of countries eliminate legal barriers in access to sexual and reproductive health services, especially</p>	<p>6. # of countries that have a monitoring system to address discrimination</p> <p>7. % of PLHIV and key populations that report discrimination in the health sector</p>		
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<p>barriers related to discrimination based on sexual orientation, gender identity or age</p> <p>90% of countries have protective systems, policies and/or legislation with mechanisms for reporting and resolving human rights violations, including those related to HIV and key populations</p>			
<p>Strategic Objective 1.2 Promote the development and acceptance of positive social norms and behaviors that support healthy and equitable societies</p> <p>Zero Discrimination Targets:</p> <p>HIV responses in 90% of countries are gender-transformative, address the specific needs of all women, including trans women, and girls in the context of HIV and their sexual and reproductive health and rights</p> <p>50% reduction in the number of countries that have cases of forced or coerced sterilization against women living with HIV</p> <p>75% of countries have reduced the number of violent acts/hate crimes, against people who live with or are affected by</p>	<p>8. # of countries with national HIV responses that are gender transformative</p> <p>9. # of countries with established minimum package of SRH services for key populations</p> <p>10. # of countries that have cases of forced sterilization</p> <p>11. # of countries that have reduced the rate of violent acts/hate crimes against PLHIV and other Key Populations (including LGBTI, Sex Workers)</p>	<p>CARICOM Secretariat, UNFPA, CVC, UN Women, UNDP, CIPA,</p>	<p>GARP 2015 Indicator</p> <p>CRSF 2014 (new indicator)</p>

interventions			
Strategic Objective 4.1 Expand and sustain access to high quality care, treatment and support, including management of STIs and co-morbidities	19. Percentage of eligible people in ART by treatment line (first, second, third) disaggregated by sex and age group (< 15 and >15) 20. Percentage of countries that provide STI services or referrals to such services in all primary, HIV, reproductive health, family planning and ante- and post-natal care services	PAHO , CRN+, UWI, UNAIDS, OECS, CARPHA, CDC, USAID, PEPFAR	GARPR (2013, 2014 & 2015), PEPFAR, UA AMDS-Antiretroviral medicines and diagnostics survey , WHO <i>Draft</i> WHO Global Health Sector Strategy on Sexually Transmitted Infections 2016-2021
Strategic Objective 4.2 Improve linkage, adherence and retention in care, treatment and support	21. Percentage of patients on ART tested for viral load (VL) with VL <1000 copies /ml after 12 months of therapy 22. Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	PAHO , CARPHA, CMLF, UWI, CRN+, CDC, USAID, PEPFAR	PAHO HIV Continuum of Care Monitoring Framework 2014 PEPFAR
Strategic Objective 5.1 Integrate HIV services into national health systems	23. Percentage of health facilities offering integrated HIV clinical care and treatment services in primary health care	PAHO , UNFPA, CARPHA, UWI, CMLF, PCU, PSI, OECS, USAID, CDC, PEPFAR	CRSF, 2014 (new indicator)
Strategic Objective 5.2 Integrate HIV prevention into social and economic development efforts	24. Number of national programs implementing <u>interventions</u> to address the <u>social determinants of HIV</u> with at least one non-health partner	CARICOM Secretariat , UWI, CARPHA, CRN+, CVC, UNAIDS	CRSF, 2014 (new indicator)
Strategic Objective 6.1 Sustainable financing of national responses	25. Percentage countries with adequately resourced National Strategic Plans	UNAIDS , OECS, CARICOM Secretariat, UWI, PCU, PAHO, USAID, PEPFAR	CRSF, 2014 (new indicator)
Strategic Objective 6.2 Policy, planning and evaluation for sustainable high-impact programs	26. Number of national programs undertaking mid/ end of term national evaluation plan	UNAIDS , UWI, CARPHA, USAID, PEPFAR	CRSF, 2014 (new indicator)

