Caribbean Regional Operational Plan

(ROP) 2016

Strategic Direction Summary

July 6, 2016

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Goal Statement

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program in the Caribbean region will support Caribbean governments to achieve HIV epidemic control and attain the UNAIDS 90-90-90 goals by 2020. To do so, the Caribbean Regional Program (CRP) has developed a Regional Operational Plan (ROP) that focuses on supporting governments as they adopt Test and Start in fiscal year (FY) 2017 and strengthen the HIV clinical cascade, particularly for underserved key populations (KP): men-who-have-sex-with-men (MSM), female sex workers (FSW), and transgender persons (TG). ROP 2016 also includes the integration of Guyana into the regional program. This plan has been developed in consultation with partner governments, multilateral organizations, civil society and other key stakeholders to ensure the U.S. government's programs add maximum value to the full complement of the Caribbean HIV/AIDS response.

PEPFAR activities will focus on countries with the highest HIV disease burden: Jamaica, Trinidad and Tobago, and Guyana, Tier I countries that comprise 77 percent of the total HIV burden within the region. Programs in these three countries will provide support to the government to adopt Test and Start; institute sustainable financing strategies and improve retention and reduce loss to follow up, particularly for KP. They will also reduce stigma and discrimination, address supply chain weaknesses, build capacity within surveillance and information systems, and strengthen laboratory networks to support improved access and coverage for viral load. Furthermore, the programs will support HIV services in the community, facility, and at the national level to ensure sustainable systems that decrease barriers to access treatment for all people living with HIV (PLHIV). Suriname, Barbados, and the Bahamas, Tier II countries, will also continue to receive targeted bilateral assistance to strengthen systems as these governments move to Test and Start, address stigma and discrimination for key populations, improve surveillance and build viral load laboratory sample referral networks. All programs are tailored to the country-specific development context and readiness for implementation of Test and Start, with the eventual goal of graduation from PEPFAR support.

The CRP recognizes that stigma and discrimination (S&D) creates significant barriers to service uptake by KP. A variety of activities in the region will mitigate S&D related to HIV, sexual orientation, and gender identity. These include integration of KP in service delivery at facility levels, KP sensitive clinical care training & mentoring, facility staff sensitization, addressing self-stigma, and responding to S&D within the MSM community. Along with these strong mitigation interventions, the CRP will implement equally rigorous monitoring and measurement activities. Key among these will be quarterly stakeholder meetings to provide comprehensive tracking of multi-funder S&D reduction projects and interventions. PEPFAR partners will utilize a tracking tool to ensure that activities are complementary rather than duplicative across multiple funders and implementers. Efforts will also be made to strengthen and link multiple S&D reporting and redress systems. This will standardize documentation of discrimination complaints and allow disaggregation of sub-population data, including transgender and youth complainants. Ongoing discrimination monitoring will continue at the

facility level through continuous quality improvement initiatives, as well as client and provider score cards to routinely document levels of perceived discrimination. Implementing partners will collect and analyze score card results and provide a detailed report to the MoH for redress and continued systems strengthening. More formal S&D documentation will occur in Jamaica through a longitudinal quantitative and qualitative research project focused on the impact of facility-based S&D mitigation interventions. Finally, at the regional level, the CRP will strengthen and support the Stigma Index Studies and Legal Environment Assessments in all Tier I and Tier II countries. PEPFAR will also continue to provide support to regional organizations and networks that provide support to all twelve nations within the region. This includes programs to improve surveillance systems and laboratory services.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

HIV prevalence in the Caribbean Region is estimated to be 1.1 percent (UNAIDS, 2014). Of the 6.6 million[1] people in the 12 PEFPAR-supported countries, approximately 71,000 are HIV positive. Ninety-five percent of these come from 6 countries: Jamaica (n=29,690), Trinidad and Tobago (n=13,000), Guyana (n=7,800), Suriname, the Bahamas and Barbados. HIV prevalence ranges from <1 percent in the Organization of Eastern Caribbean States (OECS) to 2.8 percent in the Bahamas. Spectrum estimates for the OECS indicate that burden is low, with estimates ranging from 318 PLHIV in St. Kitts to 1,056 in St. Lucia.

Across the region, HIV disproportionately affects men who have sex with men (MSM), transgender people (TG), and female sex workers (FSW). Available data have shown MSM HIV prevalence to be 32.9 percent in Jamaica (GARPR 2016), 20.4 percent in Trinidad and Tobago (Lee *et al* 2004), 4.9 percent in Guyana (MOH 2014) and 6.7 percent in Suriname (MOH, 2013). These rates are among the highest in the world and underscore the need to ensure MSM are the primary target population of the Caribbean regional HIV/AIDS response. Other KP groups such as FSW have lower but still substantial rates of HIV infection. In Jamaica, available data have shown FSW HIV prevalence fell from 4.1 percent in 2008 (GARPR 2014) to 2.9 percent in 2014 (GARPR 2016). FSW prevalence is 5.5 percent in Guyana, 5.8 percent in Suriname (2012, MOH), and is unavailable for Trinidad and Tobago. A full description of HIV/AIDS statistics for Jamaica, Guyana, Trinidad and Tobago, Suriname, The Bahamas, and Barbados is presented in tables 1.1.1.

There has been a decline in new infections in the region from 27,000 in 2000 to an estimated 13,000 in 2014 (UNAIDS, 2015). The numbers of newly infected individuals are estimated to be ~1,400 Jamaica, <1000 in Trinidad & Tobago, <500 in Guyana, <500 in the Bahamas, <200 in Suriname, and <100 in Barbados (UNAIDS, 2013). AIDS related deaths have also declined in the region. This has coincided with the provision of antiretroviral therapy (ART) through national care and treatment programs. Additionally, strengthened health systems, including improved laboratory capacity, have contributed to the governments' ability to offer comprehensive care and treatment for PLHIV.

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

Data in the region suggest a male dominated epidemic – higher numbers and proportions of men test positive for HIV – even though coverage of testing, early initiation and treatment is higher amongst females. Late diagnosis of HIV infection continues to be a problem, as evidence shows that approximately 40 percent of PLHIV receive a concurrent HIV and AIDS diagnosis (PAHO, 2013).

[1] Refers to population in the 12 countries covered by the PEPFAR Caribbean program

The total number of TB cases is low in all countries; however, approximately 30 - 50 percent of reported TB cases are HIV-positive. In 2013, there were 146 TB cases in Suriname, of which 56 (38 percent) were HIV positive (WHO, 2013). In Barbados, 2 of the 4 reported TB cases were HIV positive (WHO, 2013). The low rates of HIV testing amongst TB patients make it difficult to reliably estimate the HIV burden amongst TB patients (PAHO, 2013).

Regional estimates indicate that 70 percent of PLHIV in the Caribbean know their status (UNAIDS, 2013). The proportion of PLHIV diagnosed is estimated to be 60 percent in Suriname (MOH, 2014), 75 percent in Guyana (MOH, 2014), 83 percent in Jamaica (MOH, 2013) and 91 percent (MOH, 2012) in Barbados, which is the only country to have reached the first of the "90-90-90 targets". Even so, there is the need to strengthen early linkage to and retention in treatment. Late presentation to care is common with approximately 40 percent of PLHIV receiving a concurrent HIV and AIDS diagnosis (PAHO, 2013). Retention amongst ART patients is also low and has been shown to decline after 12 months (PAHO 2013; GARPR 2014 reports).

Regional ART coverage amongst eligible patients, using previous national eligibility criteria, was 71 percent in 2012. This varies by country with 66 percent in Suriname, 69 percent in Jamaica, 72 percent in Trinidad & Tobago, 73 percent in The Bahamas, 80 percent in Guyana and 95 percent in Barbados (PAHO, 2013). ART coverage rates based on total PLHIV are estimated to be 30 - 50 percent. These gaps in coverage are partly explained by current eligibility criteria; where national guidelines recommend ART initiation at CD4 500 for Jamaica, Barbados and Guyana, and CD4 350 for all other countries. Earlier ART initiation is currently being addressed across the region, with Jamaica and Guyana having agreed to adopt Test and Start in FY17. The Bahamas Ministry of Health has informally moved to Test and Start in a subset of HIV clinics and is expected to formally adopt Test and Start by the end of CY 2016. Representatives from the Ministries of Health of Trinidad and Tobago, Barbados and Suriname have indicated that they will move to Test and Start during FY 2017. Evidence indicates that the potential barriers delaying rapid transition to Test and Start include the increased costs of patient care, staffing shortages, weak and/or ill prepared supply chain and logistics systems, and weak data collection systems. Based on 2013 reports, Jamaica and the OECS (with the exception of St. Lucia) rely on external funding to cover 75 – 100 percent of ARV costs (PAHO, 2013).

In November 2015 a feasibility assessment was performed in Jamaica which noted that a change in national policy to offer ART to all PLHIV as soon as they are diagnosed is operationally feasible, especially as the country already updated its ART eligibility criteria to CD4 500 in January 2016. The assessment noted that the adoption of Test and Start would likely result in only a small number of additional PLHIV becoming eligible for ART and, by extension, a small increase in the national treatment budget. A cost analysis is currently being planned in Jamaica to inform effective program adoption. Similar assessments are also planned for Trinidad and Tobago, The Bahamas, Suriname and Barbados in FY 2016.

The Caribbean region is not on track to achieve the third 90, with viral suppression amongst all PLHIV only at 38 percent in Barbados, 29 percent in Guyana and 12 percent in Jamaica (2012). These data should be compared with the viral testing coverage rates, which were ~67 percent of ART patients in Jamaica receiving a viral load test (2014), compared to 77 percent in Guyana (2014) and over 90 percent in Barbados (2012). Results are better for patients on ART, with 43 percent in Jamaica, 65 percent in Guyana and 83 percent in Barbados virally suppressed. Additionally, in Jamaica, data indicates that viral suppression rates for ART patients vary by site from 13 – 80 percent (2015). Several factors could be responsible for low levels of viral suppression including poor medication adherence and the presence of HIV drug resistance (HIVDR) mutations. Data from one treatment site in Jamaica demonstrated that 12.6 percent of new HIV infections resulted from strains carrying HIVDR mutations (Barrow et al, 2013)[2]. Poor adherence amongst ART patients is also contributing to low rates of viral suppression. Different adherence support models are being considered in FY2016 to better understand and address deficiencies and ensure improved clinical outcomes of patients on ART.

Program monitoring data suggest low rates of prevention intervention coverage for KP (~20 percent). Low positivity rates from key population testing events, and low coverage rates suggest the need for revised strategies to reach and diagnose MSM and FSW. Although recognized as a priority by national governments, KP programs have historically been implemented by community based organizations with funding from external sources.

Table 1.1.1 Key National Demographic and Epidemiological Data
Jamaica

	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	2,717,991		320,822		331,492		1,051,661		1,014,016		STATIN 2013
HIV Prevalence (%)		1.62		NA		NA		NA		NA	Spectrum estimates 2015
AIDS Deaths (per year)	812										MOH Spectrum Estimates (2015)
# PLHIV (2015)	29,690		703				11,163		17,825		MOH Spectrum Estimates (2015)
Incidence Rate											
New Infections (2015)	1419										MOH Spectrum Estimates (2015)
Annual births	NA										
% of Pregnant Women with at least one ANC visit	NA	NA	NA	NA			NA	.94			MOH (2015)

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

Pregnant women needing ARVs	442										GARPR (2014)
Orphans (maternal, paternal, double)	NA		NA		NA		NA		NA		
Notified TB cases (2014)	86		NA		NA		NA		NA		WHO Tuberculosis Country Profile, (2014)
% of TB cases that are HIV infected (2014)	19	24%	NA	NA	NA	NA	NA	NA	NA	NA	WHO Tuberculosis Country Profile, (2014)
% of Males Circumcised	NA	NA			NA	NA			NA	NA	
Estimated Population Size of MSM*	33000	4.5%									GARPR (2014)
MSM HIV Prevalence		32.8									GARPR (2014)
Estimated Population Size of FSW	18696	2.5%									GARPR (2014)
FSW HIV Prevalence		2.9%									GARPR (2016)
Estimated Population Size of PWID	5000						250		4750		Ministry of Defense

Table 1.1.1 Key National Demographic and Epidemiological Data Guyana											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	751,223		131,518	18	135,629	18	243,671	32	240,405	32	National Census (2002)
HIV Prevalence (%)		1.5						1.6 (15-49)		1.4 (15-49)	Guyana Spectrum (2016)
AIDS Deaths (per year)	226										GAPR (2015)
# PLHIV	7,800		<200				3,900		3,700		Guyana Spectrum (2016)
Incidence Rate (Yr)		0.11 (15-49)									Guyana Spectrum (2014)
New Infections (Yr)	<500										Guyana Spectrum (2016)
Annual births	14,581										MoH Statistical Bulletin
# of Pregnant Women with at least one ANC visit (2014)							15,494				GAPR (2015)
Pregnant women needing ARVs (2014)	<200										GAPR (2015)
Orphans (maternal, paternal, double)	NA										
Notified TB cases (2014)	648										WHO Tuberculosis Country Profile, (2014)
% of TB cases that are HIV infected	148	25%									WHO Tuberculosis Country Profile, (2014)
% of Males Circumcised	NA										
Estimated Population Size of MSM*	3,327										Draft Size estimates (2015)
MSM HIV Prevalence	4.9										
Estimated Population Size	5,256										Draft Size estimates (2015)

of FSW											
FSW HIV Prevalence	5.5										
Estimated Population Size of PWID	NA										
PWID HIV Prevalence	NA										
Estimated Size of Priority Populations (specify)											
Estimated Size of Priority Populations Prevalence (specify)											
**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*											

* All Data based on nationally available estimates, program, and surveillance data

Table 1.1.1 Key National Demographic and Epidemiological Data Trinidad											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	1,328,019	100.00	134,263	10.11	139,179	10.48	527,478	39.72	527,125	39.69	MOH, Census (2012)
HIV Prevalence (%) 2010		1.7		NA		NA		NA		NA	MOH, HACU Report (2012)
AIDS Deaths (2014)	101		0		0		46	45.5	55	54.5	MOH, NSU/HACU ANNUAL REPORT (2014 released 23/09/2015)
# PLHIV	13,000		NA		NA		NA		NA		MOH, HACU Report (2012)
Incidence Rate (Yr)		NA		NA		NA		NA		NA	
New Infections	1,053										MOH,

(2014)											NSU/HACU ANNUAL REPORT (2014)
Annual births (2011)	19,888										MOH, Census (2012)
% of Pregnant Women with at least one ANC visit	NA	NA	NA	NA			NA	NA			
Pregnant women needing ARVs	NA	NA									
Orphans (maternal, paternal, double)	NA		NA		NA		NA		NA		
Notified TB cases (2014)	293		NA		NA		NA		NA		WHO Tuberculosis Country Profile (2014)
% of TB cases that are HIV infected (2014)	71	25	NA	NA	NA	NA	NA	NA	NA	NA	WHO Tuberculosis Country Profile (2014)
% of Males Circumcised	NA	NA			NA	NA			NA	NA	
Estimated Population Size of MSM*	8271										PEPFAR Estimate
MSM HIV Prevalence		20.4									Lee, Poon-King, Legall, Samiel, & Trotman (2005)
Estimated Population Size of FSW	13,536										PEPFAR Estimate
FSW HIV Prevalence		NA									
Estimated Size of Priority Populations (military)	4,500						225		4,275		

Table 1.1.1 Key National Demographic and Epidemiological Data Suriname											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	541,683		72,048		74,341		170,916		170,820		World Bank (2013)
HIV Prevalence (%)		0.9									UNAIDS (2012) Suriname HIV Epidemiological Profile, 2013
AIDS Deaths (per year)	101		NA		NA		38		63		Suriname HIV Epidemiological Profile (2013)
# PLHIV	4,000		NA		NA		NA		NA		UNAIDS –GAP (2013)
Incidence Rate (Yr)		NA		NA		NA		NA		NA	Not available
New Infections (Yr)	500										Suriname HIV Epidemiological Profile (2013)
Annual births	2.29										WHO (2012)
% of Pregnant Women with at least one ANC visit		88.6					93.2				WHO (2006 and 2010)
Pregnant women needing ARVs	111										UNAIDS (2012)
Orphans (maternal, paternal, double)	NA		NA		NA		NA		NA		
Notified TB cases (2014)	158		NA		NA		NA		NA		WHO Tuberculosis Country Profile (2014)
% of TB cases that are HIV infected (2014)	44	29	NA	NA	NA	NA	NA	NA	NA	NA	WHO Tuberculosis Country Profile (2014)
% of Males Circumcised	NA	NA			NA	NA			NA	NA	
Estimated Population Size of MSM*	5,000 (2,813 - 7,500)										NSP (2014)
MSM HIV Prevalence		6.7									Suriname HIV Epidemiological Profile (2013)
Estimated Population Size of FSW	2,228										NSP (2014)
FSW HIV Prevalence		5.8									Suriname HIV Epidemiological Profile (2013)

Estimated Size of Priority Populations (military)	3,000						750		2250		Ministry of Defense (2014)

Table 1.1.1 Key National Demographic and Epidemiological Data The Bahamas											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	367,000	NA	NA		NA		NA		NA		Bahamas Statistics Department (2014)
HIV Prevalence (%)		2.8									GARPR (2015)
AIDS Deaths (per year)	<1000		<1000		<1000		<1000		<1000		UNAIDS (2013)
# PLHIV (2013)	6,949						3598		*3351*		GARPR (2015)
Incidence Rate (Yr)		0.20		NA		NA		NA		NA	
New Infections (2013)	328										GARPR (2015)
Annual births	5,000										GARPR, 2015 – newly reported cases
% of Pregnant Women with at least one ANC visit	NA	NA	NA	NA			NA	NA			
Pregnant women needing ARVs (2014)	93	NA									GARPR (2015)
Orphans (maternal, paternal, double)	NA		NA		NA		NA		NA		
Notified TB cases (2014)	50		NA		NA		NA		NA		WHO Tuberculosis Country Profile (2014)
% of TB cases that are HIV infected (2014)	10	36	NA	NA	NA	NA	NA	NA	NA	NA	WHO Tuberculosis Country Profile (2014)
% of Males Circumcised	NA	NA			NA	NA			NA	NA	
Estimated Population Size of MSM*	4,000										MOH data
MSM HIV Prevalence	IQ										
Estimated Population Size of FSW	4,715										PEPFAR estimate
FSW HIV Prevalence	NA										
Estimated Population Size of PWID	N/A										
PWID HIV Prevalence	N/A										
N/A- not applicable ND- no data NA= Data not available											

Table 1.1.1 Key National Demographic and Epidemiological Data Barbados						
	Total	**<15**		**15+**		***Source, Year***
		Female	**Male**	**Female**	**Male**	

	N	%	N	%	N	%	N	%	N	%	
Total Population	287,733		26,990		26,989		121,537		112,217		GARP Report (2014)
HIV Prevalence (%)		1.2									GARP Report (2014)
AIDS Deaths (per year)	45						8		37		Surveillance Data (2015)
# PLHIV	2,200										Surveillance Data (2015)
Incidence Rate (Yr)											
New Infections (Yr)	R										Surveillance Data (2015)
Annual births	NA	NA									
% of Pregnant Women with at least one ANC visit	NA	NA									
Pregnant women needing ARVs	21										PMTCT Surveillance (2015)
Orphans (maternal, paternal, double)	NA		NA		NA		NA		NA		
Notified TB cases	5										WHO Tuberculosis Country Profile (2014)
% of TB cases that are HIV infected	2										WHO Tuberculosis Country Profile (2014)
% of Males Circumcised	NA	NA			NA	NA			NA	NA	
Estimated Population Size of MSM*	2,784										PEPFAR Estimate
MSM HIV Prevalence		14.4									PEPFAR Estimate (BBS 2011)
Estimated Population Size of FSW	5,644										PEPFAR Estimate
FSW HIV Prevalence	NA										
Estimated Population Size of PWID	NA										
PWID HIV Prevalence	NA										
Estimated Size of Priority Populations (specify)	N/A										
Estimated Size of Priority Populations Prevalence (specify)											
**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*											

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months) Jamaica		
	HIV Treatment and Viral Suppression	**HIV Testing and Linkage to ART**

	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	2,717,991	1.6	29,690	NA	8,781	4,329	NA	NA	NA
Population less than 15 years	NA	NA	NA	NA	NA	NA	NA	NA	NA
Pregnant Women	NA	NA	NA	NA	NA	NA	NA	NA	NA
MSM	33,000	31.4	6,600	131	131	56		976	
FSW	18,696	2.9	542	56	35	12		243	
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months) Guyana

				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	751,223 (2002 Census)	1.5	7,800	4,295	435/536 (2013-2014 cohort)	940/1340	68,863	751	539
Population less than 15 years	267,147 (2002 Census)	NA	<200	174	20/22 (2013-2014 cohort)		-	11	20
Pregnant Women	NA	1.9 (GAPR 2014)	<200(GAPR 2014)	188			12,621	Total :294	77

								124 new ; 170 known (PMTCT)	
MSM	3,327 (Draft KP Size estimates 2015)	4.9 (BBSS 2014)					1,429 (FY 15 NGO data)	22 (FY 15 NGO data)	
FSW	5,256 (Draft KP Size estimates 2015)	5.5 (BBSS 2014)					2,306 (FY 15 NGO data)	25 (FY 15 NGO data)	
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months) Trinidad									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population (2011)	1,328,019	**1.7**	**13,000**	6,399 (2014)		NA	71,485 (2014)	NA	NA
Population less than 15 years (2011)	273,415	**0.9**	NA		**60**	NA	NA	NA	NA
Pregnant Women (2014)	NA	NA	NA	NA	NA	NA	NA	**19,250**	**167**
MSM	8,271	20.4	NA	NA	NA	NA	NA	NA	NA
FSW	15,356	NA	NA	NA	NA	NA	NA	NA	NA
PWID	4,901	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months) Suriname									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**On ART (#) ($CD4 < 200$ cells/ml)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months (<1000 copies)**	**Tested for HIV (#) 2000-2011**	**Diagnosed HIV Positive (#) 2000-2013**	**Initiated on ART (#)**
Total population	539,276	0.9%	4,000	1148	NA	290	188,217	7090	NA
Population less than 15 years	NA	NA	NA	**71 (2013)**	NA	NA	NA	NA	NA

(2011)									
Pregnant Women	NA	NA	NA	112 (2013)	NA	NA	NA	116	112/116
MSM	5,000	9.2%	460	NA	NA	NA	NA	NA	NA
FSW	2,228	5.8%	129	NA	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)
The Bahamas

				HIV Treatment and Viral Suppression			**HIV Testing and Linkage to ART**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population (2014)	367,000	2.8	6,979	2,212	NA	NA	NA	NA	*NA*
Population less than 15 years (2014)	NA	NA	128	53	NA	NA	NA	NA	NA
Pregnant Women (2014)	NA	NA	93	93	93	NA	NA	NA	NA
MSM	4,000	NA	NA	NA	NA	NA	NA	NA	NA
FSW	4,715	NA	NA	NA	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months) Barbados									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population (2013)	287,733	1.2	2,147	1.043	NA	571	2,044 (PEPFAR, 2014)	23 (PEPFAR, 2014)	NA
Population less than 15 years (yr)	NA	NA	NA	NA	NA	NA	NA	NA	NA
Pregnant Women (yr)	NA	NA	NA	NA	NA	NA	NA	NA	NA
MSM	2,784	14.4	NA	NA	NA	NA	NA	NA	NA
FSW	5,633	NA	NA	NA	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA
* The HTC data presented a PEPFAR FY14 APR data based on PEPFAR's support to rapid testing in Barbados.									

1.2 Investment Profile

The economic profile of the 12 PEPFAR countries varies considerably. According to the World Bank, Jamaica and Suriname are considered upper middle income with GNIs between $ 4,126 and $12,745. Barbados, Trinidad and Tobago and The Bahamas are considered high income, with GNIs above $12,746. Guyana is considered lower middle-income with a GNI of $3775. OECS countries fall within both upper middle and high income categories. These differences affect the countries' borrowing power and eligibility for donor funding. The differences in economic profiles and available finances can also be seen in the levels of domestic and external funding for national HIV responses.

Many countries within the Caribbean region are characterized by high debt to gross-domestic-product ratios and tight fiscal budgets. Across the region, the global economic crisis has resulted in strong growth contraction of member countries' economies, which has led to increased

dependence on donor and other foreign financing initiatives. Even where countries continue to finance the majority of their HIV/AIDS programs, the weak global economy has increased their fiscal vulnerability. Jamaica's most pressing challenge is the country's debt, currently estimated at 141.6 percent of GDP (World Bank March 2014). Total Health Expenditure (THE)[3] per capita across the Caribbean is estimated to be approximately $551 with the highest expenditures recorded by The Bahamas at $ 1,647, Trinidad and Tobago at $972 and Barbados at $1,291. The Caribbean average of THE as a percentage of Gross Domestic Product is 6.1 percent with Barbados being 8.7 percent, Bahamas 7.5 percent and Trinidad and Tobago 5.4 percent. Studies have shown that governments and households are the two biggest spenders on health in the Caribbean. Government health expenditure (GHE) as a percentage of the THE average is 61 percent in the Caribbean with the Bahamas' at 46.1 percent, Trinidad and Tobago's at 50.4 percent and Barbados' at 55.5 percent. Corresponding percentages for out-of-pocket spending for these three countries is 29 percent, 42 percent and 38 percent respectively as compared to a Caribbean average of 32 percent. The Government of Guyana spends an estimated 6.6 percent of its GDP on health expenditures (World Bank, 2013). With the exception of HIV programs, Guyana government revenues represent the largest source of public health financing.[4]

The majority of HIV/AIDS programs across the PEPFAR CRP coverage area are funded at levels greater than 50 percent by national governments, with the exception of Suriname and Guyana. In the Caribbean regional Tier I countries for example, the Government of Jamaica (GOJ) funds 70 percent of its annual HIV/AIDS expenditure of $20,392,492, while the Government of Trinidad and Tobago (GOTT) funds 74 percent of its $3,790,535 annual HIV/AIDS expenditure. For Trinidad and Tobago, the remaining 26 percent of HIV/AIDS annual expenditures are supported by PEPFAR. In Guyana, the donor community primarily sustains the national HIV response. As of 2016, Guyana's HIV budget is an estimated $17 million, a significant decrease from past years. PEPFAR provides approximately 65 percent of support, followed by the Global Fund (GF) at 25 percent. GF's reprogramming of phase two of the RCC from January 1, 2015 through December 31, 2017 is $9.6 million. GF finances first-line ART; voluntary counseling and testing; support services for orphans and vulnerable children; condom procurement and distribution; home-based care for PLHIV; and behavioral prevention packages for KP, miners and loggers that includes HIV testing and linkage to care. GF also funds a portion of its sub-recipient's direct and indirect costs.

In PEPFAR Tier II countries, the Government of Suriname (GOS), funds only 49 percent of its $4,593,000 HIV/AIDS annual expenditure with Global Fund supporting 22 percent, other donors supporting 29 percent and historically, minimal PEPFAR support. On the other hand, the

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

Government of Bahamas (GOBAH) funds 91 percent of its HIV/AIDS response and PEPFAR makes up the vast majority of additional donor support at 8.7 percent, while the Government of Barbados (GOB) funds 81 percent of its national HIV/AIDS response, PEPFAR seven percent and other donors 12 percent.

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

The Government of Jamaica (GOJ) plans to gradually increase funding for ARVs that are currently being provided by the Global Fund (GF), such that the GOJ will fully fund ARVs in 2018. The Government of Guyana (GoG) has increased its domestic funding for HIV/AIDS programs. The National HIV Strategic Plan (2013-2020) acknowledges the impending decrease in donor funds. The GoG has been steadily absorbing the cost for previously funded PEPFAR commodities. As of October 2014, for example, the GoG began fully funding first and second-line pediatric ARVs– ARVs that were previously funded by PEPFAR. It is anticipated that by June 2016, the GOG will assume the cost for the remaining 50 percent of the adult second line HIV treatment, currently procured by PEPFAR. In addition, the GoG has undertaken the financing of all previously PEPFAR-funded human resource costs under the prevention of mother to child transmission (PMTCT) program and the national public health reference laboratory (NPHRL). The projected GOG contribution to HIV funding is expected to increase to approximately 65 percent in 2016.

With the move to Test and Start, the Tier I and II countries are calculating, with PEPFAR's support, the investments needed to effectively adapt and implement the WHO 2015 guidelines. This will mean additional one-time funding for ARVs in some countries and also additional one-time investments in system components to ensure effective delivery of appropriate KP services. Support for viral load reagents will also be necessary as procurement issues are seen across the region. Jamaica has estimated $200,000 will be needed to purchase ARVs and viral load reagents to support the move to Test and Start in FY17. Guyana has also identified a need for one-time additional investment to procure ARVs (estimated cost $159,000) and viral load reagents ($40,000).

The financial data available indicates that PEPFAR investments in HIV/AIDS programming across the Caribbean region represent a relatively small proportion of overall expenditures. However, PEPFAR funding often represents the only funding, or a large share of funding, that supports targeted key population programming. This underscores the critical importance of strong partnerships with national governments and with other donors to direct more resources towards

high quality and widely accessible KP services for epidemic control and ultimately the achievement of an HIV-free Caribbean.

Table 1.2.1 Investment Profile by Program Area - Guyana

Program Area	Total Expenditure	percent PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	3,681,702	70.42%	25.42%	3.39%	0.77%
Community-based care	183,414	41.00%	45.01%	13.99%	0.00%
PMTCT	509,897	80.39%	0.00%	19.61%	0.00%
HTC	892,821	43.99%	41.49%	13.85%	0.67%
VMMC	-	-	-	-	-
Priority population prevention	262,779	77.38%	4.39%	4.67%	13.56%
Key population prevention	317,162	15.72%	69.30%	13.53%	1.45%
Behavior Change Programs	160,817	1.70%	50.93%	38.85%	8.50%
Program for Children & Adolescents	7,116	1.17%	98.83%	0.00%	0.00%
Workplace Program	36,178	1.05%	1.06%	24.44%	73.45%
Community Mobilization	158,650	23.09%	20.36%	44.02%	12.53%
Program for PLHIV	96,772	37.17%	59.14%	0.34%	3.35%
Advocacy	21,766	0.00%	3.07%	1.92%	95.01%
Education	48,275	0.08%	50.65%	49.27%	0.00%
Gender Program & Stigma Reduction	989	64.41%		28.01%	7.58%
Other Prevention	2,084,952	77.97%	4.91%	17.03%	0.08%
OVC	435,619	22.12%	4.37%	9.01%	64.51%
Social Protection	531,000	0.00%	0.00%	100.00%	0.00%
Laboratory	1,990,630	18.57%	0.29%	81.12%	0.02%
SI, Surveys and Surveillance	196,515	1.91%	41.72%	26.52%	29.85%
HIV & AIDS Related Research	595,618	99.48%	0.50%	0.02%	0.00%
Planning & Coordination, Procurement & Logistics	6,522,038	86.87%	10.20%	2.43%	0.50%
AIDS Specific Institutional Development	209,557	99.98%	0.00%	0.00%	0.02%
HSS	2,137,266	93.30%	4.58%	0.04%	2.08%
Other Activities Not Classified	77,990	100.00%	0.00%	0.00%	0.00%
Total	21,159,523				

Red font indicates NAPS categories
2012 NASA Estimation

Exchange Rate Used: $200

Table 1.2.1 Investment Profile by Program Area[4] - Jamaica

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

Table 1.2.1 Investment Profile by Program Area[5] - Trinidad & Tobago

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support Community-based care PMTCT HTC VMMC Priority population prevention Key population prevention OVC Laboratory SI, Surveys and Surveillance HSS	DETAILS NOT AVAILIBLE				
Total	$3,790,535	26%	-	74%	-

Table 1.2.2 Procurement Profile for Key Commodities – GUYANA (FY 2014 expenditure)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
ARVs	$1,167,372.62	28.9	71.0	0.1	
Rapid test kits	$241,972.47	63.0	14.0	23.0	
Other drugs					
Lab reagents					
Condoms					
VMMC kits					
Other commodities					
Total	$1,409,345.09	35.0	61.0	4.0	-

Table 1.2.2 Procurement Profile for Key Commodities - Jamaica

Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$3,305,111				
Rapid test kits	$1,702,811				
Other drugs	$10,222				
Lab reagents	$660,511				
Condoms	$1,845,957				
VMMC kits					
Other commodities					
Total	$7,524,612				

Table 1.2.2 Procurement Profile for Key Commodities – Trinidad & Tobago

Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	NO INFORMATION AVAILIBLE				
Rapid test kits					
Other drugs					
Lab reagents					
Condoms					
Viral Load commodities					
VMMC kits					
MAT					
Other commodities					
Total					

Table 1.2.3 U.S. government Non-PEPFAR Funded Investments and Integration - GUYANA

Funding Source	**Total U.S. government Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**O**
USAID MCH					
USAID TB					
USAID Malaria					
Family Planning					
NIH					
CDC NCD					
Peace Corps					

DOD Ebola MCC						
Total						

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP - BARBADOS

Funding Source	Total PEPFAR Non-COP Ressources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT DREAMS DREAMS Innovation DREAMS Test & Start-Men VMMC Viral Load						
Other PEPFAR Central Initiatives Other Public Private Partnership	**$2,100,000**					LCI – To build the capacity of a regional organization and local CSOs that specifically focus on key populations to become more sustainable.
Total	**$2,100,000**					

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP - GUYANA

Funding Source	Total PEPFAR Non-COP Ressources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT DREAMS DREAMS Innovation DREAMS Test & Start-Men VMMC Viral Load						
Other PEPFAR Central Initiatives Other Public Private	$500,000					LCI – To strengthen the network of civil

Partnership		society organizations to advocate for critical issues affecting key populations and to become more sustainable.
Total	**$500,000**	

1.3 National Sustainability Profile

Sustainability is a critical concern of the Caribbean region and incorporated in all activities. Traditionally, donors have served as the sole funder of key population programming. As global donor resources plateau and funding shifts to countries with the highest HIV burden and the lowest economic income status, donor resource envelopes for the Caribbean will contract. In turn, countries are left to ensure local government and other domestic resources are available to cover the gaps in funding. There is concern that, even when governments have funds to support the National HIV Programs, they will not focus on critical key population activities and gains made will be lost.

The CRP organized and completed the Sustainability Index and Dashboard (SID) in Jamaica and Guyana for ROP16. The SIDs were developed in collaboration with government, civil society, multilateral organizations, key population groups, private sector and other donors, and will allow all partners to monitor progress towards sustainability. The CRP plans to conduct additional SIDs in other Tier I and II countries in the region in the coming year. The SIDs will serve as a foundation for developing country-specific plans for the eventual graduation from PEPFAR programs. Transitions will not happen overnight and will not all happen at the same time for all aspects of the program. Special focus will be on safeguards for key populations during and post transition. Since Guyana already has a transition plan in place, it will be important to review and update based on the SID scores and ensure all stakeholders are aware and clear on the timeline and activities for Guyana's successful transition.

SID Jamaica

Jamaica's SID stakeholder meeting builds upon a successful model of implementation done in ROP15, where the Ministry of Health (MoH) in Jamaica took full ownership of the data collection, hosting the meeting, and finalizing the results. The U.S. government, MoH, other government partners, PLHIV representatives, civil society organizations, UNAIDS and other development partners gathered to validate the SID, which was pre-populated by MoH and other stakeholders. Participants within four domain subgroups discussed and revised the SID questionnaire based on the data and information assembled. The full group of approximately 30 people then reconvened at the end of the day to review the completed tool, discuss the findings, and identify priorities.

The SID analysis identified the following strengths of the national program: planning and coordination, public access to information and performance data. The HIV response has always been grounded in a strategic planning process with a collaborative approach for its development. The reporting requirements are robust: they are mandated to produce results on an annual basis and dissemination channels are also standardized. Significant efforts are also made by the host country government to actively and routinely collect, analyze, and make data available on the HIV/AIDS epidemic.

Efforts are required to improve policies and governance, civil society engagement, service delivery, domestic resource mobilization and technical and allocative efficiencies. Domestic resource mobilization data on private sector HIV funding is not readily available. Private sector engagement also needs to be strengthened. Although data driven models are used to inform resource allocation, Technical and allocative efficiencies scored low as the resources assessed and allocations do not take into account the source of funding which is largely external. Whilst CSOs play an active role in programmatic and donor funding decisions, the sustainability of the CSO HIV response is uncertain in the absence of donor funding. Implementation of policies needs to be monitored and followed up where no action has taken place.

Increased investments are also required to address human resources for health (HRH), quality management, commodity security and supply chain, laboratory, private sector engagement, epidemiological and health data as well as financial/expenditure data. With respect to human resources for health it is noted that a significant proportion of the staff providing HIV services are not fully institutionalized. Therefore, sustainability of the response is fragile. Commodity security and Supply Chain activities have been managed largely through the national HIV/AIDS response; however, capacity building is needed to strengthen this component. There are perceived gaps in laboratory-capacity and broad agreement that assessments are needed to measure and address key gaps. Jamaica has a strong culture of conducting research and using the findings to guide programming; however, additional support is needed to institutionalize research capacity. Financial data is collected routinely using a standard tool but this is primarily donor funded.

SID Guyana

The PEPFAR Guyana team co-convened SID consultations with UNAIDS and the Ministry of Public Health (MoPH), and invited a broad range of Ministry counterparts (e.g. Ministry of Finance, Social Protection etc.), CSO groups, and the private sector. Guyana, overall, is still struggling across all four domains; nonetheless, the two highest scores were found in three elements within Governance, Leadership and Accountability and two elements in National Health System and Service Delivery. The former scores ranged from 7.00 to 8.90 indicating high sustainability. Similar scores were seen in two elements of the National Health System and Service Delivery domain for Human Resources for Health (7.33) and Laboratory (8.47).

PEPFAR Guyana has made significant investments in the national laboratory system, which might explain the score. The reality, however, is that there are persistent weaknesses in the national laboratory system, one of which is human resources. The HRH score is surprisingly high considering the pervasive HR gaps in Guyana. This score may reflect the new government's commitment towards HRH but not yet the reality.

Aside from the aforementioned strengths, the overall scores were as low as 1.43 for Technical and Allocative Efficiencies (Strategic Investments) to 6.81 for Quality Management (National Health System). The Guyana SID scores indicate that Guyana is still struggling to reach 'emerging sustainability' in critical areas across the health system. There are systemic vulnerabilities with low scores in domestic resource mobilization, technical efficiencies, strategic information, commodity security and supply chain, quality management, private sector engagement and civil society engagement. PEPFAR Guyana activities are designed to provide TA/TC and some DSD in all of the vulnerable elements except for private sector engagement. With the potential of private sector growth in Guyana a private sector strategy should be developed to identify common country interest and areas of collaboration in the future. [1]

1.4 Alignment of PEPFAR investments geographically to disease burden

In ROP 14, the CRP underwent a program shift to align investments with the epidemic in the region. Three Tiers emerged after examining the HIV burden in each country. In 2014- Tier I: Jamaica, Trinidad and Tobago, and Suriname (83 percent of new infections and 80 percent of PLHIV); Tier II: Barbados and the Bahamas (12 percent of new infections); and Tier III: the six OECS countries (5 percent of new infections). Through this process, the total planned investment in each Tier aligned with the burden; however, disparities between countries within Tiers remained. For example, Jamaica, which carries approximately 50 percent of the PLHIV burden, was allocated less than 43 percent of the programmatic budget for the region. The disparity was even greater when Cost of Doing Business expenditures were included. In addition to a geographic refinement of expenditures, activities were carefully reviewed to align with the epidemic. Through this process, Caribbean Regional Program resources only included core and

near core activities with a focus on KP. In ROP15, investments were further refined to focus on priority regions and facilities within the Tier I and Tier II countries.

For ROP16, Guyana was added to the CRP and prompted the CRP to revise the criteria for ranking of countries. As a result Guyana was classified as Tier I country and Suriname shifted from Tier I to Tier II. As Jamaica contains 50 percent of the regional burden (excluding Guyana), an additional $1.13M, inclusive of program and administrative funds, will be shifted to accelerate progress towards epidemic control.

Although Guyana's data are included in the regional graphs and analyses below, these data are interpreted separately since Guyana was not part of the CRP during the implementation period. Furthermore, interpretation of the FY15 expenditure data should take into account the shift in ROP14 where non-core activities were discontinued, investments in the OECS were being transitioned, and Tier I and II investments were being scaled up through new programming and expanded partnerships with governments, civil society and KP networks. Additionally, the programmatic shifts from primarily prevention to a broader focus on the full HIV/AIDS care and treatment cascade (a new area for the CRP) required recruitment and contracting of new sub-partners in many existing programs and start-up of totally new activities.

Primarily due to these programmatic shifts, combined with the formation of new governments during FY15, the total expenditure in the CRP was lower in FY15 ($9.8 M) compared to FY14 ($15.5M) in the 11 CRP countries. Despite the reduction in the total spend, the investment in FY15 better aligns with the burden in each country (Figure 1.4.1a). This is expected to improve further in FY16. Expenditure was also lower in Guyana in FY15 ($5.0M) compared to FY14 ($6.3 M). These lowered expenditures reflect discontinuation of non-core investments in all countries and delays with implementation of new activities in Tier I and II countries. There was marked reduction in expenditure in all of the 6 OECS countries; the total investment reduced from $4.1M in FY14 (26 percent of total spend) to $1.8 Million (18 percent of the total spend) in FY15. Expenditure in Tier III countries continued due to transition and close out of PEPFAR programs; investments will decline further in FY16. Due to this shift in resources, the percent of total spend increased in most Tier I and II countries, with Trinidad and Tobago showing a small decline (due to implementation delays).

Figure 1.4.1b shows the percent of PLHIV by country and the PEPFAR FY2015 expenditure per PLHIV by country. There is a marked reduction in spend per PLHIV in the OECS countries, where investments ranged from FY14 $638.54 to $1954.79 per PLHIV down to FY15 $163.95 to $849.31 per PLHIV. Guyana also shows a high spend per PLHIV. Expenditures per PLHIV are lowest in Trinidad and Tobago, primarily due to implementation delays, and in Jamaica, primarily due to funding constraints. The decline in investment per PLHIV in all countries is related to lower expenditure across the regional program as a result of the ROP14 pivot and reasons noted above.

In FY2015, the CRP invested $14,865,162 across the 12 countries ($9,862,378 without Guyana). Health systems strengthening and program management accounted for 37 percent and 28

percent, respectively, of PEPFAR investment (48 percent and 22 percent, respectively, when Guyana was not included in the analysis). In most countries, and consistent with the PEPFAR TA/TC model, the program focused on the national level rather than the site or service delivery level. Expenditure analysis shows that 21 percent of the total expenditure went to Facility Based Care and Treatment Sites (FBCTS) and 7 percent went towards Community Based Care and Treatment Sites (CBCTS). Above-site expenditures accounted for 78 percent of spending.

Figure 1.4.2 shows the CRP FY2015 expenditure and estimated number of PLHIV by country. The total country expenditures roughly correspond with the total number of PLHIV in each country (Figure 1.4.2a); however, Barbados shows a high spend compared to the number of PLHIV. Jamaica and Trinidad & Tobago both have a low spends relative to the number of PLHIV. Figure 1.4.2b shows the FY2015 PEPFAR expenditure and estimated number of PLHIV by SNU in Jamaica. In Jamaica, total expenditure in each SNU roughly corresponds with the burden on HIV; however, St. James and St. Catherine show low expenditure. In FY15, the CRP had yet not shifted investments according to subnational burden, therefore better alignment of expenditure and parish/district level burden is expected in FY16. Figure 1.4.2c shows the FY2015 PEPFAR expenditure and estimated number of PLHIV by SNU in Guyana. Total expenditure in each SNU corresponds with the burden of HIV by SNU in Guyana (Figure 1.4.2b).

Figure 1.4.1a Total PEPFAR Expenditures and Total PLHIV by Country by Fiscal Year

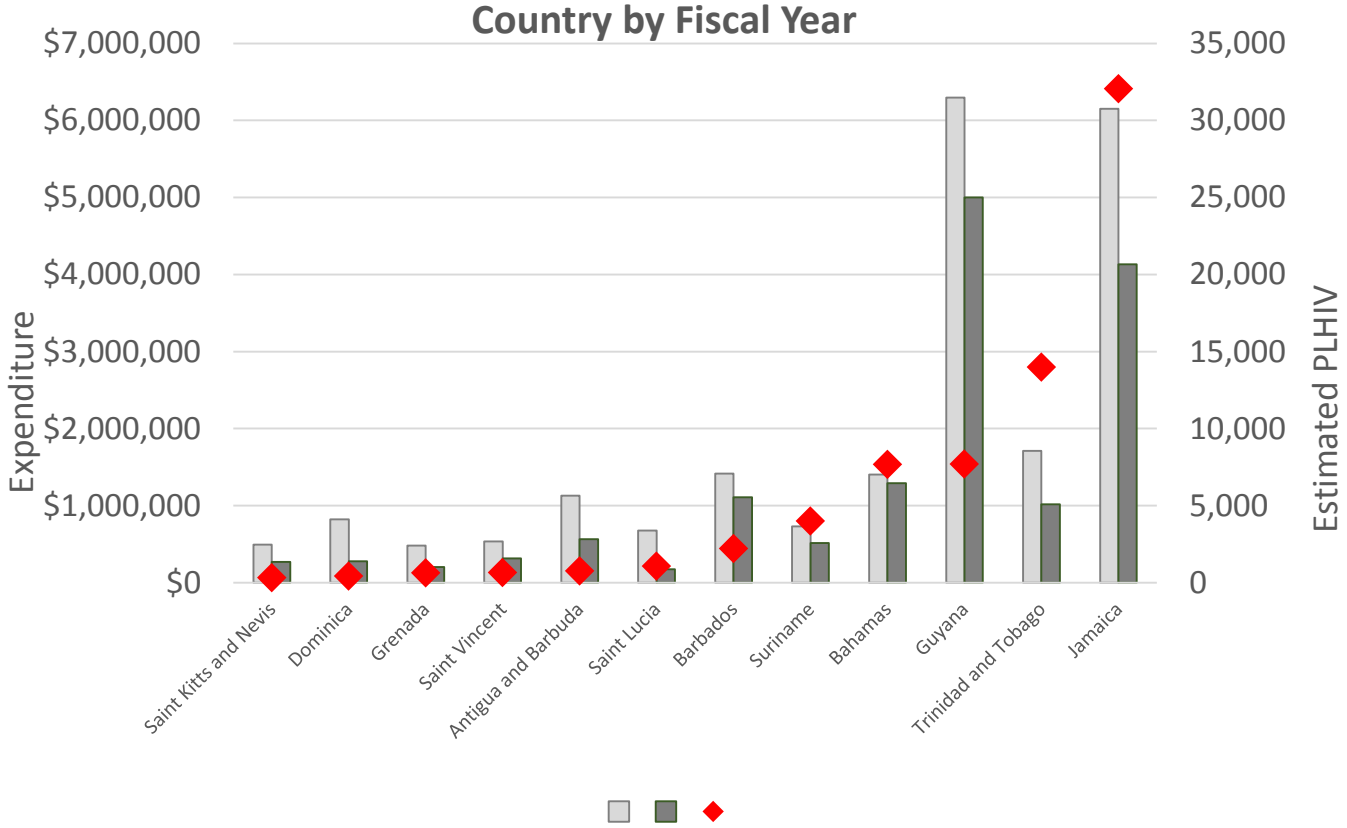
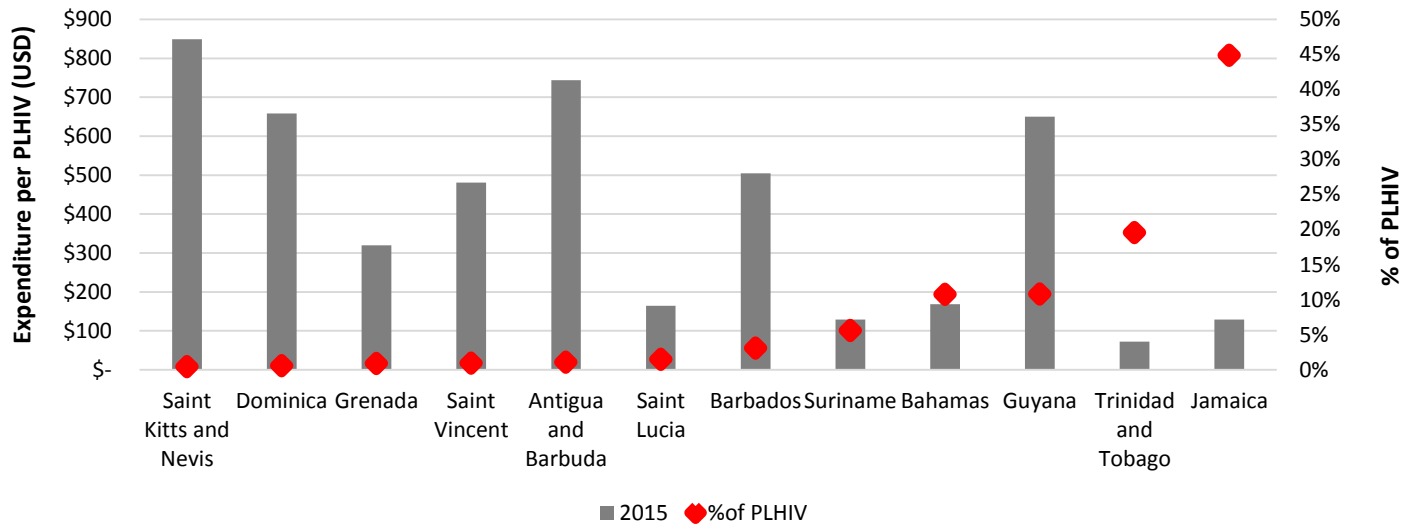


Figure 1.4.1b Percent of PLHIV by Country and PEPFAR 2015 Expenditure Per PLHIV



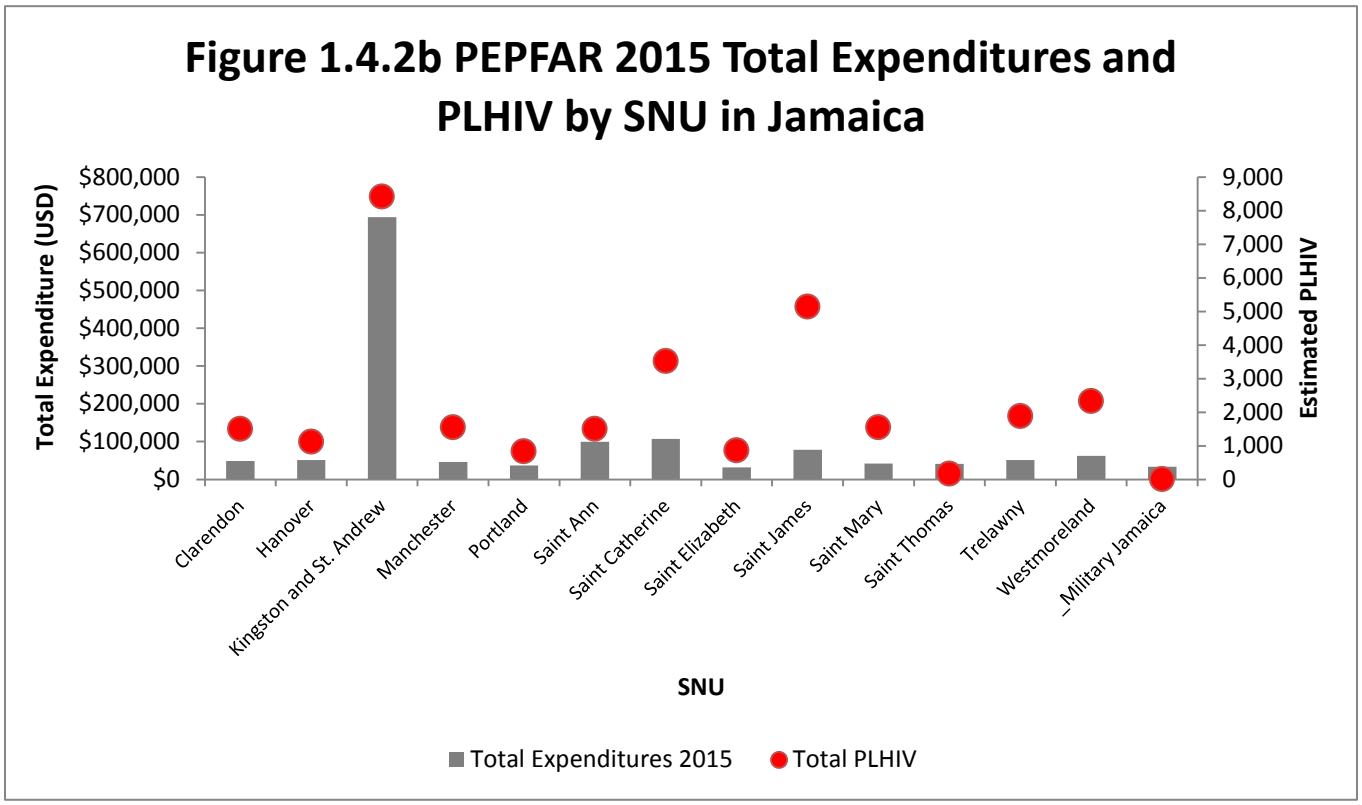


Figure 1.4.2b PEPFAR 2015 Total Expenditures and PLHIV by SNU in Jamaica
Total Expenditure (USD)
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Estimated PLHIV
Clarendon
Hanover
Kingston and St. Andrew
Manchester
Portland
Saint Ann
Saint Catherine
Saint Elizabeth
Saint James
Saint Mary
Saint Thomas
Trelawny
Westmoreland
_Military Jamaica
SNU
Total Expenditures 2015
Total PLHIV

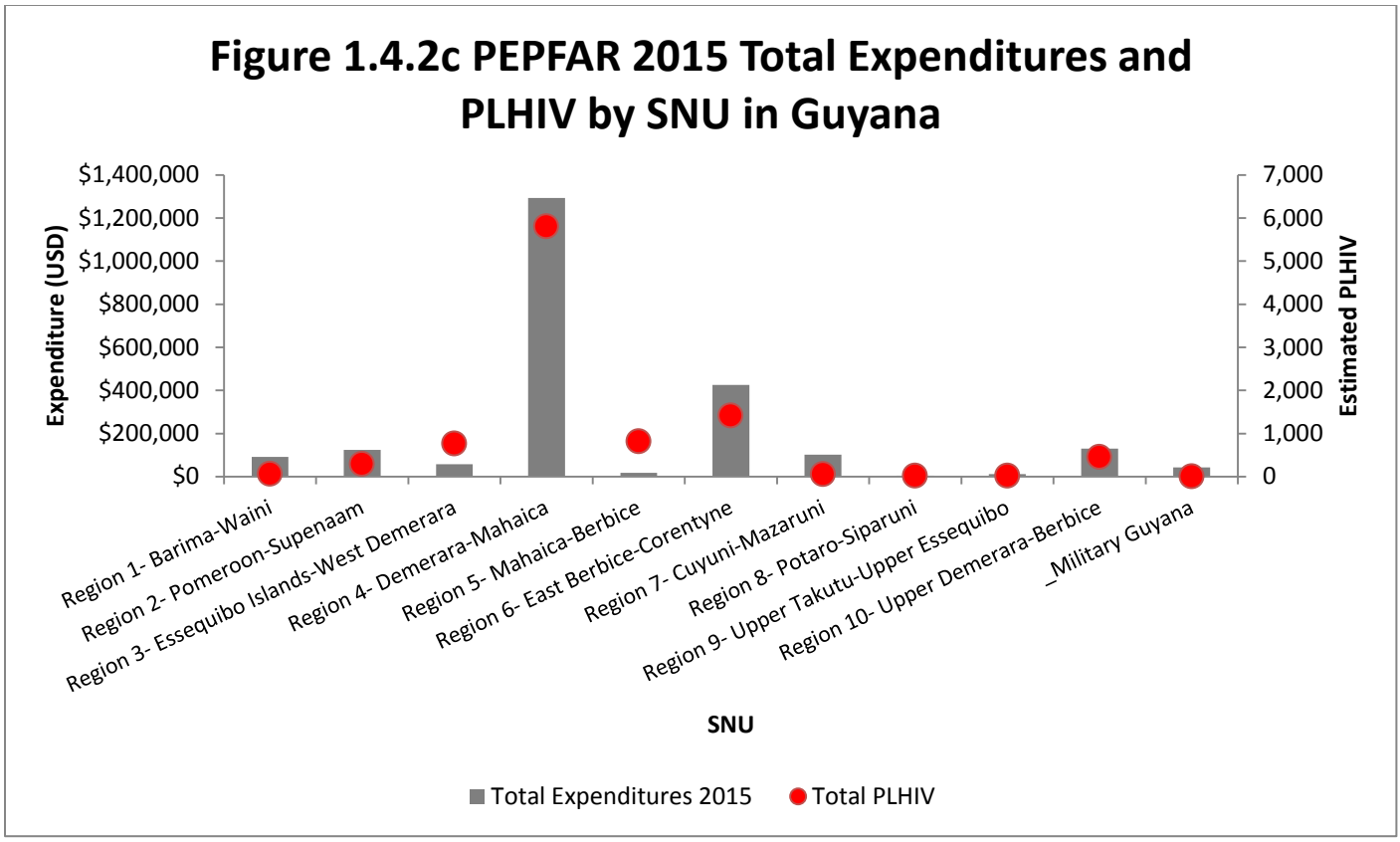


Figure 1.4.2c PEPFAR 2015 Total Expenditures and PLHIV by SNU in Guyana
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
Expenditure (USD)
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
Estimated PLHIV
Region 1- Barima-Waini
Region 2- Pomeroon-Supenaam
Region 3- Essequibo Islands-West Demerara
Region 4- Demerara-Mahaica
Region 5- Mahaica-Berbice
Region 6- East Berbice-Corentyne
Region 7- Cuyuni-Mazaruni
Region 8- Potaro-Siparuni
Region 9- Upper Takutu-Upper Essequibo
Region 10- Upper Demerara-Berbice
_Military Guyana
SNU
Total Expenditures 2015
Total PLHIV

1.5 Stakeholder Engagement

For ROP 2015, the CRP developed a plan to engage external stakeholders, including civil society organizations and advocates, multilateral organizations, the private sector and partner governments. This engagement was designed to be ongoing and include ROP development and implementation. This activity was budgeted for in ROP 15 and will continue to be budgeted for in ROP 16 and onwards. The Coordinator's Office (CO) is usually the first point of contact for the engagement of partners in ROP development, implementation, and monitoring and evaluation. The CO is responsible for outlining the steps, coordinating most communications and meetings, and providing opportunities for civil society and other partners to actively engage with the CRP. Civil society engagement in Jamaica is also coordinated locally through USAID.

Engagement Opportunities:

1. CRP ROP planning meetings: CSOs and other partners are sent a briefing package and invited to participate in country consultation calls for each of the Tier I and II countries. During this meeting, the team shares PEPFAR's programming focus and solicits recommendations for PEPFAR activities.
2. Quarterly POART reporting: Starting with Q2 2016, CRP will share quarterly reports with external partners and engage them through conference calls or in person meetings. Data had not been shared previously due to ongoing discussions with partner governments on sharing national data.
3. CRP technical meetings: Where appropriate, the technical working groups engage civil society and other partners in consultations aimed at gathering inputs specific to the technical direction and geographic focus of the program.
4. Multilateral Partner meetings: PEPFAR will continue to advocate for and support the attendance of civil society partners at higher level meetings whether coordinated or funded by multilateral partners or PEPFAR, including UNAIDS civil society engagement and the Global Fund CCM.
5. Regional and other partner meetings including regional civil society organizations: PEPFAR will continue to collaborate with regional civil society partners in the development, implementation and reporting of the PEPFAR program.
6. Civil Society consultation meetings: PEPFAR will continue to host individual meetings and consultations to facilitate the inputs of civil society partners into the PEPFAR program. PEPFAR will continue to use these opportunities to also provide information including updates and data to civil society partners.

The CO documents all formal engagements and prepares minutes that are shared and open for comment. The CRP is also committed to ensuring all written feedback is taken into consideration and that commenters are responded to in writing in a timely manner.

For ROP 2016, the CRP engaged external stakeholders as part of the SID consultations in both Guyana and Jamaica. In addition, the CRP organized stakeholder consultations (in person

meetings, teleconferences) to discuss gaps in the HIV cascade prior to the DC management meetings (DCMM). In Jamaica, this consultation was held after the DCMM and emphasized Test and Start and patient recovery.

The CRP is also benefitting from the Local Capacity Initiative (LCI) and there are opportunities to expand engagement of civil society and the building of CSO capacity across the LCI benefitting countries. Implementation of LCI activities is ongoing and expected to be completed in FY17.

2.0 Core, Near-Core and Non-Core Activities

For ROP16, the PEPFAR CRP reviewed all proposed programs and activities to make core, near-core or non-core determinations. The first step of this review was informed by the PEPFAR 3.0 Blueprint, the COP/ROP 2016 Guidance and the PEPFAR Technical Considerations. In the second step, core activities were defined as those *directly* contributing to sustainable epidemic control in Tier I and Tier II countries through implementation of Test and Start, with a focus on key populations. This includes activities to improve patient-centered service delivery models and to strengthen surveillance and viral load testing and counseling. Near-core activities were categorized as those directly *supporting core activities.* Core and near-core activities were further refined for each country by assessing clinical cascade data, current national responses and associated investment portfolios. In the third step, country consultations informed the finalization of core and near-core program activities. In the last step, technical assistance activities and support that did not target key populations (including PLHIV) or did not support Test and Start were categorized as non-core. Non-core activities included in ROP16 include OVC programming in Guyana, which is scheduled to transition by the end of FY17, as well as military supported programs in both Tiers, which will involve a responsible transition work plan focused on providing direct quality assurance and improvement in technical assistance. See Appendix A for full list of core, near-core, and non-core activities.

The PEPFAR CRP will provide intensive technical support to Tier I countries (Guyana, Jamaica, and Trinidad and Tobago), whereas Tier II countries (The Bahamas, Barbados and Suriname) will receive less intensive and time-bound support towards transition to country ownership in the short term. Tier III countries will receive minimal technical assistance support from PEPFAR CRP through regional platforms. This consists of regional SI training and participation in regional laboratory networks.

System and site-level core and near-core activities have been selected based on country needs, PEPFAR's role within the region, and the comparative advantage of PEPFAR-supported IMs and planned support through other partners in the region. In addition to working closely with host governments, PEPFAR works collaboratively with UNAIDS, PAHO and the Caribbean Regional Public Health Agency (CARPHA) to implement the strategic information agenda.

3.0 Geographic and Population Prioritization

The FY14 expenditure and program data for the CRP demonstrated that PEPFAR's investments were not aligned to the geographic burden or activities of greatest need. Although shifts are seen with the FY15 data (Section 1.4), further realignment will be initiated in ROP16 to ensure priority interventions, populations, facilities and geographic districts/parishes receive the greatest investments. Transition from general population testing to key population specific testing is now fully realized. Further programmatic shifts are planned in ROP16 to ensure PEPFAR invests in high impact activities to:

- Identify higher risk KP, test them and enroll KPLHIV into treatment
- Find KPLHIV/PLHIV who were lost to follow-up, initiate or re-initiate treatment, and support ART adherence
- Initiate ART for KPLHIV/PLHIV who were previously ineligible for treatment
- Reduce barriers to services for KP through stigma reduction and service delivery optimization
- Increase ART coverage and expand viral load testing and counseling (including patient literacy)
- Address supply chain management, policy and systems issues to health systems are prepared for sustainable implementation of Test and Start.

These core investments will be necessary if countries are to achieve 90-90-90 and reach epidemic control.

Geographic Prioritization

The PEPFAR team engaged in an extensive review of national epidemiologic and expenditure data to inform programmatic decisions. In the ROP16 planning process, the criteria used to assign countries to Tiers was changed to include key population sizes, Gross National Income, Global Fund support, health expenditure per capita and readiness for Test and Start. As a result, Suriname was shifted from a Tier I to a Tier II country. Jamaica, Trinidad and Tobago and Guyana are the CRP's Tier I countries and account for 76 percent of the ~ 71,000 PLHIV in the 12 supported countries. Tier II countries, the Bahamas, Suriname and Barbados, account for 18 percent of PLHIV. The CRP no longer provides direct funding for activities in the Tier III OECS countries; however, these small island nations account for 6% of the burden and therefore still receive support from relevant regional training, strategic review and planning meetings.

Robust subnational modeling estimates for HIV prevalence are unavailable for CRP countries. In ROP15 proxy estimates were developed using trends in HIV case reports by parish of residence, which is assumed to mirror the geographic distribution of where HIV positive individuals live. Building on the approach used in ROP15, the CRP reviewed the most recent available national and PEPFAR-specific data to determine if PEPFAR priority facilities and districts in Tier I and II

countries should be maintained. A few revisions were made based on these analyses. First, PEPFAR's support will be limited to Paramaribo in Suriname (instead of three priority districts identified in ROP15 -Paramaribo, Nickerie and Marojwne) to align with the largest number of KPs at risk for acquiring HIV. In Trinidad and Tobago, activities will expand to include the county of St. George as recent case reports indicate higher rates of infection. ROP15 priority geographic regions and facilities for Jamaica, Guyana, Barbados and the Bahamas remain unchanged.

Since activities at care and treatment (C&T) sites target 80 percent of the PLHIV in care, the CRP anticipates that focused interventions to improve ARV coverage, retention and viral suppression at these sites will impact national outcomes. With a shift to implementation of Test and Start, PEPFAR's technical assistance to the MOH is expected to contribute to increase ART coverage in priority districts in all supported countries. With PEPFAR's assistance an estimated over 5,000 PLHIV will be newly initiated on treatment in the 6 priority countries.

Viral load and other clinical testing coverage rates for PLHIV in care and treatment are anticipated to be at least 80 percent in facilities participating in CQI activities and receiving support for clinical testing through laboratory strengthening activities. The systems level investments will contribute to achieve 100 percent coverage of viral load testing for ART patients and facilitate a shift in use of viral load testing as a monitoring tool. Viral suppression rates are anticipated to increase by FY17 when patient retention and adherence interventions are scaled up through PEPFAR support. The current projections are to increase viral suppression rates in Jamaica from a baseline of 12 percent in 2012 to 55 percent through ROP16 investments.

Population Prioritization

The regional prevalence of HIV is 1.0 percent and national prevalence estimates range from <1 percent in the OECS to 2.8 percent in the Bahamas. Where estimates are available, HIV prevalence amongst FSW and MSM is disproportionately high (e.g. 32.8 percent amongst MSM in Jamaica and 5.8 percent amongst FSW in Suriname). Preliminary KP-specific cascades also suggest larger gaps along the continuum of prevention, care and treatment (CoPCT) for MSM and FSW compared to non-KP living with HIV/AIDS. For these reasons, the program will retain a key population focus throughout activities. It is important to note that HIV prevalence amongst FSW in Jamaica has shown a downward trend (9 percent in 2004; 5 percent in 2005, 4.1 percent in 2011, to 2.9 percent in 2014), approaching the general population prevalence. FY16 Q1 yields for FSW tested in Jamaica were low and comparable to generable population testing. The CRP will continue to follow this issue closely to determine continued programming for FSW in Jamaica.

KP-specific testing results (FY16 Q1) show an increase in yield for supported countries: Jamaica (8 percent), Guyana (3 percent), the Bahamas (8 percent) and Suriname (15 percent). Investments in KP-specific testing will continue in all four countries and interventions will support countries with identifying and scaling-up effective strategies to find and test hard to reach KPs, and ensuring linkage of those identified positive to treatment. These PEPFAR programs are designed to be catalytic and therefore will have lower targets initially, but support a greater impact over

time as they are taken to scale by government partners. For ROP16, PEPFAR will reach 4,147 (11 percent) of key populations in Guyana, Jamaica, Trinidad, Suriname and the Bahamas with targeted prevention messages. In addition, PEPFAR will test 3,580 KPs with the goal of identifying approximately 254 new KPLHIV. Upon analyzing the available national cascade data and preliminary KP specific cascades (data not shown), the program also agreed to invest in the latter stages of the cascades, where the gaps are greatest and ensuring those identified are started and retained on ART.

In FY16, HTS investments for military populations in Suriname, Trinidad and Tobago and Jamaica concluded due to low programmatic yield. Facility based provider initiated testing of military populations will continue in Guyana with plans to transition to the Government of Guyana in FY18.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for priority locations and populations

Key Population Reach and Test Targets

Targets for prevention activities were based on PEPFAR's historical data (FY15) and expected achievements for FY16. FY16 Q1 was the first time many of the CRP partners reported the unique number of individuals (MSM and FSW) reached with prevention interventions through PEPFAR. For this reason, FY16 Q1 figures were used to extrapolate FY16 achievements and determine targets for FY17. In "Scale up SNUs", ROP16 targets assume that PEPFAR will reach similar numbers of MSM for testing and counseling as FY16. In 'Scale up to Saturation SNUs' (Region 4, Guyana) PEPFAR will increase testing in order to reach 80 percent coverage by FY 18. FY 17 targets for KPs are lower than FY 16 as a result of new KP regional size estimates that were not available during ROP 15. Overall PEPFAR will reach 11 percent of key populations within the priority locations with HIV counselling and testing services. Planned KP coverage ranges from 3 percent (Jamaica) to 72 percent (Guyana) within priority locations (Table 4.1.4).

Priority Population Testing

In addition to community HTC services, DSD targets were also maintained for provider initiated testing at the two PEPFAR supported high yield private HIV clinics in Guyana (Region 4). TA targets for testing among the military population are included for Guyana. These targets were estimated based on historical trend data.

Care and Treatment Targets

The CRP reviewed national and facility level cascade data to assess gaps in ART coverage and quantify the gap to reaching 90-90-90 targets. Using the COP Guidance for "Scale up to

Saturation SNUs", the target level of 80 percent coverage was selected for Guyana. Default coverage rates of 80 percent were reviewed for all "Scale up Aggressive" countries and adjusted in consultation with Ministries of Health and implementation partners. Targets for new ART patients were based on implementation of Test and Start in all countries.

Technical assistance (all countries) and Direct Service Delivery (Guyana only) targets were estimated based on expected national or subnational results for the MOH C&T programs. The total number of new ART patients was determined based on the current number of pre-ART patients that are in care at PEPFAR-supported facilities, identification of new positives through prevention and testing activities and return of lost patients to care. Additionally, activities to strengthen the quality of services for PLHIV and KPLHIV at priority sites will assist MOHs with retaining patients on treatment (Table 4.1.2).

Key population prevention activities will identify 406 KPLHIV, all of whom are expected to initiate treatment. Care and retention interventions (including retention and "return to care") will support the Ministries of Health with initiating new patients on treatment. The final care and treatment targets represent a scale up in ART coverage over the expected FY16 results.

Orphans and Vulnerable Children

The OVC program in Guyana is centrally supported and is being actively transitioned to the government. In COP 15, targets were maintained for Regions 2, 4, 6, and 10. For ROP16/ FY 17 targets are maintained for Region 6 only based on the assumption that OVC programs will be transitioned fully for Regions, 2, 4 and 10 in FY 16 and that no new clients will be enrolled in FY 17.

Viral Load Scale up Targets

Viral load testing data were reviewed for all Tier I and II countries. FY17 targets are based on ensuring patients receive routine viral load testing, with a goal to achieve 100 percent VL testing coverage for ART patients. Therefore, these targets also reflect systems level investments to address the viral load sample referral network, reduce turnaround time for receiving results and ensuring that clinics include viral load testing as part of their standard package of services for PLHIV. Facility level viral load testing targets are linked to expected number of ART patients during FY17 and assume that all countries will be implementing Test and Start.

Key Considerations for FY17 Targets

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

recognizes, however that PLHIV and KP accessing prevention interventions may be resident in different locations.

There is a need to strengthen data collection and reporting for KP interventions. UNAIDS provides support to countries to develop PLHIV size estimates. Ongoing PEPFAR-supported BSS surveys will provide national MSM and FSW population size estimates. Moving forward, PEPFAR will also support KP hotspot mapping and local size estimations in priority SNUs. Where data are unavailable, PEPFAR estimated the total MSM population size to be 2 percent of the adult male population and FSW sizes to be 3.8 percent of the adult female population.

A significant limitation of the target setting process was the denominator used for PLHIV in Guyana. The PLHIV estimate used was based on the published UNAIDS estimates for 2014. The host country did not have consensus on the published number and is currently in the process of developing the 2015 HIV estimates. Should the updated number be significantly different, targets may need to be updated during the POART process. In addition, while improvements have been made in the availability of key population data, it still remains a significant gap.

Cross-cutting Issues

Community-based organizations (CBOs) that serve key populations continue to be important partners with host governments to 1) strengthen HTS, including linkage to facility- and community-based care and treatment and 2) supporting return to treatment, treatment adherence, retention in care and regular VL testing for KPLHIV. Through the sustained partnership of KP-friendly civil service organizations, partner nations and PEPFAR will realize greater gains in increased access to HIV and STI services, diagnostics, improved retention, adherence, and documentation. PEPFAR will continue to invest in efforts to improve community and facility partnerships, engage in social network approaches for community mobilization, and apply innovative technologies to reduce LTFU and return HIV positive persons to care and treatment. These models will also address system barriers related to stigma and discrimination, focus on treatment literacy at both the community and facility levels, and expand the use of peer navigators to support patient and country readiness. These approaches are important gateways to reaching "hard to reach" key populations and link them to necessary services.

Stigma and discrimination remains as a barrier to key populations getting tested and accessing prevention services. PEPFAR will support the MoHs and civil society partners to build on regional and global best practices in S&D reduction for health systems by rolling out and evaluating a comprehensive health facility-based S&D-reduction package, while simultaneously strengthening S&D measurement.

Complementary to these critical components, PEPFAR will continue to strengthen the data collection platforms and supply chain management and logistics as needed, including HMIS and surveillance. Systems strengthening efforts will ensure clinical data are available for case

management and site level data reviews are completed routinely to identify and scale-up effective program strategies.

Table 4.1.1 ART Targets in Scale-up **Sub-national Units for Epidemic Control**

SNU	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) *TX_CURR*	Newly initiated (APR FY 17) *TX_NEW*	ART Coverage (APR 17)
Jamaica_priority parishes	23,752	9,391	9,611	**12,728**	**3,437**	**53%**
Guyana_Region 4	4,669	3,355	380	**3,579**	**671**	**77%**
Trinidad & Tobago	13,000	7,372	2,721	**1291**	**724**	**10%**
Suriname_Parimaribo	4000	1,796	1,327	**464**	**366**	**13%**
Barbados_*St. Michael*[6]	2,200	1,262	498	**1262**	**170**	**57%**
Bahamas	6,949	2,481	3,304		**240**	
Total						

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Priority Districts (FY 17)

Entry Streams for ART Enrollment	Tested for HIV (in FY17)	Identified Positive (in FY17)	Enrolled on ART (in FY17)
[7]Clinical care patients not on ART **Jamaica**	-	-	**5,287**
Clinical care patients not on ART **Trinidad and Tobago**	-	-	**700**
Clinical care patients not on ART **Guyana**	-	-	**461**
Clinical care patients not on ART **Suriname**	-	-	**320**
Clinical care patients not on ART **the Bahamas**	-	-	**192**
[8]Clinical care patients not on ART **Barbados**	-	-	**284**
Other priority and key populations **Jamaica**	**1,953**	**156**	**156**
Other priority and key populations **Trinidad and Tobago**	***600***	**34**	**34**
Other priority and key populations **Guyana**	**4,152**	**142**	**142**
Other priority and key populations **Suriname**	**782**	**46**	**46**
Other priority and key populations **the Bahamas**	**882**	**48**	**48**
PITC **Guyana**	**1,955**	**78**	**78**

[6] TX_CURR for Barbados is estimated based on reaching 95% of those who are eligible for treatment.

[7] Includes patients in priority facilities who were lost to follow-up, returned to care and initiated on treatment.

[8] Includes patients in priority facilities who were lost to follow-up, returned to care and initiated on treatment

Total

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
KP_PREV _Jamaica	**31,807**	**7%**	**2,203**
KP_PREV _Guyana_Region 4	**3,658**	**72%**	**2,652**
KP_PREV_Trinidad & Tobago	**5,706**	**18%**	**1000**
KP_PREV_Suriname	**5,160**	**26%**	**1345**
KP_PREV_Bahamas	**4,408**	**25%**	**1102**
PP_PREV_Guyana	**2,300**	**26%**	**600**
Total			

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (priority SNUs)	Coverage Goal (in FY17)	FY17 Target
KP_PREV_Kingston & St. Andrew	13,140	7%	877
KP_PREV_St Catherine	9,749	7%	644
KP_PREV_James	3,512	9%	299
KP_PREV_Westmoreland	2,593	8%	214
KP_PREV- Manchester	**1,236**	**6%**	**74**
KP_PREV- St. Ann	**1,111**	**6%**	**67**
KP_PREV- Trelawney	**466**	**6%**	**28**
KP_PREV_ Guyana region 4	**3,658**	**72%**	**2,652**
KP_PREV_ Trinidad and Tobago _	**5706**	**18%**	**1000**
KP_PREV_ Suriname_Paramaribo	**5160**	**26%**	**1345**
KP_PREV_ Bahamas_New Providence	**4408**	**25%**	**1102**
Total			

Table 4.1.5 Targets for OVC and Linkages to HIV Services			
	Estimated # of Orphans and Vulnerable Children	**Target # of active OVC (FY17 Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target) OVC_KNOWNSTAT***
Guyana_Region 6		**162**	
TOTAL			

4.2 Priority population prevention

To maximize program impact, targeted prevention efforts will focus on reaching and testing key populations using a combination of facility and community-based strategies and promoting timely linkages and referrals to HIV-related services.

Traditional venue-based outreach activities have reached relatively small proportions of the estimated populations in priority countries. In the Bahamas, PEPFAR reached less than 10 percent of the estimated MSM in FY15. There have been greater successes with reaching FSW in some countries. In Jamaica PEPFAR reached 4 percent of MSM compared to 22 percent of estimated FSW in FY15. Although the HIV testing yield has increased, only a subset of individuals reached are tested. To respond to this, outreach strategies are being shifted to access strategic hotspots and permeate sexual networks to reach KP who are at highest risk of HIV. For example, MSM are increasingly using electronic media to expand their social networks and meet individuals with similar sexual orientation. To respond to this change in behavior, PEPFAR will deploy Information Communication Technology (ICT) to improve reach to higher risk and more "hidden" KP and promote health-seeking behavior.

The CRP will also support a combination-prevention package targeted to KPs that will expand to support activities related to Test and Start (e.g., returning patients to care; retention in care), including second-generation HIV surveillance information system for KPs that can help inform programming in real time. Activities implemented at the facility-level will also leverage PEPFAR CRP's community-based support, such as peer navigators, and clinician-focused CQI activities. For example, peer navigators can help create demand for services, assist with return to care strategies and medication adherence. Peer navigators can reinforce the value of viral load testing to create demand for testing. CQI efforts can also reinforce activities related to loss to follow up, retention in care, and medication adherence.

PEPFAR will support behavioral and structural prevention activities that address sexual risk reduction, demand creation for clinical services and the reduction of stigma and discrimination. Such activities target higher risk youth such as girls and adolescent LGBTI.

Tier II countries will receive less intensive and time-bound support. Activities will focus on targeted assistance to update treatment guidelines and implement KP-specific program pilots.

These countries will also receive limited support for targeted KP outreach in high volume locations, HIV testing and counseling and linkage to care, viral load testing, and quality assurance. PEPFAR will also support intensive focus on S&D and LGBT rights advocacy and protection. A surveillance study will be conducted in Suriname specifically and PEPFAR's contributions will be limited to one sub-national unit, Paramaribo.

4.5 HIV Testing and Counselling

In ROP15, the PEPFAR CRP eliminated investments in HTC activities targeting general population in the region and successfully transitioned to focus on KP-targeted testing strategies. The objectives of ROP16 activities are to: 1) increase the number KPs tested for the first time; 2) increase earlier diagnoses (median CD4); 3) increase KP HIV positive testing yields; and 4) ensure timely linkage of newly identify KPLHIV to care/treatment.

The WHO Consolidated Guidelines on HIV Testing Services 5C's (consent, confidentiality, counselling, correct results and connection) were used to inform development of the focused HTS activities being implemented in the region, particularly as an initial component in the Test and Start strategy. To improve overall access and quality of HIV testing, rapid testing quality improvement initiative (RTQII) will continue at PEPFAR supported sites to: increase use of the standardized logbook for data collection and analysis; and improve the implementation of the Dry Tube Specimen External Quality Assurance (DTS EQA).

In Tier I & II countries, PEPFAR CRP service delivery models for HTC generally fall into two main approaches: 1) outreach (i.e., street-based; venue-based; social marketing; ITC) and 2) social networks (e.g., incentivized peer networking). Outreach efforts focus on evidence-based interventions and best practices including community-mapping; identifying hotspots; conducting formative research; involving, recruiting, and training community members; and using targeted ITC information. Social network approaches are considered a best practice as they are peer-driven and can often reach the more difficult to reach KPs. In a few instances, facility-based routine PITC (including opt-out) will be supported.

Tier I

In Jamaica, PEPFAR will support KP testing through outreach interventions. For MSM, expanded social media strategies will increase the demand for and uptake of HTC. PEPFAR will continue to support incentivized "Peer Links" in the MOH and CSOs who will refer peers to prevention and testing services. This strategy has made an important contribution to increased yield among MSM (up to 23 percent in the Kingston/St. Andrew SNU) and will be expanded. The focus will be on MSM who have not been tested before in order to reduce late diagnosis. PEPFAR supported Health Navigators will also work with Contact Investigators at priority treatment sites to strengthen contact tracing and partner notification. At the subnational level, PEPFAR will support monitoring of the National Referral and Linkage Protocol to ensure that all priority SNUs are adhering to the policy and that all individuals who test positive, whether in outreach settings or at

facilities, are quickly enrolled at a treatment site. This is particularly important as Jamaica moves to Test and Start.

In Guyana, PEPFAR will support local NGOs to improve targeting of outreach and testing services. A formalized paper-based referral system will be instituted to allow NGOs to track whether testing referrals have been successful, and to follow up with clients who do not present for testing within a set timeframe. NGOs will also roll out incentivized peer-based networking and snowballing strategies to refer MSM, TG and SW for testing; KPs who test positive will be provided incentives upon successful referral of partners and contacts for testing. PEPFAR will continue to support opt out PITC services. This is intended to provide services to high-risk groups seeking facility services and for identifying asymptomatic cases presenting at facilities.

In Trinidad & Tobago, PEPFAR will provide technical assistance support for HTC through an implementing partner. The implementing partner will work with KP and Family Planning organizations to train and mobilize teams of Peer Educators and Peer Navigators to increase uptake of KP for testing services through referrals to KP-friendly testing sites. Peer navigators will also refer and promote HTC for KP partners and children. Support will be provided to continue the development of a mobile-to-web application that will allow NGO (including peer educators) and government health staff to enroll clients, disseminate health information, provide referrals and reminders, update education and clinical services received, to track people enrolled through the clinical cascade.

Tier II Countries

In the Tier II countries, PEPFAR will provide limited technical assistance support for HTC through an implementing partner in Suriname and The Bahamas. Similar to Trinidad and Tobago (as described above, but with a more limited investment) the implementing partner will work to improve MOH engagement with KP through supporting KP and Family Planning organizations to train and mobilize teams of Peer Educators and Peer Navigators to refer KP clients for testing and other services. Peer navigators will also refer and promote HTC for KP partners and children. PEPFAR will support the development of strategies to use ICT approaches for promoting HTC, providing HTC and other services referrals.

In addition, support will be provided to Suriname for the development of the mobile-to-web application to track people enrolled through the clinical cascade. PEPFAR will fund targeted KP outreach using mobile community KP partners to frequent KP hot spots (MSM bars, brothels, and sex clubs) and offer condoms, lubricants, and HTC focused on those who have never been tested for HIV. Partners will use a “buddy” and an incentive system to refer and link newly diagnosed persons to care and treatment services. One facility has specific hours of operations for sex workers to access services. Fiscal year 2017 activities will aim to strengthen and reduce the linkage to care timeframe; with the expectation that all diagnosed persons will be successfully linked to care within 3 months of diagnosis. The updated and formalized referral system implemented

because of recent SIMS findings will allow both facility and community partners to record, report successfully linkages, and increase the number of persons initiating treatment.

Timely Linkage to Care

PEPFAR's current activities include updating, implementing, monitoring, evaluating, and strengthening key protocols and standard operating procedures (SOPs) that support improving linkage to care among KP; as well as retention and adherence among PLHIV. PEPFAR activities will assist with the linkage of clients to quality, non-stigmatizing HTC and to clinical and community-based services.

In Jamaica, PEPFAR will support peer-based linkage to care, with some outreach staff as Peer or Health Navigators (MOH to emphasize health navigators, CSO will emphasize peer navigators). These navigators will ensure that those who test positive are linked to treatment quickly and have a designated officer who will chaperone them through the early treatment process until viral suppression is achieved. These navigators will work closely with the case managers, social workers, adherence counsellors and other health staff to ensure comprehensive treatment and care services are provided to those newly diagnosed or who have been returned to care.

4.6 Facility and community-based care and support

The CRP, through its public, private and civil society sector partnerships will continue to deliver a comprehensive array of HIV services for both KP and KPLHIV/PLHIV. These partnerships will be enhanced by integrating facility and community services across the CoPCT in PEPFAR priority settings. The integrated models will optimize service delivery (e.g., through task shifting, including the use of peer counselors/navigators), be more patient-centered, and better address KP-specific needs. This will involve implementation of CQI and SIMS, using the findings to provide tailored technical support to strengthen current service delivery models.

Tier I and II Countries

PEPFAR will support the strengthening of community-based high volume sites to increase the number of newly diagnosed KP who are linked to treatment services. In addition, CRP will scale up efforts, including piloting innovative strategies, to identify and return PLHIV who were lost and return them to (facility or community-based) treatment. KP-led and focused CBOs will be supported to partner with health facilities to expand coverage and enhance the quality of services targeting KPs by:

- promoting testing within the Test and Start strategy
- improving targeted outreach for testing and linkage to treatment,
- returning people who have been lost to follow up to treatment and care,
- enrolling people previously diagnosed but who did not meet eligibility criteria in treatment and care, and

- supporting KP health, treatment and testing literacy (PHDP services)

Attention will also be placed on training clinical providers at high volume sites to increase their knowledge, support non-discriminatory attitudes and strengthen skills to serve KPs. A strong emphasis will be placed on strengthening contact tracing/partner notification (including individuals returned to care) and medication adherence, which will be supported by PEPFAR CRP at the community level (e.g., peer support programs) and at facility level (e.g., hiring contact investigators, nurses; at priority sites). Both community-based and facility-based counsellors will be trained to use viral load testing as a tool to reinforce adherence and prompt necessary interventions (e.g., changing drug regimens).

4.7 TB/HIV

Data suggests that, although the number of TB cases is relatively low in the region, HIV-TB co-infections rates are high. For example, in Trinidad and Tobago national data show a co-infection rate of 25 percent among TB patients. Across the region, national policy guidelines to support the integration of TB and TB/HIV care have not been established and the implementation of collaborative TB/HIV services is not standardized. PEPFAR, PAHO and CARPHA all are working in coordination to strengthen national TB programs in Tier I and II countries. Specifically, the PEPFAR Lab TWG is supporting TB diagnosis through MOH Cooperative Agreements as well as working closely with CARPHA to strengthen regional TB diagnostic capacity. This support will continue in FY2017.

4.10 Adult Treatment

The WHO 2015 Consolidated Guidelines for Use of Antiretroviral Drugs for Treatment and Prevention of HIV recommends that ART should be initiated in all adults living with HIV regardless of CD4 cell count or disease stage. Currently, all Tier I and Tier II countries initiate treatment based on CD4 cell count, contributing to the low rate (44 percent) of PLHIV in the region on ART. Jamaica, Guyana, Trinidad and Tobago, Barbados and The Bahamas have recently committed to adopt Test and Start during FY17. The CRP has engaged with Suriname and it is likely they will adopt the WHO recommendations within FY17. All six countries have requested PEPFAR assistance to complete an economic analysis for Test and Start implementation, most of which will be completed in FY16. PEPFAR CRP seeks to invest in a number of core activities that support the Tier I and Tier II countries as they adopt and implement the 2015 WHO Test and Start Treatment Guidelines. These activities will occur in high disease burden priority locations (scale-up SNUs) and contribute to the overall goal of achieving epidemic control.

The CRP will provide TA to countries to review current service delivery models and to identify and address bottlenecks, improve efficiencies, and increase 'patient output' of facilities. This will include support to adopt differentiated ART care for eligible patients by extending ART refills, reducing frequency of clinical consultations, and strengthening supply chain systems to support extended ART refills. Differentiated care package elements will be supported for different PLHIV categories including: new patients, clinically well new patients, advanced disease stable patients

on ART, stable patients on ART, and unstable patients on ART. PEPFAR will have greater investments in TA to establish differentiated care models in Tier I countries compared to Tier II.

With the move to Test and Start, there will be increased levels of VL testing and a reduction in CD4 testing. PEPFAR will support procurement of viral load reagents and TA to improve procurement systems in both Tier I and 2 countries. A viral load and CD4 needs assessment was completed in Jamaica. Under ROP 16, a similar assessment will be conducted in Trinidad and Suriname. The data or gaps identified through these assessments will be used to strengthen viral load referral networks. The cost of viral load testing is still high - ranging between $40-50 per test. The PEPFAR Lab TWG is currently coordinating a conversation between countries and Roche Diagnostics so they could benefit from the discounted reagent price through the UNAIDS Diagnostic Access Initiative.

At the national level, the scale up of viral load testing and capacity building to address drug resistance is pivotal to retention and viral suppression. PEPFAR will support the enhancement of the viral load sample referral networks in Tier I countries, facilitate improved communication between treatment sites and laboratories, and strengthen turnaround times, sample management, procurement systems and laboratory data management. This support is intended to improve VL testing coverage by 50 percent during FY17 and progress towards achieving the third 90 target by 2018. In Jamaica specifically, coverage will accelerate from 64 percent to 90 percent, with similar results expected in other Tier I countries.

PEPFAR CRP will provide technical assistance to ensure that viral load testing results regularly enable the early identification of people experiencing treatment failure. This will include training clinicians and adherence counsellors, as well educating PLHIV to understand what their viral load result means and when they should be asking for a viral load test. Both community and facility-based counsellors will be trained to use viral load a tool to reinforce adherence and prompt necessary interventions (e.g., changing drug regimens).

4.10 OVC

In ROP 16, two CBOs will continue limited service delivery in one sustained area. Emphasis will be placed on retention and adherence to treatment, especially as Guyana adopts Test and Start in FY17. Hence, the limited package of core services to be provided will include: individual and support groups to address the psychosocial needs of children and their caregivers; adherence support (clinic reminders, pill/bottle counts); building health, nutritional knowledge, treatment literacy in caregivers to care for OVC; conducting positive parenting training to include communication on adolescent risk and HIV disclosure; limited education subsidies; continued referral and support to access health and HIV services; collaborating with child protection services to report instances of neglect, abuse and other forms of vulnerability; encouraging testing of all children affected by HIV and making the appropriate referrals; and supporting issues affecting adolescents-- particularly girls-- and making the appropriate referrals such as to sexual and reproductive health services.

These services will be complemented by the following near core components: ensuring children stay in school and routinely track enrolment, as well as supporting linkages to social, legal and other care services.

Quality Improvement

The SIMS assessments will serve as the main tool used for the identification of PEPFAR technical assistance and quality improvement priorities among PEPFAR supported sites with the CRP. This approach involves routine SIMS assessments followed up by tailored assistance including, one on one mentoring, systems and tools development and supported by periodic M&E. The assessment data will be used to prepare a technical assistance plan with emphasis on areas where the partners have scored lowest and needs attention for improvement.

Priority care and treatment sites will continue to be involved in a regional continuous quality improvement (CQI) collaborative. The purpose of CQI is to improve the quality of health care by identifying gaps in performance, testing ideas to address the gap, and using data to assess whether the change that was tested results in an improvement. The Caribbean Regional Quality Improvement Collaborative (CaReQIC) brings together multidisciplinary teams from a number hospitals and clinics to work together toward a common goal or aim, such as achieving a targeted percentage of patients who are virologically suppressed. These teams move toward their aim by addressing key drivers such as loss to follow up, retention in care, adherence to medication and lab monitoring. Quality improvement teams participate in learning sessions where they: 1) receive training in quality improvement methods, 2) share their change concepts and results/data, and 3) learn from one another and begin planning their next changes to improve the quality of care offered. Between learning sessions, the QI teams will receive onsite coaching from a QI Coach, participate in webinars, use Plan Do Study Act (PDSA) cycles to test change ideas, and track their data. Teams will be supported to continue to expand patient engagement in site level QI activities which enables teams to address barriers to accessing and staying in care. These QI activities will be critical to support (and monitor the impact of) the roll out of Test and Start as well as any differentiated models of service delivery implemented by the MOH. PEPFAR will also support the long term sustainability of QI by working with the MOH to identify regional (or parish level) QI coaches who are trained to support QI efforts at the site level. Working with the MOH to develop a national HIV QI institutionalization plan that addresses policy, leadership, resources, and infrastructure will also be critical to ensure sustainability.

Improving the quality of care to support the increased numbers of PLHIV in care and treatment is also addressed by providing onsite clinical mentoring as well as targeted in-service training. These two activities support the comprehensive care and treatment for all PLHIV and specifically for key populations to ensure retention in care, adherence and ultimately virologic suppression. To increase the practical skills of healthcare workers to provide comprehensive care for KPs, clinicians (starting in 2015) and nurses (starting in 2016) are offered a two-day intensive preceptorship in a simulated clinical setting to practice skills with key population patient trainers related to sexual history taking, risk assessment and reduction, mental health screening and ano-genital examination.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

In Tier I and II countries, military programs will receive direct military technical assistance to facilitate the successful transition to the host militaries in the coming years. Support will include minimal laboratory support in four countries (Guyana, Jamaica, Trinidad and Tobago, Suriname) to further strengthen the quality of HIV related services delivered to HIV+ service members as well as baseline assessments of HIV testing services. In Guyana, specifically, minimal support is provided to procure reagents, commodities and phlebotomy training of laboratory personnel as well as materials to support the annual HIV education and training for recruits. QA/QI support will also include TA to monitor and evaluate HIV prevention messaging, anti-S&D activities, HTS and also to strengthen linkage to care and treatment approaches. These packages of support will assist with the long-term sustainability of PEPFAR investments and country ownership via a gradual reduction in PEPFAR support.

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

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

OVC: The OVC program began phasing out in FY 14 in centrally supported sites. Previously, seven CBOs provided family centered care, linking HIV affected families with OVC services (e.g., educational/vocational skills training, parenting skills training, psychosocial support, adherence support, age appropriate risk reduction counselling, referrals to youth-friendly services), and strengthening the family unit to care for children.

In ROP 16, PEPFAR will support two CBOs that will provide limited service delivery in Guyana with plans to transition completely by the end of FY17. Services that will be provided at this site is described in section 4.10.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

Section 6.1: Critical Systems Investments for Achieving Key Programmatic Gaps

The overall goal of the Caribbean Regional PEPFAR Program's systems investments is to support partner governments to implement and sustain Test and Start and achieve epidemic control with a focus on key populations. The three major programmatic gaps which must be addressed in order to achieve this goal are: 1) low treatment coverage; 2) low service uptake by key populations; and 3) poor data quality with limited use. These three programmatic gaps are closely aligned to the ROP 16 program goals of implementing the priority policies of Test and Start and Optimized Service Delivery Models, which will be discussed in more depth in section 6.2. The specifics of how the PEPFAR/Caribbean Regional Program will address these systems barriers is outlined in Tables 6.1.1, 6.1.2, 6.1.3 and 6.2.1 and 6.2.2.

Programmatic Gap 1: Low Treatment Coverage

Approximately 44 percent of PLHIV were estimated to be on treatment in 2014. The low levels are ART coverage is partly explained by treatment initiation criteria, where only 50 percent of diagnosed patients are considered eligible for ART based on national. Three of the 6 Tier I/II countries recently adopted the WHO 2013 guidelines (ART initiation at CD4 500) and others use CD4 350 as the initiation threshold. If all currently eligible PLHIV were on ART, treatment coverage would still be too low to achieve epidemic control. Therefore, advancing "Test and Start" is paramount to paving the way to ensure all PLHIV can access treatment. See specific systems barriers discussed for Test and Start in section 6.2. Key barriers identified that cross over between this programmatic gap and the policy gap are: sustainable financing and expenditure tracking for more efficient resource allocation, supply chain strengthening, and increased coverage of viral load testing.

1. **Weak systems at facility and community level for identifying KP and PLHIV, linking them to care and promoting consistent adherence to treatment:**
   There is limited knowledge of the proportion of KP living with HIV (KPLHIV) that are on treatment. This gap is partly due to the absence or inconsistent screening of patients to identify risk factors and the availability of KP friendly services. The role of community based organizations in HIV prevention is well established. All PEPFAR supported countries have NGOs that provide outreach and testing to MSM and FSW; however, more work is needed to ensure that all countries have facility or community based organizations that provide care and treatment tailored to MSM and FSW. Innovative methods for ensuring linkage and adherence are critical, especially for Key Populations in the Caribbean. There has been under-utilization of innovative methods (such as electronic/mobile KP linkage approaches) at the site level for linking KPs into treatment, lack of integrated patient tracking systems across facility and community settings, and insufficient support systems for adherence and retention within communities.
2. **Insufficient domestic resources and inefficient use of resources:** Systems for tracking and reviewing expenditures to ensure efficient use of resources for HIV treatment are insufficient or nonexistent. In addition, as countries consider putting more people on treatment there is concern about sufficient domestic resources to fund new patients. A subset of countries has the potential for private sector opportunities for funding treatment but has not sufficiently explored these opportunities to date.
3. **Weak Supply Chain Management Systems:** Most Tier 1 and 2 countries currently experience periodic stock outs of critical commodities and Lab reagents. The supply chain management systems are ill-prepared for supporting the forecasting and management of ARV, HIV Testing, Viral Load, and other commodity demands with current patient loads.

Viral Load Testing Coverage: Across the region there is low coverage of viral load testing for ART patients. Jamaica and Trinidad report only 63 percent of ART patients have access to routine VL testing. There is weak VL sample referral and other systemic structures to support expanded testing and coverage. Only 15 – 37 percent of PLHIV have achieved viral suppression, in part due to the presence of HIV drug resistance (DR) mutations. Data from one treatment site in Jamaica shows 12.6 percent primary HIV DR (Barrow et al, 2013)[1]. Therefore more assistance will be provided to ensure full functioning of the existing HIV genotype testing platforms and support for the implementation of HIV DR Surveillance protocols. This will ensure prompt clinical decision making for patients presenting with virologic failure and provide data to support HIV DR early warning indicators.

Programmatic Gap 2: Low Uptake of KP Services

1. **Stigma and Discrimination:** MSM, SW, and TG in the Caribbean have HIV prevalence rates that are among the highest in the world. Jamaican MSM, for example, has an HIV prevalence of 32 percent. The service uptake by Key Populations (KPs) in the Caribbean is negatively impacted by pervasive and entrenched S&D, both at the community, facility and national level. Anti-buggery laws are still in effect in the majority of countries, if not frequently enforced. Though human rights language has been incorporated into HIV policies across the Caribbean, policy environments generally do not protect LGBT or PLHIV sufficiently.
2. **Ineffective Service Delivery Models and Support Systems for KP:** KP HIV testing yields across the Caribbean remain too low and demonstrate clearly that activities are still not adequately tailored to KPs. The quality of testing services should also be effective enough to prevent unacceptable error rates and promote confidence in test results regardless of the venue. Innovative KP service delivery models and cutting edge uses of technology and electronic/mobile health applications that address KP-specific needs and ensure client protection are essential to meeting fiscal year 2016 and 2017 targets. A large portion of KP are "hidden" and difficult to reach through prevailing service delivery systems. Data suggest that dedicated MSM programming is limited in scope and quality and that fewer than 50 percent of Female Sex Workers (FSW) in Guyana and Suriname have access to and use HIV services.
3. **Facility and Community Service Providers are not KP Friendly:** Access to KP sexual reproductive health (SRH), gender-based violence (GBV), "KP friendly" prevention, care and treatment services and support is limited. Stigma and discrimination is still pervasive in health facilities and represent a major barrier to service uptake and retention, especially for KPs PLHIV who face double stigma and discrimination.

Programmatic Gap 3: Poor Data Quality with Limited Use

There have been incremental improvements in the availability and use of HIV data in the Caribbean region; however, important gaps remain. Deficiencies in SI include insufficient skilled personnel, inadequate documentation of key population data and gaps in case surveillance reporting. The quality and timeliness of data are negatively impacted by incomplete reporting of risk factor data, mortality data and inconsistent compliance with national reporting standards. There is a need to strengthen reporting and use of laboratory data to ensure timely updating of patient monitoring systems. Poor site level data management results in slow reporting to national levels and insufficient data-driven programming at site level.

1. **Insufficient SI Expertise:** Ministries of Health (MOHs) lack adequate numbers of skilled personnel to implement routine SI activities. Insufficient personnel jeopardizes the ability of the PEPFAR and National HIV Programs to routinely collate and analyze data. In the absence of timely data, MOHs are unable to efficiently target activities to the geographic locations and populations in greatest need.

2. **Fragmented Information Systems:** There is a need to improve the interoperability and data transfer across prevention, care, treatment and laboratory systems in the supported countries. The absence of unique identifier codes (UIC) or poor collection of patient identifiers hampers the timely collation, analysis and use of data. The concurrent strengthening of reporting between laboratories and treatment sites will ensure the timely availability of clinical care data at treatment sites. Additionally, data systems in the region are not fully aligned to monitor concentrated epidemics; for instance, providers do not routinely collect and report KP identifier data, as a result, tracking of service uptake by KP is inadequate.

3. **Poor data use at Site, Sub-National and National Levels:** Data use in the region is challenged by several issues including delays with data sharing. Program managers often do not routinely use site specific data for program improvements and decision making. This is partly due to the use of paper based systems that hamper timely collection, analysis, and use of data. Reporting cycles are often donor driven. When limited integration of donor funded initiatives occurs, reporting timelines make using data difficult. Laboratory data do not always match national program data or quickly reach clinical service providers to be recorded in patient files/monitoring systems. Where population based surveys are implemented, there are often lengthy delays in approving and disseminating key research findings which impacts data use and strategic planning.

4. **Limited Domestic Financing for SI:** HIV SI activities have been externally funded and donor driven in the region. In order for SI investments to be sustained, donor supported activities must be transitioned to national budgets. For example, the investment in SI was $100,000 in Barbados (2012 -2013) of the total $10.525 million investment in HIV. This was less than 1 percent of the national investment and 100 percent supported by PEPFAR. Sustaining gains in SI will transition of PEPFAR supported staff to national budget; greater emphasis on routine systems strengthening and transition of SI activities to national budgets.

Table 6.1.1 Key Programmatic Gap #1: Low treatment coverage						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Weak systems at facility and community level for identifying KP and PLHIV, linking them to treatment and promoting consistent adherence to treatment	90% Tier 1 & 2 countries have systems to link KPs testing positive to treatment and strong adherence and retention support 70% improvement in KP retention across the treatment cascade in Tier I & II countries	***Activity 1*** Implement innovative KP Information Communication Technology (ICT) outreach strategies through social media and mobile platforms (Jamaica, Trinidad and Tobago, Suriname, Bahamas and Barbados).	HVOP HVCT HBHC	($160,000)[9] ($20,000) ($20,000)	17366 LINKAGES/ESC 17760 LINKAGES/JA 12567 MOH/JA	Semiannual reporting Annual Reporting
		Activity 2 Build integrated patient tracking systems across the facility and community settings (Jamaica, Trinidad and Tobago and Suriname).	HVOP HBHC HVCT OHSS	($345,000) ($80,000) ($15,000)	17366 LINKAGES/ESC 17760 LINKAGES/JA 12567 MOH/JA	Annual reporting
		Activity 3 Strengthen the support systems for adherence, and retention in care/treatment (Jamaica, Guyana, Trinidad and Tobago, Suriname, Barbados, The Bahamas).	HBHC	($80,000) ($320,000) ($555,000) ($120,000) ($20,000)	17366 LINKAGES/ESC 17760 LINKAGES/JA 12567 MOH/JA 17902 HP+/JA 18187 APC	Monthly reporting
		Activity 4 Train healthcare staff, and in particular adherence counselors, on the new national adherence counseling protocol (Jamaica).	HTXS	$75,000	17921 IAETC	
		Activity 5 Evaluation of Loss to follow- up and implementation of strategies (Jamaica, Trinidad and Tobago, Suriname, The Bahamas and Barbados).	HTXS	$200,000	18395 HQ 12606 MOH BDS 18393 MOH BHS 13593 MOH SUR 12668 MOH T&T	Annual Reporting

[9] Amounts in parentheses are not included in above site budget totals. These activities are intended to address systems barriers, but they have been budgeted as site-level activities.

Table 6.1.1 Key Programmatic Gap #1: Low treatment coverage						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Sub-optimal resource mobilization, allocation and expenditure tracking for decision making and accelerated epidemic control	70% of Tier 1 & 2 countries increase domestic spending on HIV/AIDS prevention, care and treatment 90% of Tier 1 & 2 countries institutionalize use of health economics data for resource allocation, efficiency and effective decision making	***Activity 1*** Work with the National HIV/AIDS Center to track expenditures and assess current financing sources and levels of funding, and determine where efficiencies may be sought and current donor funding may be replaced by domestic sources (Bahamas).	OHSS	$118,750	17469 HFG	Annual reporting
		Activity 2 Building off of the NHA work with the National HIV/AIDS Commission and the MOH to integrate spending data for HIV /AIDS as part of regular data collection (Barbados).	OHSS	$118,750	17469 HFG	Annual reporting
		Activity 3 Conduct expenditure analysis mapping, develop an HIV investment case, and develop a resource mobilization strategy for HIV/AIDS (Suriname, Guyana).	OHSS	$303,250	17569 HFG	Annual reporting
		Activity 4 Conduct a public expenditure review with a focus on HIV/AIDS efficiency; build institutional capacity to use data for sustainable HIV response management, work with stakeholders to develop of a Resource Mobilization Strategy for HIV /AIDS and, advocate and track domestic resource mobilization and use. (Trinidad & Tobago)	OHSS	$134,250	17469 HFG	Annual reporting

Table 6.1.1 Key Programmatic Gap #1: Low treatment coverage						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Sub-optimal resource mobilization, allocation and expenditure tracking for decision making and accelerated epidemic control Limited capacity of existing supply chain management systems	90% of Tier 1 & 2 countries adopted new forecasting, procurement, warehousing, distribution, and other management and logistic protocols to efficiently and sustainably support scale up of HIV Treatment programs	***Activity 1*** Provide technical assistance for improving supply chain logistics in all tier 1 and 2 countries for forecasting, procurement, warehousing, and distribution of RTK, VL reagents, ARV and other HIV consumables. (Jamaica, Guyana, Trinidad and Tobago, Suriname, Bahamas and Barbados)	OHSS	$1,400,000 $100,000	GHSC TBD (Jamaica)	Semiannual reporting Annual reporting
Low rates of viral load coverage	Year 1 50% increase in ART patients receiving viral load tests Year 2 75% increase in ART patients receiving viral load tests Year 3 90% of ART patients receive routine viral load tests and their results are used to monitor treatment efficacy	***Activity 1*** Improve the access to and uptake of HIV viral load testing and counselling (Jamaica, Trinidad and Tobago).	HBHC	($40,000) ($30,000) ($20,000)	17366 Linkages 12567 MOH/JA 17902 HP+/JA	Annual reporting
		Activity 2 Strengthen the national and regional viral load sample referral network (Tier I & II).	HLAB	$275,000	18405 TBD	Annual patient Viral load testing reports
		Activity 3 Strengthen the national and regional lab capacity for HIV drug resistance to increase access and coverage (Tier I & II).	HLAB	$153,000	18405 TBD	Annual patient Drug resistance testing reports
		Activity 4 Procure viral load reagents to increase number of ART patients receiving VL tests (Jamaica, Trinidad and Tobago, Suriname, Bahamas and Barbados).	HTXS, HBHC	$345,000	18395 HQ, 12606 MOH BDS, 18393 MOH BHS, 13593 MOH SUR 12668 MOH T&T	Annual reporting
		Activity 5 Scale up viral load counseling through clinician/counselor training and patient literacy (Jamaica, Trinidad and Tobago, Suriname, Bahamas and	HTXS, HBHC	Included in Activity 4	18395 HQ, 12606 MOH BDS, 18393 MOH BHS, 13593 MOH SUR	Annual reporting

Table 6.1.1 Key Programmatic Gap #1: Low treatment coverage						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
		Barbados).			12668 MOH T&T	
TOTAL				$3,223,000		

Table 6.1.2 Key Programmatic Gap #2: Low uptake of services by key populations						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Limited facility and community based systems to effectively combat stigma and discrimination of KP and PLHIV which presents a barrier to effective service access and uptake	100% of PEPFAR supported sites in Tier 1 and Tier 2 countries include comprehensive S&D and gender sexual diversity modules for in-service training, preceptorships and coaching 100% of PEPFAR supported sites have functioning S&D redress systems that inform CQI/QA investments 80% reduction in reported levels of S&D as measured by the stigma index LGBTI protection measures are institutionalized at all PEPFAR supported sites in Tier 1 & 2 countries PEPFAR actively collaborates	***Activity 1*** Policy level support for effective implementation of sensitive and targeted services for KPs (Trinidad and Tobago, Suriname, Bahamas, Barbados and Regional)	OHSS	$267,511 $200,000 $300,000	17366 LINKAGES 12588 PANCAP 17809 K4H	Annual reporting
		Activity 2 Support MOHs to develop linkage between national or facility level redress systems and QI protocols and activities (Tier I and Suriname)	OHSS	$112,494	17921 IAETC	Annual reporting
		Activity 3 Comprehensive care for KPs, including addressing S&D as well as KP specific knowledge and skills which are barriers to care, will be addressed via clinical mentoring, onsite targeted training, intensive preceptorships, and the development of KP specific training modules. (Tier I, Suriname and Barbados, Guyana).	HBHC	($288,000) ($20,000)	17921 IAETC 18187 APC	Annual reporting

Table 6.1.2 Key Programmatic Gap #2: Low uptake of services by key populations						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
	with PANCAP Human Rights and S&D work funded by Global Fund					
Limited implementation of innovative support systems to enhance KP service uptake and retention in care	90% of Tier 1 and Tier 2 countries will update policy/guidelines for sustainable and high-impact KP support and service delivery 70% of Tier 1 and Tier 2 countries mobilize and allocate domestic resources for KP support and service delivery 90% decrease in HIV rapid testing (RT) errors 90% of RT sites utilize standardized logbooks for data collection and analysis consistently and correctly	***Activity 1*** Improve access and quality of HIV rapid testing through the Rapid Testing Quality Improvement Initiative (HIV-RTQII) at KP friendly HTC sites (Tier I & II)	HLAB	$315,000	18405 TBD	Annual HIV Rapid testing report
		Activity 2 Implement systems for routine cost and expenditure data generation, analysis and use for resource allocation. (Trinidad and Tobago, Suriname, Bahamas and Barbados, Guyana)	OHSS	($675,000) (Amount included above in 6.1.1 , 2nd systems barrier)	17469 HFG	Annual reporting
		Activity 3 Implementation of combination prevention with a focus on increasing access to a care & treatment package, including returning lost PLHIV to services and KP retention (Jamaica, Trinidad and Tobago, Suriname, The Bahamas and Barbados)	HTXS HVSI HBHC	$331,700	18395 HQ 12606 MOH BDS 18393 MOH BHS 13593 MOH SUR 12668 MOH T&T	Quarterly Reporting
		Activity 4 Assessment of service provider system for KPs and recommendations to improve community-based referral systems (Guyana)	OHSS	$50,000	17581 -MEASURE Evaluation IV	Annual reporting

Table 6.1.2 Key Programmatic Gap #2: Low uptake of services by key populations						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Facility and community service provider training systems do not adequately address KP specific health needs	90% of Tier 1 and Tier 2 countries institutionalize KP specific training in pre-service and in-service curricula 90% of Tier 1 and Tier 2 countries adopt supervision and CQI/QA systems at facility and community levels that promote high quality, high impact and non-S&D KP services and support for epidemic control	***Activity 1*** Policy level support for effective implementation of sensitive and targeted services for KPs (Trinidad and Tobago, Suriname, Bahamas, Barbados and Regional)	OHSS	($267,511) ($200,000) ($300,000) (amounts included under S&D in 6.1.2 above	17366 LINKAGES 12588 PANCAP 17809 K4H	Annual reporting
		Activity 2 Update and implement the national care and treatment guidelines for physicians in MSM. (Suriname)	OHSS	$5000	13593 MOH SUR	Quarterly reporting
TOTAL				$1,266,705		

Table 6.1.3 Key Programmatic Gap #3: Poor data quality with limited use						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/Customized Indicator Reporting Frequency for POART**
Insufficient SI expertise leading to gaps in timeliness and quality of data	100% of Tier I and II countries have SOPs and trained staff to implement quarterly data quality assurance procedures for clinical cascade and key population data at PEPFAR SNUs by September 2019.	***Activity 1*** : Provide support for dedicated strategic information (M&E, surveillance, epidemiology) staff within partner Ministries of Health and community based organizations	HVSI	$22,500 $27,500 $40,000 ($40,000) $25,000 ($25,000)	12688- MOH Trinidad and Tobago 12606- MOH Barbados 12570- MOH Bahamas 13593 – MOH Suriname	100% of Tier I and II countries have dedicated strategic information staff in MOHs and CBOs by December 2016. **Annual Reporting**
		Activity 2 Targeted capacity building to implement SOPS for data collection,	HVSI	$100,000 $110,258	12688 REPDU 16661 CARPHA	(3/6) 50% of Tier I and II countries have data quality

		analysis and use of key population specific HIV prevention, care and treatment data (CBS & M&E systems improvements).		$100,000	17577 – CARPHA Guyana	assurance SOPs by December 2016. 100% have SOPs by September 2017 – **Semiannual reporting**
		Activity 3 Capacity building through regional training and site level TA to strengthen routine data quality assurance procedures for monitoring and reporting at site, sub-national and national levels.	HVSI	$100,000 $52,871 ($47,129)$ 75,000	12688 REPDU 16661 CARPHA 12575 PAHO	50% of PEPFAR supported sites in Tier I countries have personnel trained in data review and quality assurance by June 2017. 50% of PEPFAR supported sites in Tier I countries receive quarterly data quality assurance visit by December 2017. **Semiannual reporting**
		Activity 4 Build capacity of data collectors at the community and facility level to solicit sensitive data (including key population identifier data).	HVSI	($61,500) ($100,000)	12688 REPDU 16661 CARPHA	100% of PEPFAR supported countries have staff trained in KP sensitive data collection methods by March 2017. All PEPFAR supported sites have staff trained in data collection methods by June 2017. **Semiannual reporting**
		Activity 5 Capacity Building for the National AIDS Program Secretariat and the Ministry of Public Health on Routine Data Quality Assessment (Guyana, Jamaica)	OHSS	$50,000 $30,000	17581 -MEASURE Evaluation IV MOH/JA	Annual reporting
Fragmented information systems prevent case based and KP specific analyses	83% of PEPFAR of priority countries report timely (< 2 year old) key population (MSM, FSW), facility, age and sex	***Activity 1*** Improve collection of patient and key population identifier data, including PUID pilots for enhanced tracking between prevention, care, treatment and laboratory information systems. (Jamaica)	HVSI	$25,000 ($175,000) (Included in 6.1.1; Gao 1; Act. 2) $15,000	13534 – NASTAD 13384 – PUSH 12567 MOH/JA	33% of Tier I and II countries implement PUID pilots with PEPFAR support by September 2016 33% of Tier I and II countries decentralize electronic laboratory information systems.

	disaggregated clinical cascade data by September 2019.	***Activity 2*** Implement collection of bio-behavioral data for key populations (sentinel surveillance) at targeted sub-national units and facilities.	HVSI	($22,500) ($27,000)	12688- MOH Trinidad and Tobago 12606- MOH Barbados 12570- MOH Bahamas	33% PEPFAR supported countries establish at least 1 FSW sentinel surveillance site (FSW or MSM) by June 2017. **Semi-annual Reporting**
		Activity 3 Provide technical assistance to link (paper-based & electronic reporting) disparate systems in order to conduct key population specific analyses.	HVSI	$8,000 $25,000	12632 – M&E Regional training 13534 - NASTAD	100% Tier I countries receive technical assistance and have linked key population prevention and HIV care and treatment databases by June 2017. **Semi-annual Reporting**
		Activity 4 Support MOHs/CBOS to conduct data validation and triangulation to harness missing data for continuum of care analysis (e.g. validate mortality, lost to follow up, viral load testing).	HVSI	$8,000 ($25,000)	CDC Direct TA 12632 – M&E Regional training 13534 – NASTAD	100% of Tier I countries receive training/technical assistance to validate clinical cascade data by March 2017. **Semi-annual reporting**
Insufficient data use among staff at various levels (site, sub-national and national level	83% of Tier I and II countries conduct quarterly performance review meetings using subnational prevention, clinical cascade and systems key performance indicator data at 80% of PEPFAR priority sites by December 2019 Lab audit scores show a 25% increase in CQI annually	**Activity 1** Support continuous quality improvement (CQI) in laboratories regionally to ensure the release of timely and quality assured results (Tier I and II).	HLAB	$80,000	TBD 18405	80% of sites in Tier I countries with 90% of patient records with complete laboratory (CD4, viral load etc.) data for the most recent 30 day period by September 2017. –**Semi-annual reporting**

		Activity 2 Provide technical assistance to validate/ generate robust subnational estimates ("denominators") for PLHIV, KP estimates in order to improve the quality of subnational analyses.	HVSI	$9,000 $45,000 ($5,000)	CDC Direct TA 12632 – M&E Regional training 12542 - UCSF	83% of Tier II and III countries receive training/technical assistance to validate PLHIV estimates and KP estimates by December 2016 50% Tier I and II countries have recent subnational estimates for PLHIV and KPs by June 2017. **Semi-annual reporting**
		Activity 3 Assist partners with identifying key performance indicators and implementing routine site level, interdisciplinary, program planning meetings to review performance (output/outcomes of KP, C&T, S&D interventions).	HVSI	$50,000 $23,000 $45,000	CDC Direct TA 12688 REPDU 12575 PAHO	83% of Tier I and II countries complete technical meetings to identify priority indicators for quarterly review by December 2016. **Quarterly reporting** 50% of Tier I and II countries implement quarterly performance review meetings at 50% of PEPFAR priority sites by June 2017. **Quarterly reporting**
		Activity 4 TA to validate/improve size estimates and HIV prevalence among KPs (Guyana)	OHSS	$100,000	17581 -MEASURE Evaluation IV	Annual reporting
Limited domestic financing for SI and generating evidence	50% of Tier I and II have an increase in the domestic allocation for strategic information by September 2019	***Activity 1*** Provide TA to develop data dissemination products (advocacy tools) for mobilizing increased government resources for data driven and high impact HIV policies and programming.	HVSI	$25,000 $23,000 $25,000	CDC Direct TA 13534 NASTAD 12688 REPDU 12575 PAHO	**Semi-annual reporting** 100% of Tier I countries complete technical meetings to review data dissemination products by December 2016. 83% of Tier II and II countries develop dissemination products (to be updated annually) by June 2017.
		Activity 2 Support MOHs to transition PEPFAR supported SI personnel and activities to national budgets. (Tier 1 and 2)	HVSI		CDC Direct TA	100% of PEPFAR supported countries develop a staff transition plan by December 2016.

						50% of PEPFAR supported MOH staff transitioned to MOH payroll by March 2018
TOTAL				$1,489,258		

6.2 Critical Systems Investments for Achieving Priority Policies

Test and Start

1. **Delayed Adoption of Test and Start:** Across the region there is slow implementation of both the 2013 and 2015 WHO Treatment Guidelines. Jamaica, Barbados, and Guyana officially adopted CD4<500 only within the last year. Bahamas, Suriname, Trinidad and Tobago are currently at CD4<350. All six countries have indicated they will move to Test and Start in FY 17, but expressed concerns about sustainable financing for the approach. In addition, governments are concerned about the unknown cost implications and unknown needs in terms of HRH, Supply Chain, Laboratory and other system support components to have an effective implementation of Test and Start.
2. **Sustainable Financing for Test and Start:** A number of Tier 1 and 2 countries still rely heavily on dwindling donor funding and/or do not optimize domestic resource mobilization (both public and private) as possible revenue to sustain Test and Start. Barbados is still in the process of repaying a prior World Bank loan that funded the HIV/AIDS response and does not have the capacity to assume more loans due to their lowered economic status. Jamaica is under IMF restrictions and cannot hire more health care workers (HCWs). Trinidad faces economic challenges due to the dropping oil prices. There has been limited exploration of the private sector engagement in provision of ARVs and new private sector industries coming into a subset of countries.
3. **Inadequate Supply Chain Management for Test and Start Implementation:** The majority of Tier 1 and 2 countries currently experience periodic stock outs of critical commodities and Lab reagents. The supply chain management and logistics systems are ill-prepared for supporting a sustainable "Test and Start" policy, which would require more precise forecasting, warehousing and distribution systems.

New and Efficient Service Delivery Models:

1. **Lack of Political Will to Adopt, Institutionalize and Implement Differentiated Models of Care:** Many of the Tier 1 and 2 countries could realize improved efficiencies by adopting differentiated models of care. This will require enhanced engagement to promote buy-in from policy makers and powerful medical and health professional associations. Implementation of differentiated models of care in these countries requires substantial systems modifications such as: task shifting, cross-facility; operationalization of community service and support systems.
2. **Supply Chain Systems Do Not Support Efficient Implementation of Differentiated Models of Care:** In many of the Tier 1 and 2 countries, procurement practices result in higher cost for viral load, rapid test, ARV, and OI drug regiments and reagents. Forecasting, delivery management and logistics systems do not currently meet the requirements for an optimized HIV treatment model specifically with respect to ARV and viral load testing needs. Some countries are currently experiencing stock-outs of critical commodities and supplies.
3. **Healthcare workers Lack Training and Experience to provide optimized Service delivery:** Tier 1 and 2 countries have limited capacity to optimize collaboration between facility and community service and support delivery required for differentiated service delivery models. The CSO sector in many of the Tier 1 and 2 countries is limited and will need strengthening for optimal scale-up of service delivery differentiation. KPs and PLHIV lack differentiated models of care literacy potentially jeopardizing already low uptake of services. To address the training needs in-service training, clinical mentoring and supportive supervision will be provided. In addition, task sharing strategies will be implemented to address the human resource needs to implement the differentiated delivery models. Laboratory services require quality improvement initiatives to ensure timely release of reliable results and consistent collaboration with treatment and care programs to ensure access and coverage by patients.

Table 6.2.1 Test and Start						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Delayed adoption of "Test and Start"	All Tier 1 & 2 countries adopt and implement the "Test and Start" policy during year 1 All Tier 1 & 2 countries adopt optimized service delivery systems and differentiated care models based on patient characteristics by the end of year 2 90% of laboratories obtain satisfactory EQA scores in each EQA challenge HIV Drug Resistance testing is available to all countries in the region	***Activity 1*** Support countries to advance to a policy of "Test and Start" in the Caribbean and implement or where necessary fund demonstration pilots. (Jamaica, Trinidad and Tobago, Suriname, Bahamas, Barbados and Regional)	OHSS HBHC	- - ($50,000) (Amounts for HFG and PANCAP are included in entries in 6.1.1 and 6.1.2)	17469 HFG 12588 PANCAP 12575 PAHO	Annual reporting Monthly reporting
		Activity 2 Support the use of EQA to monitor quality of core HIV-related laboratory tests including HIV, CD4, TB, VL, Chemistry, and Hematology. (Tier I & II).	HLAB	$45,500	18405 TBD, 13593 MOH Sur, 18393 MOH Bah	Semi-annual EQA reports
		Activity 3 Strengthen the viral load sample referral network to increase access and coverage in support of Test and Start implementation. (Tier I & II)	HLAB	$250,000	18405 TBD	Annual patient viral load testing reports
		Activity 4 Strengthen the regional lab capacity for HIV drug resistance to increase access and coverage. (Tier I & II)	HLAB	$150,000	18405 TBD	Annual Drug Resistance testing reports
		Activity 5 Conduct a desk review of SPNS projects to inform best practices related to linkage to care, loss to follow up, and retention, disaggregated by key population groups. (Tier 1, Suriname, Barbados)	OHSS	$50,000	17921 IAETC	

Table 6.2.1 Test and Start						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Limited capability to promote use of health economic data to justify "Test and Start" investment and for sustainability planning	100% of Tier 1 & 2 countries incorporate economic analyses into annual budget processes to maximize investment impact 90% of Tier 1 & 2 countries build and/or strengthen health economic data systems for resource allocation, efficiency and effectiveness decision making	***Activity 1*** Build capacity in Health Financing/Sustainability Planning and support efficiency and costing of HIV service delivery models (Public, Community and Private Sectors) for sustainability. (Trinidad and Tobago, Suriname, Bahamas and Barbados)	OHSS	($337,500) (Amount included in 6.1.1 above)	17469 HFG	Annual reporting
		Activity 2 Implement systems for routine cost and expenditure data generation, analysis and use for resource allocation. (Trinidad and Tobago, Suriname, Bahamas and Barbados)	OHSS	($337,500) (Amount included in 6.1.1 above)	17569 HFG	Annual reporting
Sub-optimal supply chain management and logistics to support "Test and Start"	All Tier I & II countries adopted new forecasting, procurement, warehousing, distribution, and other management and logistics protocols to efficiently and sustainably support scale up of Test and Start policy	***Activity 1*** Provide technical assistance for improving supply chain logistics in countries promoting "Test and Start" for forecasting, procurement, warehousing, and distribution of RTK, VL reagents, ARV and other HIV consumables. (Tier I & II)	OHSS	($1,400,00) (Amount included in 6.1.1 above)	GHSC	Monthly reporting Annual reporting
TOTAL					$545,500	

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Sub-optimal political will to adopt, institutionalize and implement differentiated models of care	90% of Tier I & II countries adopt policies/guidelines that promote differentiated models of services based on patient characteristics 80% of Tier I & II technical and political leaders across Ministries of Finance, Planning and Health are actively engaged in advancing the Test and Start differentiated models of service delivery agenda meet 100% of Tier I & II increase sustainability through efficiency gains of Test and Start service delivery models for KP concentrated epidemics Regional lab referral network is providing services and support to all countries in the region by the end of year 2	**Activity 1** Strengthen and support the coordination of the regional lab referral network capacity for viral load and HIVDR testing to support ART uptake/viral suppression. (Tier 1,2,3)	HLAB	$50,000	18405 TBD, 16661 CARPHA	Annual Network report and work plan

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Limited capacity of current supply chain management and logistics systems to support efficient implementation of differentiated models of care	90% of Tier I & II countries modify supply chain management and logistics systems to meet criteria of differentiated models of care delivery schedules 80% of Tier I & II countries adopt simplified ARV procurement for efficiency gains promoting Test and Start	***Activity 1*** Provide technical assistance for improving supply chain logistics in countries promoting "Test and Start" for forecasting, procurement, warehousing, and distribution of RTK, VL reagents, ARV and other HIV consumables. (Tier I & II)	OHSS	($1,400,000) (Amount included in 6.1.1 above)	GHSC	
Regional Healthcare workers lack training, experience and strong skills to provide optimal service delivery	At least one lab achieves accreditation annually	**Activity 1** Support laboratory quality improvements and accreditation to ensure the release of timely and quality assured results to support core interventions for HIV prevention, care and treatment. (Tier I and Suriname)	HLAB	$404,000	18405 TBD, 18188 CARPHA	Lab audit scores
TOTAL				$454,000		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3 Other Proposed Systems Investments

Systems Category* (only complete for categories relevant to country context)	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Milestones Timeframe/ Customized Indicator Reporting Frequency for POART
Finance							
	Support the capacity development of UWI-HEU during year 1 that will allow the implementing partner to work together with the UWI-HEU staff on expenditure tracking, financial data tracking and efficiency measurement. (Regional)	First 90, Second 90, Third 90 and Sustained Epi Control	The UWI HEU would have the ability to provide the necessary routine sustainable financial data analysis in addition to developing an advocacy platform for continued domestic resource mobilization by the end of year 3.	($20,000) (Amount is included above in 6.1.1 , 2nd systems barrier)	OHSS	17469 HFG	Annual reporting
Governance							
	Strengthen policy and regulatory environment to increase efficiency and impact of national and regional HIV/AIDS responses (Regional)	First 90, Second 90, Third 90 and Sustained Epi Control	Strong National and Regional HIV policy and regulatory environment which results in 100% policy enforcement by year 3.	($60,000) ($20,000) ($20,000) ($20,000) (Amounts included in 6.1.2 above)	OHSS	12588 PANCAP 17809 K4H	Annual reporting
HRH - Systems/Institutional Investments							
	Strengthen and support	First 90, Second	90% of Laboratories	$104,500	HLAB	18405 TBD,	

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	**Activity**	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
	laboratory capacity for HIV, Viral Load, HIV Drug Resistance, sexually transmitted infections (STIs) and opportunistic infections including TB	90, Third 90,	providing HIV and related testing within required turnaround times.			18394 MOH TT, 18190 Guy, 18392 Bar, 18393 Bah	
Inst & Org Development							
Laboratory							
	Strengthen and support laboratory capacity for sexually transmitted infections (STIs) and opportunistic infections including TB	First 90, Second 90	90% increase in reliable STI, TB and OI testing services.	$56,680	HLAB	16661 CARPHA	
	Support TB drug resistance capacity building including training of staff	Second 90	90% increase in quality of TB drug resistance testing.	$55,000	HLAB	18190 Guyana MOH	

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	**Activity**	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Strategic Information							
	TA to support completion of ongoing bio behavioral surveys (Suriname –MSM; Trinidad FSW; Jamaica – MSM)	First 90, Second 90, third 90	100% of Tier I countries recent estimates (<5 year old) for GARPR KP indicators 1.7 – 1.14 (HIV prevalence, condom use, etc) by September 2019.	$175,000 ($100,000) $125,000 ($125,000)	HVSI	12542 UCSF 13534 NASTAD	Protocols for BBSS surveys are approved by September 2016. Data collection has commenced by January 2017 **Annual Reporting**
	Conduct TA missions to monitor implementation of WHO 2015 Guidelines and progress towards achievement of 90-90-90 prevention, care and treatment targets	Second 90, Third 90	100% of PEPFAR supported countries have National Treatment policies/guidelines that align with the most recent WHO treatment guidelines (2015 Guidelines in 2016)	$70,000	HVSI	12575 PAHO	100% of Tier I and II countries receive annual Treatment 2.0 technical assistance missions. **Semi-annual reporting**
	Conduct economic analyses to determine the costs of earlier initiation of ART (Guyana, Suriname)	Second 90, Third 90	100% of tier I and II countries have completed HIV Costing analyses and use data to inform finance planning for Treat All implementation	$545,157	HVSI	18398 GDATA	50% of Tier I and II countries complete economic analysis by December 2017 **Annual reporting**

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	**Activity**	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism ID**	**Milestones Timeframe/ Customized Indicator Reporting Frequency for POART**
Systems Development							
TOTAL				$1,286,337			

*Reference Appendix C for a list of activity types that fit in each category.

7.0 Staffing Plan

There were significant changes in the CRP regional program in FY2016 due to the merger of Guyana into the regional program. This, coupled with the pivots in ROP14 and ROP15, prompted the CRP to undertake a staffing review with support from S/GAC, which identified a few organizational issues that needed redress. Most pressing was that many technical staff were not spending the majority of their time focused on TA to government, but instead were focused on interagency work flows.

The CRP has a broad mix of technical, financial and administrative staff that are adequately distributed to prioritize the implementation of core activities, though some gaps are evident and described by agency below. This distribution will be reassessed annually as resources are further aligned to disease burden and Tier II countries move towards transition of PEPFAR programs. The cost-of-doing business for the regional program will increase approximately 10 percent, primarily due to hiring of a coordinator and CDC filling vacant positions.

CRP Coordinator's Office - To address areas identified in the staffing review, the CRP proposes to strengthen the Coordinator's Office by repurposing existing positions. First, the Strategic Information officer hired under the Department of State mechanism in Guyana will be repurposed to provide interagency SI support. Second, the Data Management Specialist position, which was approved in ROP 15 but remained vacant, will be filled. The existing Coordinator's Assistant position in the Bahamas will be repurposed for a Program Management Position to be placed in Embassy Kingston, Jamaica. This position will help improve interagency and regional coordination. Finally, the Coordinator's Office also a Program Management Specialist and an Administrative Assistant (currently filled). This repurposing of existing staff/positions, along with hiring of a coordinator, will alleviate some of the interagency work being performed by members of the TWGs.

USAID Jamaica - The Staffing Plan for USAID Jamaica was updated in ROP 14 based on recommendations from an OGAC Technical Working Group report from the in-country review of the Jamaica PEPFAR program in October 2014. The new configuration included a full-time, local hire USPSC HIV/AIDS Senior Technical Advisor, who serves as the Jamaica agency lead and manages the strategic and overall programmatic visioning for USAID activities; a full-time, local hire Program Management Specialist, who manages two IMs (including a G2G grant with the MOH); a full-time, local hire Monitoring and Evaluation Specialist, who will manage MER, SID and EA reporting in addition to providing direct TA to the MOH and CSOs; and a half-time, local hire Project Management Specialist, who manages one IM and coordinates SIMS. While these positions offer coverage of the basic functions, the USAID/JA Team remains understaffed in terms of administrative support to the CRP. USAID/JA also has the lowest CODB budget (approximately 13% of total budget) across agencies. Given these challenges and the increased focus on Jamaica due to its high disease burden, the Jamaica Staffing Plan recommends increasing PEPFAR support for the Project Management Specialist from 50% to 100%, commensurate with the current workload precipitated by SIMS implementation. The Staffing Plan also calls for the addition of a full-time, local hire position to provide direct TA to the

MOH in the implementation of Test and Start with a focus on Treatment and Care. Within one to two years, this position will also manage a mechanism focusing on health financing and governance to support the long-term sustainability. This position has the support of the Embassy and the MOH. The position will also contribute to the CRP by providing technical expertise in the areas of treatment and sustainability that are currently lacking.

USAID Eastern and Southern Caribbean - USAID/Eastern and Southern Caribbean (ESC) is not proposing any new positions in ROP 16. Rather, it is proposing to repurpose existing positions to ensure that technical staff are in the field and closer to project implementation for maximum oversight and quality assurance. A Technical HIV/AIDS Program Manager position previously based in Barbados will now be based out of Trinidad. Another Technical HIV/AIDS Program Manager position based in Barbados will remain in Barbados but will focus exclusively on Strategic Information, serving as USAID/ESC's lead for all POART related analysis and reporting and also of all data analysis related to program planning, monitoring and quality assurance. The incumbent will ensure that all staff are adequately trained to ensure high quality data from implementing partners across all POART areas. Finally, a Technical HIV/AIDS Program Manager position based out of Guyana will be reconfigured to focus primarily on providing technical assistance and managing activities in Guyana and regionally in commodity procurement, supply chain and logistics management for Test and Start roll-out.

Additional changes in support of USAID/ESC programmatic and administrative support positions have been made and have resulted in changes in funding of these partially PEPFAR funded staff positions supported in ROP 16. Some positions previously supported by PEPFAR have been shifted over to Operating Expense budget. Remaining support positions partially supported by PEPFAR are now supported at 29% which represents an equal split between USAID/ESC's three Development Objective Agreements (DOAGs) of which PEPFAR is one. Overall, these changes have resulted in a decrease in USAID/ESC's Management and Operational (M&O) costs in ROP 2016 when Guyana staff costs are accounted for.

Peace Corps - Although Peace Corps is no longer active in most of CRP countries, Guyana maintains Volunteers working in education, environment and health. PEPFAR supports HIV activities, but does not fund Peace Corps staff positions. PEPFAR funds travel costs for the in-country PEPFAR Focal Point, which allows for monitoring visits and overall management of the PEPFAR Funded Response Volunteers. Support is also provided for short-term Response Volunteers, for duration of 3 - 6 months, who complement the USAID interventions by providing discrete technical assistance/collaboration to KP-managed CSOs, support for the OVC after-school program, gender and sexual diversity training at the national level, and other targeted HIV education activities to support demand for Test and Start. A Peace Corps sustainability/transition strategy is available for further review (see Supporting Documents).

Department of Defense - The U.S. DoD has two locally hired program staff who manage the key and priority populations programs regionally. The Barbados based program manager oversees the military and key populations programs in Trinidad and Tobago, Suriname and Jamaica while the Guyana based program manager is responsible for the Guyana military program. Military programs are Central

Support Districts, therefore the staffing footprint, which combines a management strategy that blends administrative competencies and prevention technical expertise, are adequate and no staffing changes are expected. Field staff conduct SIMS assessments for their respective countries, assist each other and receive support from the inter-agency team as needed. Both program managers participate in inter-agency processes and are distributed across the prevention, care and treatment and health systems strengthening technical working groups. Military programs will receive direct military to military QA/QI technical assistance. With two implementing partners for the key population and military programs that have an established presence in Suriname and Guyana, respectively, staff time will be divided to respond to reporting requirements, site monitoring and TA.

Centers for Disease Control and Prevention (CDC) Caribbean Regional Office - CDC's technical staff will work with MOHs and other partners to implement core activities along the HIV continuum of care and to adapt successful strategies and activities from other PEPFAR programs to the Caribbean region. Staff in Tier 1 countries will have a greater role in guiding Ministries of Health to assess program needs and identify gaps, access appropriate TA implementing partners and oversee implementation of activities, as planned.

CDC CRO's Behavioral Scientist leads the prevention team. This team works with the MOHSs to provide technical assistance, through an implementing partner, to 1) adapt the VICITS combination prevention model; 2) pilot innovative strategies to return HIV+ individuals back into care and treatment; 3) improve retention in care and treatment adherence; and 4) support viral load testing and counseling. Roles and responsibilities of existing staff , as in the case of Jamaica, will be re-focused to provide more support for core activities. There are three HIV Program Specialists stationed in Barbados, Jamaica and Trinidad and Tobago respectively. These HIV Program Specialists play a key role in supporting their respective MOHs to implement CDC-MOH prevention, care and treatment work plans. The prevention staff aim to strengthen their scientific skills and understanding of policy interventions by attending CDC's regional training classes. Staff members will also increase their knowledge and skills related to PEPFAR monitoring and reporting requirements by participating in trainings related to DATIM, PROMIS, and Site Improvement through Monitoring System (SIMS). In turn, staff members will provide direct technical assistance to MOHs on these requirements, rather than through external partners. Practical experience on combination prevention activities will occur through participating in the scale up of VICITS activities throughout the region.

The four-member laboratory team provides TA to countries and partners to improve the quality and availability of diagnostic and monitoring services and systems under a tiered laboratory network to meet PEPFAR goals for scaling up core HIV prevention, treatment, and care interventions. Specifically, staff provide oversight for the Quality management systems improvement initiatives to monitor successes and mitigate challenges as needed. TA is also provided to engage all stakeholders and support the implementation of the Rapid testing quality improvement initiative and strengthening of the viral load referral network to ensure adequate access and coverage in each country.

The strategic information team will continue to provide direct TA to MOHs, work with partners to implement SI activities, and support the interagency PEFPAR team. The SI team will also oversee the SIMS initiative. The team will work with MOHs to strengthen case-based surveillance and M&E systems. No new bio behavioral surveys are proposed, emphasis will be placed on integration of bio behavioral data collection for KPs into routine SI activities. The SI Team has grown from 3 personnel to 5. The previous staff complement was insufficient to meet the needs of the MOHs and manage monitoring and reporting requirements.

A Management and Operations team, led by the Deputy Director, manages all finance responsibilities related to the PEPFAR budget, cooperative agreements, and contracts and provides support services for the CDC CRO team. This team provides leadership, coordination, reporting and management of financial support services for CDC CRO agency programs as well as provides support for all aspects of cooperative agreement management.

CDC CRO projects an approximate 21% increase in CODB costs for ROP16 compared to ROP15. This is due to an increase in mandatory costs: 1) Capital Security Cost Sharing; 2) Salary increase for contractors; 3) CDC is now fully staffed which increased salary costs; and 5) ICASS costs increase yearly. To mitigate costs CDC CRO has flat lined other budget categories to the CODB 15 level. Please note that even with this flat lined budget, all SIMS requirements will be met. The CDC Guyana office CODB has projected a 50% reduction. This is attributed to the removal of the US Direct Hire position.

CDC CRO organized a SIMS implementation team comprised of existing technical staff to ensure all SIMS requirements are met. CDC CRO technical staff are trained to conduct SIMS, this allows for full implementation and utilization of SIMs throughout the region.

CDC CRO will continue to assess our staff to ensure that it aligns with the priorities of the Caribbean Regional Program (both in terms of countries and activities).

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• [DOD/USAID] Target high risk KPs with appropriate prevention and HTC delivery models, including using community KP networks (Tier I & II) • [USAID] Enhance care coordination between CBO (including private sector) and public health facility sites, including patient tracking and community/facility follow up and support (Tier I & II) • [USAID/CDC] Implement HIV+ contact tracing/partner notification strategies, including linkage to testing (Tier I & II) • [CDC/USAID] Assess factors influencing LTFU among KPLHIV/PLHIV (Tier I & II) • [CDC/USAID] Scale up facility- and community-based strategies to return lost PLHIV to treatment services, including harnessing technology and other innovations (Tier I & II). • [CDC] Monitor trends in KP uptake of prevention, care and treatment services using sentinel surveillance (Tier I & II) • [USAID] Integrate KP staff at select civil society and private sector service delivery sites (Tier I & II) • [CDC] Provide training to improve compliance with national standards for collection and reporting of KP prevention, care and treatment data (Tier I & II) • [HRSA] Implement clinical mentoring and training to improve capacity to care for PLHIV, specifically KPLHIV (Barbados, Jamaica, Suriname, Trinidad & Tobago) • [HRSA] Train and mentor QI teams to implement CQI to improve the quality of care & treatment services (Tier I, Barbados, Suriname) • [HRSA] Provide KP preceptorships to build the practical skills of healthcare workers to provide comprehensive care & treatment for MSM, SW and Transgender individuals KP (Tier I, Suriname, Barbados) • [HRSA] Train adherence counselors on the new national adherence counseling protocol (Jamaica) • [CDC] Improve access and quality of HIV rapid testing through Rapid Testing Quality Improvement Initiative (RTQII) at KP friendly HTC sites (Tier I & II) • [CDC] Increase the use of clinical data for program monitoring and evaluation (Guyana, Jamaica and Trinidad) • [CDC] Support paper and electronic based lab data collection at PEPFAR supported care & treatment sites (Tier I & II) • [CDC] Support the use of EQA to monitor quality of core HIV-related laboratory tests including CD4, VL and TB (Tier I & II) • [CDC] Support laboratory quality improvement and accreditation at KP-friendly care and treatment sites (Tier I, Suriname) • [CDC/USAID] Conduct clinician/counselor training for viral load counselling (Tier I & II)	• [HRSA] Strengthen MOH capacity to provide coaching to QI teams • [Peace Corps] CSO capacity building for sustainability of Test and Start through Response Volunteers (Guyana) • [HRSA] Strengthen patient engagement in quality improvement activities (Tier I, Suriname, Barbados)	• [USAID] Fully transition OVC programming by COP 17 (Guyana)

	• [CDC/USAID] Deliver patient education related to understanding the need for vial testing and understanding results (Tier I & II) • [CDC] Strengthen and support laboratory capacity for diagnosis of sexually transmitted infections (STI) and opportunistic infections (OIs) including TB (Tier I, II & III)	
Sub-national level	• [USAID)] Diffuse innovative technologies, including electronic and mobile health solutions targeting KPs (Tier I & II)	• [Peace Corps] Deliver KP-focused stigma & discrimination and sexual diversity training (Guyana) • [HRSA] Build the capacity of regional teams to lead and champion QI efforts at parish/regional level (Jamaica, Suriname, Trinidad & Tobago)
National level	• [CDC] Update and implement care & treatment guidelines for physicians (to focus on MSM) (Suriname) • [CDC] Revise SOPs and protocols for HIV surveillance/ case reporting (Trinidad, Barbados) • [CDC] Procure viral load reagents (Barbados, Bahamas, Jamaica, Suriname, Trinidad) • [CDC] Strengthen national and regional viral load sample referral network to improve access and coverage for viral load testing (Tier I, II) • [CDC] Revise data collection forms and procedures to improve collection and reporting of KP specific, prevention, care and treatment data including revising electronic databases (Tier I, II, III) • [CDC/USAID] Provide TA to validate national estimates for PLHIV and KPs, map hotspots, and use data for programming (Tier I, II) • [CDC] Link disparate data systems to facilitate key population specific analyses (Guyana, Jamaica, Trinidad, Suriname) • [USAID] Capacity building for the NAP Secretariat and the Ministry of Public Health on routine data quality assessments (Guyana) • [USAID] Assessment of service provider system for KPs and recommendations to improve community-based referral systems (Guyana) • [USAID] Strengthen health financing/sustainability planning capacity (Barbados, Bahamas, Suriname, Trinidad & Tobago) • [USAID] Implement systems for routine cost and expenditure data generation, analysis and use for resource allocation (Barbados, Bahamas, Suriname, Trinidad & Tobago) • [CDC] Strengthen HIV case surveillance with focus on CoC analysis. (Guyana, Trinidad, Barbados) • [CDC/HRSA] Support service delivery optimization pilots (Tier I) • [CDC] Strengthen national and regional lab capacity for HIV drug resistance testing to support surveillance and clinical monitoring activities (Tier I & II) • [CDC] Strengthen and support laboratory capacity for diagnosis of sexually transmitted infections (STI) and opportunistic infections (OIs) including TB (Tier I, II & III) • [USAID} Develop human rights violations (including S&D and GBV/IPV incidents) reporting and redress systems (Tier I and II)	• [HRSA] Support MOH to develop and implement national QI institutionalization plan (Jamaica, Suriname, Trinidad & Tobago) • [HRSA] Review literature, including SPNS best practices, about ways to address lost to follow up and retention in care to better inform site level and national CQI interventions targeting KPs (Tier I, Suriname, Barbados) • [USAID] Implement social marketing & communication campaign to create demand for MSM testing and treatment services (Jamaica) • [USAID] Implement a Test and Start public awareness campaign to support recovery and treatment readiness (Jamaica) • [CDC] Implement bio behavioral surveys (MSM-Jamaica; MSM- Suriname; FSW- Trinidad and Tobago) • [USAID] PrEP advocacy and acceptability/feasibility assessments (Tier I and II) • [USAID] LGBT rights and advocacy for legislative reform (Guyana)

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16

	Core Activities	Near-core Activities	Non-core Activities
HTS	• [USAID] Support peer educators and navigators, and innovative ICT-based strategies to find and test hard to reach KPs (Jamaica, The Bahamas, Suriname, Trinidad & Tobago) • [DOD/USAID] Target high risk KPs with appropriate prevention and HTC delivery models, including using community KP networks & incentivized networking/snowballing-based HIV testing (Tier I & Tier II) • [USAID] Training for peer educators to improve pre/post-test counselling/treatment literacy (Jamaica, Guyana) • [DOD/USAID] Strengthen LTC systems (data entry applications and case management software) and reduce the LTC timeframe (Jamaica, Guyana, Suriname) • [CDC] Enhance provider skills for improving risk profiling (Guyana) • [USAID/CDC] Strengthen intensive HIV positive contact tracing/partner notification (Tier I & Tier II) • [CDC] Develop national HIV Testing Services guidelines/policy (Jamaica)	• [DOD] Post-test counselling for recruits (Guyana) • [Peace Corps] HIV education and demand creation for HTS to support World AIDS Day (Guyana) • [USAID] Implement social marketing & communication campaign to create demand for MSM testing and treatment services (Jamaica) • [Peace Corps] HIV education and demand creation for KP HTS to support World AIDS Day (Guyana)	
Care and Treatment	• [USAID/CDC] Strengthen care & treatment services, including the return to care/retention of KP at public health facilities and community sites (Tier I & Tier II). • [CDC] Assess LTFU and pilot facility and community-based strategies to return lost PLHIV to treatment services. Support governments to scale up successful strategies (Tier I & Tier II) and develop a rapid assessment protocol for HCWs to assess lost to follow-up (Jamaica) • [CDC] Update/implement physician care & treatment guidelines (focus on MSM) (Suriname) • [CDC/USAID] Enhance provider skills for improving risk profiling and health screening [GBV/IPV, mental health] (Guyana) • [USAID] Support incentivized peer referrals for KPs to treatment (Jamaica, Guyana) • [USAID] Inclusion of KP in clinical care (e.g. joint case conferencing) (Guyana) • [USAID/HRSA] Sensitize healthcare workers on stigma & discrimination, sexual orientation, gender identity, gender-based violence (Tier I & Barbados) • [USAID] Link IT solution to the UIC for improved linkage to treatment (Jamaica) • [USAID] Expand peer/health navigators' role in sexual network tracing (Jamaica, Trinidad & Tobago, Tier II) • [USAID] Update Patient Retention and Recovery SOP and conduct training of HWCs (Jamaica) • [USAID] Support ART uptake (e.g. ARV community-aided delivery) (Jamaica)	• [CDC] Strengthen linkage of FSW to care and treatment (Suriname) • [CDC] Support and manage clinical monitoring of treatment side effects (Guyana) • [USAID] Improve screening tools to identify KPs (Guyana) • [HRSA] Build the capacity of regional teams to lead and champion QI efforts (Jamaica, Suriname, Trinidad and Tobago) • [HRSA] Identify and train staff to become National QI Coaches and to provide coaching to QI teams (Tier I and Suriname) • [USAID] Implement a Test and Start public awareness campaign to support recovery and treatment readiness (Jamaica) • [USAID] Improve PLHIV support group facilitation with focus on expanded PHDP curriculum and increase attendance with selective travel stipends (Jamaica)	

	• [USAID] Support patient education (e.g. treatment readiness/literacy, internal stigma and resiliency) through PHDP (Jamaica, Guyana) • [USAID] Support patient-centered care models, including sessional clinic visits and alternative clinic hours (Jamaica) • [HRSA] Train and mentor QI teams to implement CQI activities at their facilities (Tier 1, Barbados, Suriname) • [HRSA] Provide clinical mentoring support related to KP care, including ART delivery and adherence, as well as screening and treatment for relevant co-morbidities (e.g., TB, Hepatitis, STIs) (Tier I, Barbados) • [HRSA/CDC] Through preceptorships, build the practical skills of HCWs to provide comprehensive care & treatment for KPs (Tier I & II) • [USAID] Develop and implement innovative strategies to reach hidden and higher-risk KPs and support them in accessing KP C&T services (Trinidad & Tobago, Tier II) • [CDC] Procure viral load reagents (Barbados, Bahamas, Jamaica, Suriname, Trinidad) • [CDC/USAID/HRSA] Conduct clinician/counselor training for viral load counselling (Tier I & Tier II) • [CDC/USAID] Deliver patient education related to understanding the need for vial testing and understanding results (Tier I & Tier II)		
Prevention	**Core Activities** • [USAID/DOD] Conduct targeted outreach using mobile community KP partners, peer links, peer educators/navigators and link to testing (Tier I, The Bahamas, Suriname) • [USAID] Conduct prevention interventions with MSM in safe spaces with access to testing (Jamaica) • [USAID] Support the development/adaption of KP-focused social media and network approaches (Tier I and Tier II) • [USAID/DOD] Implement KP-targeted prevention interventions to include condom/lubricants and HTC (Jamaica, Guyana, Suriname) • [USAID] Support commodity (e.g., condoms) forecasting and logistics (Trinidad & Tobago, Tier II)	**Near-core Activities** • [USAID/DOD] Advocacy and sensitization of stigma and discrimination, and GBV reduction. (Tier I and II) • [USAID] PrEP advocacy and acceptability/feasibility assessments (Tier I and II) • [USAID] Procure and distribute lubricants as part of prevention interventions (Jamaica) • [Peace Corps] Institutionalize curriculum 'Gender and Sexual Diversity & Stigma & Discrimination" into National Nursing School training • [Peace Corps] Deliver KP-focused stigma & discrimination and sexual diversity training (Guyana)	**Non-core Activities**
OVC	**Core Activities** • N/A	**Near-core Activities** • N/A	**Non-core Activities** • [USAID] Maintenance package with COP 17 transition. (Guyana)
	• [CDC]Develop and implement a PUID. (Guyana) • [USAID] Provide technical assistance to support supply chain logistics for Test and Start. (Guyana) • [USAID] Provide technical assistance to build capacity in Health Financing/Sustainability Planning and support costing of service delivery models. (Guyana) • [HRSA] UWI Diploma in the Management of HIV Infection Scholarships for priority site HCWs. (Jamaica) • [USAID] Strengthen procurement and supply chain management systems.(Jamaica) • [USAID] Initiative to create public-private	• [USAID] Support PANCAP for the CRSF and to work closely with Global Fund and other donors (Regional) • [USAID] Develop the capacity of regional organizations (OECS HAPU, PANCAP, UWI HEU) to offer urgent technical support towards improving the performance of the CCMs, PRs and SRs (Regional) • [USAID] Establish a knowledge management platform to share technical leadership and	

Health Systems Strengthening	partnerships for health system infrastructure, drug dispensing and national health insurance scheme. (Jamaica) • [USAID] Cost monitoring and assessment of test and start implementation. (Jamaica) • [USAID] Support further development and roll out of AKROS mobile-to-web system to enroll clients and track their referrals and linkages to and retention in treatment/care. (Trinidad and Tobago, Suriname) • [USAID] Review, update and consolidate relevant national care and treatment policies, guidelines and strategies into easy-to-use handbooks and digital formats for clinical care providers. (Trinidad and Tobago and Tier II) • [USAID] Develop and maintain a directory of services for KP-friendly care, treatment and support providers. (Trinidad and Tobago and Tier II) • [USAID] Operational research to identify barriers to access/retention of KPs across the CoPCT (Jamaica) • [USAID] Monitor linkage to care and case management practices in outreach settings (Jamaica) • [USAID] Expand roll-out of Unique Identification Code (Jamaica) • [USAID] Expand roll-out of DHIS2 platform for treatment database (Jamaica) • [USAID] Operational research to validate best approaches for providers to collect KP data in service delivery settings (Jamaica)	programming ideas (Regional) • [USAID] Initiate "think-tank" events in partnership with regional leaders and institutions (Regional) • [USAID] Institutionalize gender and sexual diversity training (Tier I & II) • [HRSA] Support the MOH to develop a national HIV QI plan that addresses policy, leadership, resources and structure (Tier I, Suriname) • [Peace Corps] Build CSO Capacity for Sustainability of Test and Start (Guyana)
Laboratory	• [CDC] Improve access and quality of HIV rapid testing through Rapid Testing Quality Improvement Initiative (RTQII) at KP friendly HTC sites (Tier I and II) • [CDC] Support paper and electronic based laboratory data collection systems at PEPFAR supported care and treatment sites (Tier I and II) • [CDC] Support the use of EQA to monitor quality of core HIV-related laboratory tests including CD_4, VL and TB (Jamaica, Trinidad & Tobago, Tier II) • [CDC] Support capacity building for TB drug resistance testing (Guyana) • [CDC] Support Laboratory quality improvement and accreditation at KP-friendly care and treatment sites (Tier I, Suriname) • [CDC] Strengthen national and regional viral load sample referral network to improve access and coverage for viral load testing (Tier I & II) • [CDC] Strengthen national and regional lab capacity for HIV drug resistance testing to support surveillance and clinical monitoring (Tier I & II) • [CDC] Strengthen and support laboratory capacity for diagnosis of sexually transmitted infections (STI) and opportunistic infections (OIs) including TB (Tier I, II and II)	

Strategic Information	• [CDC] Develop and implement a PUID (Guyana) • [CDC] Improve collection of patient and KP identifier data, including PUID pilots for enhanced tracking between prevention, care, treatment and laboratory information systems (Tier I) • [CDC] Implement collection of bio-behavioral data for key populations (sentinel surveillance) at targeted prevention, care and treatment sites (Tier I & II) • [CDC] Assist partners with identifying key performance indicators and implementing routine site level, interdisciplinary, program planning meetings to review performance (output/outcomes of KP, C&T, S&D interventions)	• Conduct regional training (all countries) and deliver site level TA to strengthen routine data quality assurance procedures for monitoring and reporting of KP specific prevention, care and treatment data (Tier I, II) • [CDC] Provide TA for implementation of bio behavioral surveys (MSM- Jamaica; MSM-Suriname; FSW- Trinidad and Tobago
Cross Cutting	• [USAID] Strengthen the complaint and redress systems (Jamaica) • [USAID} Develop human rights violations (including S&D and GBV/IPV incidents) reporting and redress systems (Tier I and II) • [USAID] Implement a cost analysis of S&D reduction efforts at priority sites • [USAID] Support implementation of Legal Environment and Stigma Assessments (Jamaica) • [USAID] Establish and support community engagement with health services using a scorecard system to assess and address issues related to accessing services, expectations of quality, and to develop and monitor action plans for improvements (Trinidad & Tobago, Tier II) • [USAID] Support capacity development of a core national training team to train providers in the provision of KP-friendly services at the facility level (Trinidad & Tobago, Tier II)	• [USAID] LGBT rights and advocacy for legislative reform (Guyana)

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 16	Estimated Funding in COP 17	# of IMs	Transition End date	Notes
• [USAID] Discrete OVC Health and Stable activities to be fully transitioned by COP 17. (Guyana)	Programmatic	$89,266	$126,351	1	September 30, 2017	Earmark was provided for ROP 17
• [DOD] Direct military to military QA/QI TA to support anti-S&D activities, strengthen HTS and linkage to care to improve the overall outcomes of HIV+ members (Tier I, Suriname)	Programmatic			1	Start of COP18	Direct military-to-military TA support for these activities [CODB]. Funding will use applied pipeline for COP16 and in outlying years.
• [DOD] Support HIV education/training for military recruits (Guyana)	Programmatic	$1,000	$1,000	1	Start of COP18	DOD Guyana serves as the direct implementer, which accounts for the low-cost of the program. Funding

				will use applied pipeline for COP16 and in outlying years.
	$90,266	$127,351	3	
Totals				

APPENDIX B REQUIRED

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
US$6,900,498	**US$22,381,643**	**US$29,282,141**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	1,608,685
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	874,886
HBHC	Adult Care and Support	4,483,824
PDCS	Pediatric Care and Support	13,364
HKID	Orphans and Vulnerable Children	70,000
HTXS	Adult Treatment	3,050,036
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	64,254
HVTB	TB/HIV Care	
HLAB	Lab	1,368,680
HVSI	Strategic Information	2,074,415
OHSS	Health Systems Strengthening	2556303
HVMS	Management and Operations	6,217,196
TOTAL		**22,381,643**

B.2 Resource Projections

As a technical assistance program, the use of the PBAC tool for target-based budgeting did not adequately cover all program areas/budget codes. Agencies worked closely with the Caribbean EA Advisor to determine the best unit expenditures (UEs) for certain mechanisms, based on the FY15 EA data, and expected changes to the programs. In addition, data was challenging to apply for effective budgeting due to major programmatic shifts in geographic coverage and program scope. Further EA work is required to derive valid UEs that are applicable to stable

programming moving forward. In some instances, the PBAC was useful to determine UEs for direct service providers. Adjustments were possible for selected expenditure areas (budget codes) based on more recent expenditure data.

Expenditure analysis data is also not conducive for target based budgeting for supported military programs due to the nature of support provided. Military activities are implemented through a direct TA model with minimal program funds. In addition, the FY15 expenditure analysis combined military and KP expenditures in one country and the resulting UE is not applicable. The estimated costs of planned activities utilized historical expenditures as a guide.

Overall, the FY15 expenditure analysis was instrumental in understanding the prior period budget codes and geographical spending patterns of implementing mechanisms. Prior year spending patterns (lump sum budgeting) were used as a basis for the ROP 16 budget development process across the majority of programs, making adjustments for the continuing shifts in program funding priorities such as; reallocation of funding from OHSS to improving data system for monitoring KP response in the region, prioritization of funding toward implementation of "test and start" strategies, and emphasis on activities to address loss-to-follow-up activities. The funding request also reflects support for varied stigma and discrimination remediation efforts, expanded PHDP training, both of which will support retention in care and viral suppression, intensified efforts to identify new positives and reduce linkage to care timeframes.