Caribbean Regional Operational Plan

(ROP) 2017

Strategic Direction Summary

June 8, 2017

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Goal Statement

The goal of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program in the Caribbean is to support the achievement of epidemic control and a sustainable response in five focus countries: Jamaica, Guyana, Trinidad and Tobago, Suriname, and Barbados. The PEPFAR Caribbean Regional Operational Plan (ROP) 2017 aligns country-level investments with HIV burden and aims to support governments and civil society organizations (CSOs) to strategically strengthen HIV prevention, care, and treatment services, prioritizing key populations (KP). This includes men-who-have-sex-with-men (MSM), transgender persons (TG), and female sex workers (FSW). People living with HIV/AIDS (PLHIV), including KPLHIV, are also a priority population.

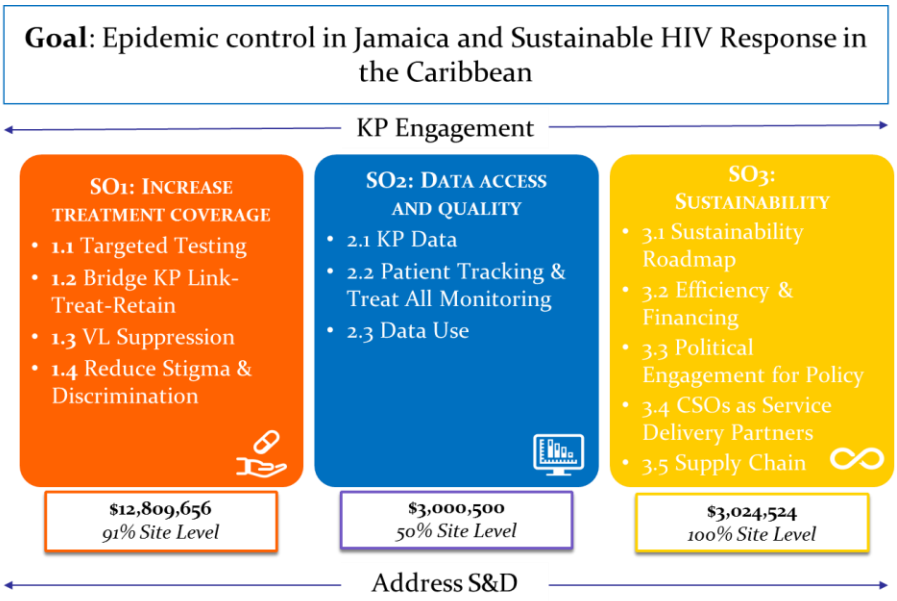
Three strategic outcomes frame the direction of the Caribbean Regional Program (CRP) ROP 17 plan: 1) Increase Treatment coverage in Jamaica focusing on Key Populations so that 75% of diagnosed PLHIV and KPLHIV are on treatment and 80% of PLHIV and KPLHIV on ART achieve viral suppression by the end of FY 19; 2) Improve data access, quality, and use, particularly for KP; and 3) Align PEPFAR resources to burden, need and impact in a sustainable manner.

PEPFAR investments in the CRP will focus primarily on Jamaica, which has the largest HIV burden among focus countries (29,000 PLHIV), the highest number of new infections per year (1,700), as well as the highest number of deaths due to HIV/AIDS (1,200), and among the lowest treatment coverage rates (37%). Approximately 65% of CRP funding will support Jamaica, while support for other focus countries aligns with lower HIV burden, lower numbers of new infections, and lower mortality rates including Trinidad and Tobago (9%), Guyana (16% respectively), Suriname (6%), and Barbados (4%),.

As the priority country for the CRP, Jamaica will receive the greatest PEPFAR investment to find HIV positive KP and diagnose PLHIV earlier, increase treatment coverage and achieve viral suppression among KPLHIV and PLHIV. In Barbados, support will build on past successes and catalytic activities that can be absorbed by the government and civil society with the goal of preparing for a USG transition by September 2018. The PEPFAR CRP team will work closely with the government and implementing partners in Trinidad and Tobago to monitor progress and prepare for transition in two years (Sep 2019) on the condition of meeting intermediate (2017) and first year (Sep 2018) benchmarks. In Suriname, PEPFAR will focus on building systems that strengthen community-based activities with the goal of a USG transition by September 2019. In Guyana, PEPFAR will work closely with Global Fund to finalize the sustainability plan currently being developed, and jointly plan for a downward glide path in donor funding, with PEPFAR support ending by September 2020. PEPFAR will continue to fund regional-level activities to improve coordination and strengthen systems that will accelerate the scale up of Treat All in all focus countries.

In quarter four of fiscal year (FY) 2017 and 2018, the team will review progress against targets and budget allocations across all countries and adjust based on results to ensure that investments will allow the successful transition of PEPFAR programs to host governments.

The following diagram represents the overall CRP goal and strategy for the upcoming two years:



The CRP will prepare for transition, working with partner governments and regional stakeholders, to conduct sustainability analyses and develop transition plans which include timeframes and co-financing action plans. Above-site level activities will focus on strengthening surveillance and information systems, laboratory systems, creative financing strategies to increase domestic resources for HIV/AIDS, reinforcing CSO capacity and addressing supply chain weaknesses to support Treat All. The table below provides an overview of PEPFAR CRP transition timeframes and key activities over the next 6-30 months:

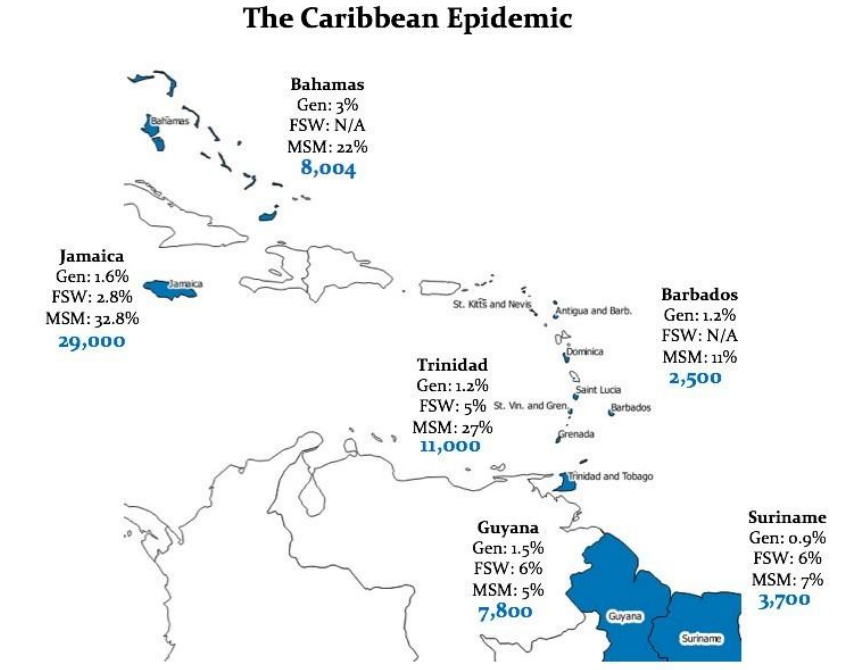
Bahamas
Closeout in FY17

Guyana Continue through Year 2 (FY19)	Barbados Closeout after Year 1 (FY18)
▪ Innovative models to improve access to and uptake of KP services ▪ Delivery of HIV Care and Treatment services ▪ Scale up viral load access and literacy ▪ Strengthening laboratory systems and services ▪ HMIS Implementation ▪ Improve collection of risk factor data for KPs ▪ Transition planning, high-level policy engagement, CSO and supply chain strengthening, and sustainable financing	▪ Fast track returning LTFU patients ▪ Innovative models to improve access to and uptake of KP services ▪ Scale up viral load access and literacy ▪ Capacity for viral load testing ▪ SI investments to establish sentinel surveillance for key populations ▪ Transition planning, high-level policy engagement, CSO and supply chain strengthening, and sustainable financing
Trinidad and Tobago **Continue through Year 2 (FY19)**	**Suriname** **Continue through Year 2 (FY19)**
▪ Implement Treat All initiative, fast track returning LTFU patients, VL Scale up, referral network for drug resistance testing, strengthening lab systems and services ▪ Improve collection of risk factor data for KPs ▪ Training, routine data analysis, and dissemination ▪ Establish MRF as a model of treatment excellence in Trinidad, transition planning, high-level policy engagement, CSO and supply chain strengthening, and sustainable financing	▪ Innovative models to improve access to and uptake of KP services ▪ Transition planning, high-level policy engagement, CSO and supply chain strengthening, and sustainable financing

CRP plans will include the transition of assistance activities from the US Department of Defense (DoD) to respective civil society and military partners. These include outreach, HTS (HIV Testing Services), prevention and clinical trainings. Final year (FY18) DoD support will be limited to above-site capacity building, prevention and SI technical assistance (TA) to improve documentation tools and quality assurance, the integration of anti-stigma and discrimination elements within military policies, and training of military leaders on data use for decision making.

2.0 Epidemic, Response, and Program Context

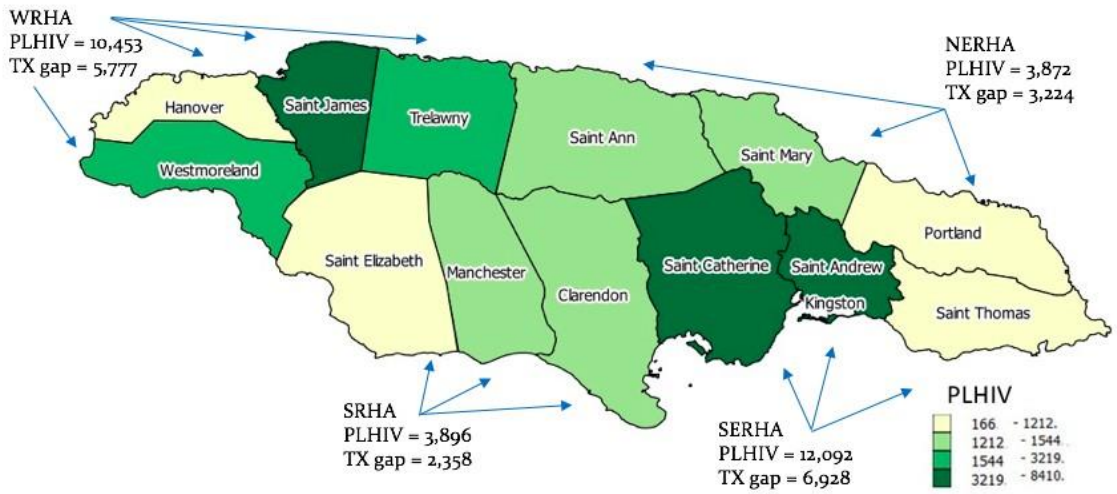
2.1 Summary statistics, disease burden, and epidemic profile: HIV prevalence in the Caribbean Region is estimated to be 1.1 percent of the adult population (UNAIDS, 2014). Of the 6.1 million people in the PEPFAR-supported countries, approximately 54,000 are HIV positive. In the general population, HIV prevalence ranges from 0.9 percent in Suriname to 3.2 percent in the Bahamas. Jamaica has the greatest burden, representing 47 percent of PLHIV among PEPFAR's focus countries.



At the heart of the epidemic across the region is pervasive S&D, which remains a principal barrier to accessing prevention, care, and treatment services for all PLHIV and particularly KP PLHIV. Other socio-cultural realities impede epidemic control including gender inequities, gender-based violence, multiple concurrent partnerships and intergenerational sex. Additional factors that affect KPs are high cross-border mobility and an inherent tension between the role of the church in setting social norms and cultural attitudes and practices of sexual expression. High levels of poverty, unemployment, and under-employment, especially among youth and women in some countries within the region, also impact their vulnerability to HIV. These factors contribute to the marginalization of KP, often driving them 'underground' and making it harder to access HIV interventions and services.[1]

Numbers of newly infected individuals per annum are estimated to be 1,700 in Jamaica, less than 500 in Trinidad and Tobago and Guyana, and less than 200 in Suriname and Barbados (UNAIDS, 2016). In Guyana, the highest burden of HIV is in Region 4 (PEPFAR's focus region), which accounts for 73 percent of the HIV reported cases (MOH, 2014) and 79 percent of the persons currently on treatment (MOH, 2016).

PLHIV Burden in Jamaica (2016) by Parish and Regional Health Authority



Regional estimates indicate that 75 percent of PLHIV in the Caribbean know their status (UNAIDS, 2016). The proportion of PLHIV diagnosed is estimated to be 85 percent in Jamaica (MOH, 2016), 71 percent in Guyana (MOH, 2015), and 70 percent in Suriname (MOH, 2014). Late diagnosis of HIV infection continues to be a problem, as evidence shows approximately 40 percent of PLHIV receive a concurrent HIV and AIDS diagnosis (PAHO, 2013). There is additional need to strengthen early linkage to, and retention in, treatment. Antiretroviral Treatment (ART) coverage among PLHIV varies by country with 37 percent in Jamaica, 58 percent in Guyana, 61 percent in Trinidad & Tobago, 54 percent in Suriname, and 47 percent in Barbados (see Table 2.1.2 for details and sources). Over the past year, all priority countries committed to adopting and rolling out Treat All during FY 17. However, barriers to success are still considerable, including the increased costs of patient care, staffing shortages, weak and/or ill-prepared supply chain and logistics systems, and weak data collection systems.

New HIV infections are estimated to have declined by 40 percent from 2005 and 2013 and AIDS related deaths have been declining in the region over the past decade (UNAIDS, 2014 GAP report). This trend has coincided with the provision of ART through national care and treatment programs. Sexual intercourse is the predominant mode of transmission in the region. Data suggest men are disproportionately affected by the epidemic – higher numbers and proportions of men test positive for HIV and higher proportions die. Coverage of testing, early initiation, and treatment is higher among females. Key population specific data are limited but suggest lower proportions of MSM and FSW receive treatment and achieve viral suppression. Strengthened health systems, including improved laboratory capacity, have contributed to the ability of governments to offer comprehensive care and treatment for PLHIV. Achieving epidemic control in the Caribbean, and in Jamaica, will require tailored services to reach underserved population such as FSWs, gay, bisexual, and other MSM.

The CRP focus countries are not presently on track to achieve the third 90, with viral suppression among all PLHIV at 13 percent in Jamaica, 7 percent in Guyana, 25 percent in Trinidad, and 29 percent in Barbados. The viral load (VL) testing coverage was approximately 90 percent in Jamaica (2016), 15 percent in Guyana (2015), and 63 percent in Barbados (partial data, 2016). Among pa-

tients who received a VL test, 60 percent were virally suppressed in Jamaica, 65 percent in Guyana, and 83 percent in Barbados. In Suriname, 81 percent of ART patients who were diagnosed in 2015 and received a VL test were virally suppressed (MOH 2017). Several factors could be responsible for low levels of viral suppression including poor medication adherence and the presence of HIV drug resistance (HIVDR). Different adherence support models are being tested in FY 17 to better understand and address deficiencies and ensure improved clinical outcomes of patients on ART. Systems-level gaps also played a role in low VL coverage rates. In Guyana, this included equipment failure, reagent stock-outs, and human resource shortages.

The following are Tables that summarize national epidemiological data related to HIV and AIDS:

Tables 2.1.1 Caribbean Region Demographic and Epidemiological Data

Table 2.1.1 Caribbean Region Demographic and Epidemiological Data					
Indicator	**Jamaica**	**Guyana**	**Trinidad and Tobago**	**Suriname**	**Barbados**
Total population	2,717,991	751,223	1,353,895	539,276	287,733
HIV prevalence (%)	1.6%	1.5%	1.2%	0.9%	1.5%
AIDS deaths (per year)	1,200	<200	<500	<200	<100
#PLHIV	29,000	7,800	11,000	3,700	2,500
Incidence rate (yr)			.04%		
New cases (yr)	1,700	<500	<1000	<200	<200
Pregnant women needing ARVs	507		180	122	18
% of pregnant women with at least one ANC visit				88.6%	
Notified TB cases (yr)	86	668	218	158	5
% of TB cases that are HIV infected	21%	24%	17.9%	29%	50%
Estimated population size of MSM	33,000	3,327	7,772	5,000	2,784
MSM HIV prevalence (%)	32.8%	4.9%	26.6%	9.2%	12%
Estimated population size of FSW	18,696	5,256	4,500	2,228	5,644
FSW HIV prevalence (%)	2.9%	5.5%		5.8%	
Transgender HIV prevalence		8.4%			
Estimated size of priority populations: Military				3,000	

*No data available, or shared for public distribution where data not presented
^ Partial data available only, underestimates viral suppression for all PLHIV. Viral load testing results available for 63% of ART patients

Tables 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression

Please note for following tables: where no data is presented, means there was none available, or no data was shared for public distribution

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression* JAMAICA										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	2,717,991	1.6	29,000	24,608	10,680	37	20	168,687	3,887	n/a
Male	1,383,881		19,110	10,459	5,038	35	14			
Female	1,427,814		10,341	13,835	5,642	39	31			
MSM**	33,000	32.8	6,600	976	131	2	1.4	3,072	300	n/a
FSW**	18,696	2.9	542	243	56	10.3	2.2	3,731	64	n/a

**The key population cascade data (diagnosed through to viral suppression) is partial based on key populations who have disclosed.

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression* GUYANA 2015										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	751,223	1.5%	7,800	5,534	4,551	58%	7% (677 tested, 536 suppressed)	55,095	939	548
Population less than 15 years	267,147		<500		157					
MSM	3,327	4.9%						3,939 (2016)	73 (2016)	
FSW	5,256	5.5%						4,692 (2016)	58 (2016)	

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression* TRINIDAD and TOBAGO, 2015										
	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	1,353,895	1.2%	11,000	NA	6,720	61%	11% (3,722 tested, 2,799 suppressed)	58,582	979	
Population less than 15 years	278,742	0.9	79	NA	77	97%	46%			
MSM	7,772	26.6%	74					382	40	
FSW	4,500							101	3	
Substance Users	428	5.1%	22							

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression* BARBADOS, 2016										
	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population 2016 (preliminary data)	287,733	1.5%	2,600	2,024	1,236	47%	24%** (776 tested, 622 suppressed)	2,044 (PEPFAR,2014)	23 (PEPFAR, 2014)	
Total population 2013			2,500	2,085	1,062	42%	899 (36%) 84% of ART patients suppressed			
MSM	2,784	12%	337	96	64	19%	9%			

**Partial data available only, underestimates viral suppression for all PLHIV. Viral load testing results available for 63% of ART patients.

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression* SURINAME										
	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year (2015)		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)*	Initiated on ART (#)
Total population	539,276	0.9%	3,700	2,804	2,002	54	290		503	265
MSM	5,000	9.2%	460							
FSW	2,228	5.8%	129							

2.2 Investment profile[2]

According to the World Bank, Trinidad and Tobago and Barbados are high-income countries, with GNIs above $14,000. Jamaica and Suriname are upper middle-income countries with GNIs between $5,050 and $9,360. For Suriname, this represents a decline from the previous year's GNI of $12,745, likely attributed to the 20% currency devaluation of November 2015. Guyana is in the lower middle-income range with a GNI of $4,090, a slight increase from the previous year of $3,775.

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 caused strong contraction of member countries' economies and negative growth, which 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 increased their fiscal vulnerability.

Estimates for total health expenditure (THE) per capita across the six countries are approximately $847, with the high expenditures recorded by Trinidad and Tobago at $1,136 and Barbados at $1,146. In the five PEPFAR focus countries, government health expenditure (GHE) as a percentage of THE average is 54 percent, with Trinidad and Tobago at 53.5 percent, Guyana at 59.5 percent and Barbados' at 63.5 percent. The Guyana government invests the largest amount of public funds into the general healthcare system[3], however they are the only country, among the five, that funds less than 50 percent of the national HIV/AIDS response.

PEPFAR and Global Fund investments in HIV/AIDS programming across the Caribbean Region represent a relatively small proportion of overall expenditures. However, PEPFAR and Global Fund funding *often represent the only funding to support targeted key population programming*. This underscores the 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.

[2] The World Bank. http://databank.worldbank.org/data/reports.aspx?Code=NY.GNP.PCAP.CD&id=af3ce82b&report_name=Popular_indicators&popular type=series&ispopular=y . Data accessed February 13, 2017.

[3] WHO, NHA indicators. http://apps.who.int/nha/database/Select/Indicators/en .Data accessed February 13, 2017.

Tables summarizing investments by PEPFAR, host governments and other donors, are below:

Table 2.2.1 Investment Profile by Program Area* GUYANA					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	$3,681,702	70%	25%	3%	0.8%
Community-based care, treatment, and support	$183,414	41%	45%	14%	0%
HTS	$892,821	45%	42%	14%	0.7%
Priority population prevention	$262,779	77%	4.%	5%	14%
Key population prevention	$317,162	16%	69%	14%	2%
PMTCT	$509,897	80%	0%	20%	0%
OVC	$435,619	22%	4%	9%	65%
Laboratory	$1,990,630	19%	0.3%	81%	0.02%
SI, Surveys and Surveillance	$196,515	2%	42%	27%	30%
HSS	$2,137,266	93%	5%	0.04%	2%
Behavior Change Programs	$160,817	2%	51.0%	39%	9%
Program for Children & Adolescents	$7,116	1%	99%	0%	0%
Workplace Program	$36,178	1%	1%	24%	74%
Community Mobilization	$158,650	23%	20%	44%	13%
Program for PLHIV	$96,772	37%	60%	0.34%	3%
Advocacy	$21,766	0%	3%	2%	95%
Education	$48,275	0.1%	51%	49%	0%
Gender Program & Stigma Reduction	$989	64%		28%	8%
Other Prevention	$2,084,952	78%	5%	17%	0.08%
Social Protection	$531,000	0%	0%	100%	0%
HIV & AIDS Related Research	$595,618	99%	1.%	0.02%	0%
Planning & Coordination, Procurement & Logistics	$6,522,038	87%	10%	2%	1%
AIDS Specific Institutional Development	$209,557	99%	0%	0%	0.02%
Other Activities Not Classified	$77,990	100%	0%	0%	0%
Total	**$21,159,523**				

Table 2.2.1 Investment Profile by Program Area* JAMAICA FY16					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	$2,420,967	7%	68%	25%	
Community-based care, treatment, and support	$475,161	32%	68%		
HTS	$275,851	55%	45%		
Priority population prevention	$85,322	100%			
Key population prevention	$1,697,811	52%	45%	3%	
SI, Surveys and Surveillance	$19,092	100%			
HSS	$751,840	21%	75%	4%	
Total	**$5,726,045**				

Table 2.2.1 Investment Profile by Program Area* BARBADOS					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	$6,060,000	6%		94%	0.4%
HTS	$435,000	68%		32%	
Priority population prevention	$1,805,000	27%		73%	
SI, Surveys and Surveillance	$100,000	100%			
HSS	$1,900,000				
Total	**$10,300,000**				

Tables 2.2.2 Procurement Profile for Key Commodities

Table 2.2.2 Procurement Profile for Key Commodities* GUYANA FY16					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$651,285	.46%	18%	82%	
Rapid test kits	$136,193		.59%	99%	
Lab reagents/other drugs	$131,796		1.7%	98%	
Condoms	$191,546		21.9%	78%	
Viral Load commodities	$704,830			100%	
Total	**$1,815,651**				

Table 2.2.2 Procurement Profile for Key Commodities* JAMAICA FY16					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$1,613,598	4%	69%	27%	
Rapid test kits	$208,430	25%	59%	16%	
Lab reagents	$448,883		100%		
Condoms **Viral Load commodities**	$92,684		100%		
Other commodities	$89,586	100%			
Total	**$2,453,181**				

Table 2.2.2 Procurement Profile for Key Commodities* SURINAME					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$1,174,899			47% (72%)	18% (22%)
Rapid test kits	$399,147			23% (96%)	1% (4%)
Lab reagents	$104,911	1% (17%)		5% (83%)	
Condoms **Viral Load commodities**	$63,600			4% (100%)	
Other commodities	$27,000			2% (100%)	
Total	**$1,769,557**				

Table 2.2.2 Procurement Profile for Key Commodities* BARBADOS					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$925,000			100%	
Condoms Viral Load commodities	$50,000			40%	60%
Other commodities	$2,020,000			100%	
Total	**$2,995,000**				

Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration

Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration*		
Funding Source	**Total USG Non-PEPFAR Resources**	**Objectives**
USAID/Jamaica (ZIKA)	$7,000,000-$9,000,000	Funding for the next 3 years to support Zika control and public education
CDC HQ NCD	$75,000	Through the Caribbean Public Health Agency (CARPHA), improve population-based cancer registries
CDC HQ Influenza	$399,854 (Jamaica)	Work with Jamaica MoH to improve capacity to conduct influenza surveillance and respond to pandemic influenza
CDC HQ GHSA	$1,250,000	Through CARPHA and MoHs across the region advance GHSA with work in the following areas: Emergency Operations Centers, Antimicrobial Resistance, and Zika
USAID/CDC IAA for Zika	$656,560	Field Epidemiology Training Program through TEPHINET is working in Zika affected countries in Latin-America and the Caribbean (includes Guyana, Suriname, Trinidad & Tobago) - Agreement expires Dec 2017
Total	**$9.381,414-$11,381,414**	

Table 2.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Table 2.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP*		
Funding Source	**Total PEPFAR Non-COP Resources**	**Objectives**
Other PEPFAR Central Initiatives	$2,100,000	LCI – To build the capacity regional organizations and local CSOs that specifically focus on KPs to become more sustainable
	$1,969,892 (Trinidad & Tobago, Bahamas, Barbados, Suriname, Jamaica)	LCI – PANCAP project assesses and builds capacity of CSOs working with KPs to focus on activities including policy advocacy, program implementation, and/or building a financially diverse organization
	$500,000 (Guyana)	LCI - To improve the operational network and increase capacity of local NGOs, and strengthen relationship between CSOs and the Government of Guyana
Total	**$4,569,892**	

*No data available, or shared for public distribution where data not presented

2.3 Sustainability Profile

In FY 16, Jamaica and Trinidad and Tobago each completed a Sustainability Analysis, one is ongoing for Barbados, and one is planned for Guyana in the second quarter of FY 17. The Sustainability Analyses takes into account results from PEPFAR's Sustainability Index Dashboards (SIDs) as well as external studies by the World Bank, American Development Bank, and UNDP, and focuses on (1) institutional capacity (2) technical capacity, and (3) economic, financial, and policy environment. These Sustainability Analyses will serve as the basis for continued work with the Global Fund, UNAIDS and PAHO to develop national transition plans in all five focus countries. This work will also help countries prepare for graduation from PEPFAR programs with special consideration paid to the sustainability of programming for key populations during the proposed PEPFAR transition periods.

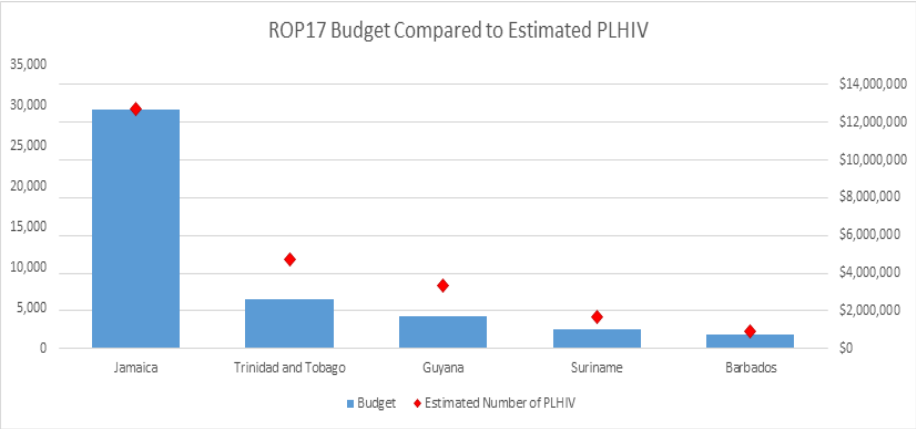
For sustainability in Jamaica, issues of poverty still plague the country, hampering improvement in its socio-economic status. Still, the government has invested domestic resources with increases projected as the Global Fund decreases its support. The government is committed to paying for all ARV costs by 2019/20, however, Government contributions are diminished by the rise in the cost of the national HIV response, driven to a degree by the increasing number of people on treatment, but also the cost of 2nd and 3rd line medications which are often needed due to high rates of treatment failure.

Factors which may significantly affect sustainability among the other four focus countries include the devaluation (over 20 percent) of Suriname's currency and generally weak economic outlook, as well as decreasing oil prices in Trinidad and Tobago, and a recent downgrade in the credit rating of Barbados, all contributing to lower public sector and health expenditures. Comparatively, Guyana expects acceleration in economic growth associated with recently discovered large oil reserves.

2.4 Alignment of PEPFAR investments geographically to burden of disease

In ROP 17, PEPFAR CRP will continue to align resources with the highest burden countries and subnational units, while also taking into consideration other factors such as program results, the potential for success and impact, economic stability, sustainability assessments, host government investments, and other donor funding.

Despite an overall funding decrease of $3 million for the regional program (from $29,282,142 in ROP 16 to $26,354,475 in ROP 17), investments in Jamaica represent 65 percent ($12.2 million) of the program budget, and will support the national program to dramatically expand access to services.



PEPFAR investments in Guyana have progressively decreased over the past three years as the country moved from a bi-lateral PEPFAR program to a member of the regional program. Planned in-vestments in Guyana ($3 million) represent 16 percent of the program budget. In Trinidad and Tobago, the CRP is taking a conservative investment approach, with approximately 9 percent ($1.6 million) of the program budget allocated, and intermediate and annual benchmarks put in place to determine if continued funding is justified. Investments in Suriname ($1 million) and Barbados ($811k) make up 6 and 4 percent of total program funding respectively, as PEPFAR aligns funding with burden, consolidates successes, and prepares to transition activities to the host governments in these countries. In year two of ROP 17, funding for Jamaica will increase to 75% or more of the portfolio, and no additional funds will be allocated to Barbados.

ROP 17 Budget Allocation by Country and Number of PLHIV

	ROP 16 Total Country Amounts	ROP 17 Year 1	% of program Budget	ROP 17 Year 2	% of Program Budget	Number of PLHIV	% of PLHIV Burden for Regional program	New *Infections	ART Coverage	Mortality**
Jamaica	$7,695,000	$12,200,704	65%	[REDACTED]		29,000	47%	1,700	37% (9,370)	1,200
Guyana	$5,158,407	$2,502,456	13%	[REDACTED]		7,800	13%	<500	58% (4,551)	<200
Trinidad and Tobago	$3,150,223	$1,578,773	8%	[REDACTED]		11,000	18%	703	61% (6,720)	<500
Suriname	$2,396,125	$955,164	5%	[REDACTED]		4,000	5%	500	29% (1,148)	101
Barbados	$1,137,370	$691,767	4%	[REDACTED]		2,500	4%	63	49% (1,236)	45
Bahamas	$1,204,770	0	0	[REDACTED]		8,004	13%		29% (2,307)	<1,000
Total (Program Budget only)	$20,741,895	$18,844,680	100%	[REDACTED]		62,304	100%			

*Data years for New Infections: Jamaica (2016), Guyana (2016), Trinidad and Tobago (2015), Suriname (2013), Barbados (2014)
**Data years for Mortality: Jamaica (2016), Guyana (2016), Trinidad and Tobago (2016), Suriname (2013), Barbados (2014), Bahamas (2015)

2.5 Stakeholder engagement

The CRP consulted partners through the solicitation of written inputs for the ROP 17 gap analysis and choice of strategic priorities, followed by in-person stakeholder meetings where feasible, and conference calls. Partners received information on FY 16 Q4 results, the new STAR process and timelines, budget changes, and anticipated transition timeframes. Discussions focused on national priorities, barriers to reaching 90-90-90, and the specific needs of KP. The PEPFAR team also discussed ways in which the USG can support sustainability in each country.

An initial draft of the Strategic Direction Summary was shared with stakeholders along with the request to provide feedback prior to submission to OGAC. Given the shortened planning period, the CRP team anticipates the need for additional consultations and integrating feedback from stakeholders after submission, as well as informing partners of revisions to the initial budget levels and timeframes. The Caribbean team will continue to actively engage stakeholders in the ROP 17 planning process, including MOH representatives, National AIDS Program Managers, CSOs, Global Fund, and regional partners, such as UNAIDS, PAHO and PANCAP. Throughout the year, meetings will take place to prepare country-specific work plans, assess implementation progress, review quarterly results, and respond to stakeholder concerns.

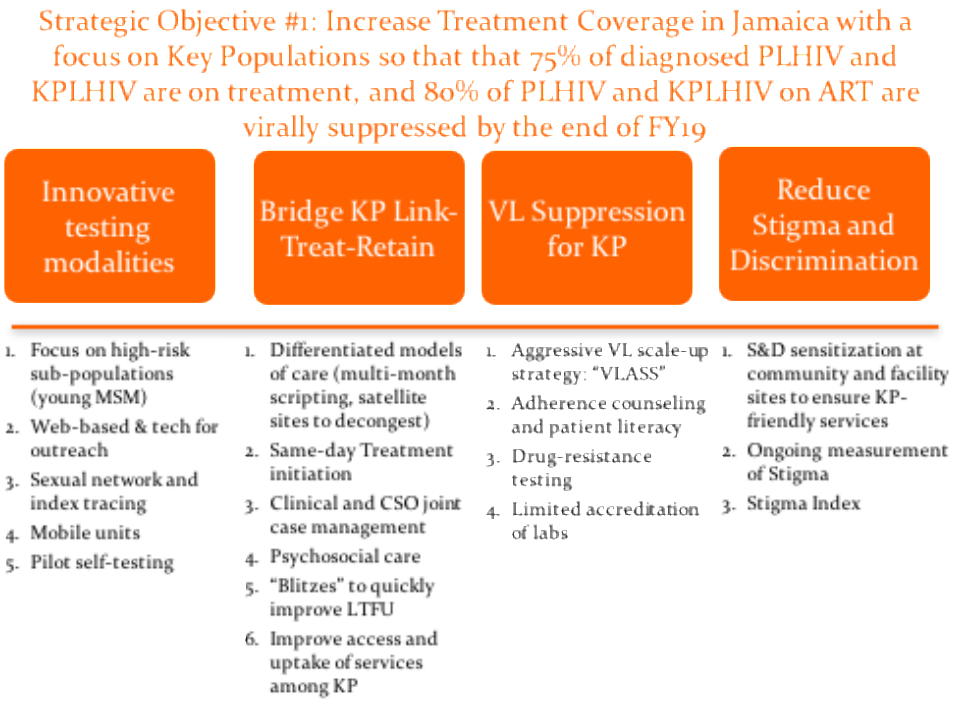
3.0 Program Activities for Epidemic Control

3.1 Description of Strategic Outcomes

3.1.1.: Strategic Outcome #1: Increase Treatment coverage in Jamaica with a focus on Key Populations so that 75% of diagnosed PLHIV and KPLHIV are on treatment and 80% of PLHIV and KPLHIV on ART achieve viral suppression by the end of FY 19.

In all five priority countries, the PEPFAR CRP will support activities along the continuum of care, with a focus on improving treatment coverage and retention. However, given the epidemiological profile and significant PLHIV burden in Jamaica, an increasing percentage of CRP investments will be used there, to support a wider scope of activities than in the other four focus countries, and specifically ensure that 75% of diagnosed PLHIV and KPLHIV are on treatment and 80% pf PLHIV and KPLHIV are virally suppressed by the end of FY19.

In Barbados, Guyana, Trinidad and Tobago and Suriname, PEPFAR CRP interventions will focus on high impact, short-term activities, that will identify, start and maintain KPLHIV and PLHIV patients on treatment within the timeframe remaining for CRP support. Specific discussions with each country during transition planning will prioritize strategies to ensure that all patients continue to receive quality, timely, KP-friendly and stigma-free services.



<u>Targeted Testing and Prevention:</u> To identify new HIV positive KP, the CRP will carefully target limited investments in all five countries to address the first 90 through testing modalities that reach into the sexual networks of high-risk sub-populations (e.g., MSM); deploying index tracing strategies; and implementing web-based and technology outreach.

Specifically in Jamaica, the CRP will use additional resources to support the MOH with conducting a pilot of self-testing in collaboration with private pharmacies, as a promising means of ensuring more confidential test results, and mitigating the impact of stigma on the first 90. Provider initiated testing and counselling (PICT) are planned at sites where patients access services for Sexually Transmitted Infections and accident & emergency care, both of which have shown higher positivity yields in Jamaica. Also in Jamaica, mobile testing efforts will be deployed to reach unidentified KP in their communities and during off-hours. Through an innovative mentorship initiative, PICT will be strengthened to identify KP clients experiencing GBV and through a PrEP pilot with private practitioners.

In all countries, hidden and non-identifying MSM will be reached through men's health interventions that promote testing in targeted communities. Where MOHs are open to piloting the provision of PrEP among key populations, the PEPFAR CRP will support CBOs to conduct PrEP literacy, preparedness assessments, and education with their communities. Eligible clients will receive support to access PrEP services and adherence. CBOs will provide first-line support to their clients to counsel and refer those experiencing GBV or Intimate Partner Violence (IPV) to appropriate social support, legal aid, and law enforcement agencies, as part of the CRP work to protect the rights and safety of the most vulnerable KPs.

The PEPFAR CRP will continue to improve access and quality of HIV rapid testing in support of SO#1 through implementation of the innovative HIV Rapid Testing Quality Improvement Initiative (RTQII). However, USG support for this initiative along with all testing activities, will be scaled-down in alignment with CRP transition timelines in Barbados (1 year), Suriname and Trinidad and Tobago (2 years) and Guyana (3 years), and handed over to national governments.

Bridge KP : Link Treat Retain: For the 2nd 90 of the cascade, the CRP will address treatment coverage and adherence gaps in each of the five focus countries, with a strong emphasis placed on Jamaica. Most resources and investment will focus on implementing key policy changes services to increase treatment coverage and retention among KPLHIV and PLHIV using differentiated models of care. PEPFAR will emphasize working with the MOH in each country to implement 6-12 month scripting, and to extend services to satellite sites for stable patients. In Jamaica, the CRP is considering options with the MOH to expand treatment services, including where to establish satellite sites and mobile clinics to most effectively handle the overflow from high-burden sites, and extend more convenient access to patients in high burden parishes.

A new strategy for ROP 17 is the use of 'loss to follow-up blitzes' that will return patients to care using a team of Case Managers, Social Workers, PLHIV Leaders, Adherence Counsellors, Community Peer Navigators and Contact Workers. This high yield approach is already demonstrating results in Jamaica, and includes intensified contact tracing as part of a new emphasis on index-case tracing. Adherence Counsellors will receive updated training to more effectively address adherence issues, and PLHIV Leaders who were trained in a comprehensive PHDP curriculum will be deployed to facilitate support groups and communication between the patient and clinical Treatment Teams. The 'blitzes' are short term, targeted investments in additional staff or training by the USG, that can have high yielding results both in Jamaica, as well as the four other focus countries.

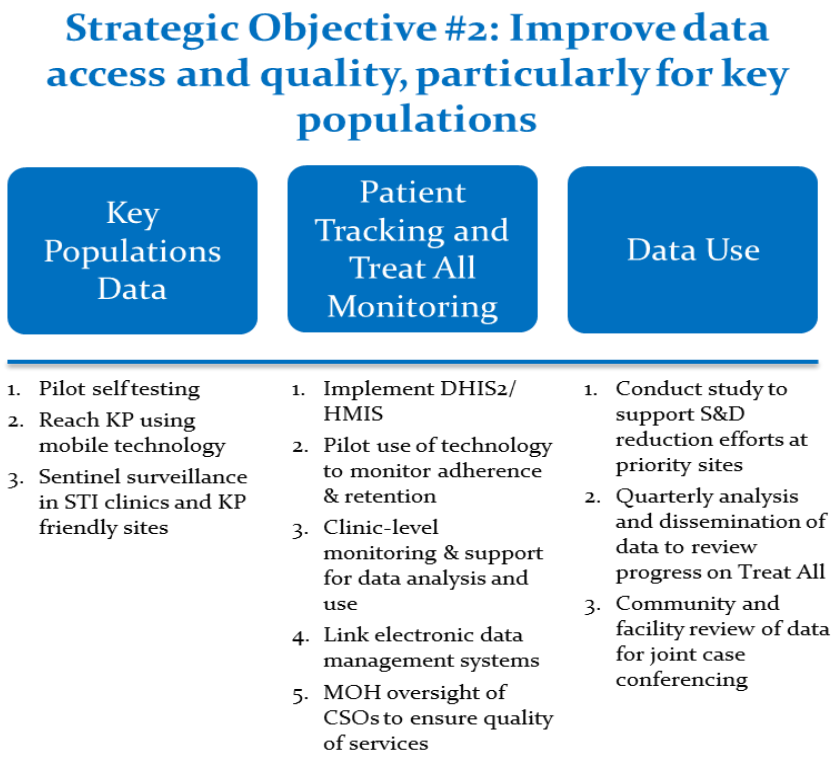
Viral Load Suppression for KP: The ROP 17 strategy will address the 3rd 90, by building on the past years' laboratory achievements with a focus on VL scale-up and coverage through the implementation of the VL Active Scale-Up Strategy (VLASS). This strategy will be fully implemented in Jamaica, with key components addressed in each of the four other countries based on identified

needs. VLASS aims to address gaps at the laboratory and treatment sites, and consists of a package of coordinated activities including a site assessment using a VL tool, support for a VL activity Coordinator, procurement of consumables, continuous QI (visit to care and treatment sites, equipment maintenance, reagent forecasting, monitoring of turnaround times at laboratory and treatment sites), electronic reporting, and linking of laboratory data with treatment data.

Technical assistance will ensure a full functioning of the existing HIV genotype testing platforms and support for the implementation of HIV drug resistance (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. To ensure sustainability, there will be targeted training of laboratory staff in HIV drug resistance, molecular testing for expansion of VL, and opportunistic infections including TB diagnosis.

Reduce Stigma and Discrimination: PEPFAR recognizes that S&D poses the most significant barrier to achieving epidemic control in Jamaica and the Caribbean. The program's comprehensive S&D reduction strategy is to intensify interventions to address internal and intra-community S&D among MSM. In both community and facility settings, PEPFAR will work with local actors to address S&D and ensure KP-friendly services are provided in an environment that upholds the rights of HIV positive clients, while their specific needs are met. Community Based Organizations will also conduct sexual orientation and gender identity (SOGI) and HIV/KP S&D reduction trainings and mentoring with health providers and auxiliary staff to address a key barrier to KP uptake and retention in services. Progress on addressing S&D will be measured using Stigma Index tools.

3.1.2: Strategic Outcome #2: Improve data access and quality, particularly for key populations



ROP 17 investments in strategic information will improve the quality and availability of data to monitor progress towards epidemic control. The focus will be improving data from routine health systems to support the measurement of SO#1. The activities within this objective fall under three areas: 1) Improving the quality of key population specific data, 2) Patient Tracking and Treat All Monitoring, 3) Data use at local and national levels.

The majority of strategic information investments will benefit Jamaica (>70% of the SI budget). Targeted support will also be provided to Guyana and Trinidad. Limited support will be provided to Barbados to establish sentinel

surveillance during FY18 only and PEPFAR supported staff in Barbados will transition to the MOH payroll. SI investments in Guyana and Trinidad will decline in Year 2 as additional funding is shifted to Jamaica. No ROP17 funding is proposed for the Bahamas and Suriname. To facilitate timely availability of data for program planning, PEPFAR will work with MOHs to support quarterly and annual program reviews with the Pan American Health Organization and the Caribbean Public Health Agency.

Key Populations Data: Routine reporting of KP specific data is hampered by poor completeness of risk factor data. Projects to improve collection of KP and risk factor data via electronic and paper-based systems are underway in Trinidad, and innovative pilot projects to improve KP data collection are proposed at KP-friendly sites in Guyana. Additional investment is planned to establish sentinel surveillance sites in Jamaica, Trinidad and Barbados. This will include use of mobile technology to facilitate self-reporting of behavioral data by MSM and FSW. These investments will yield site level and subnational KP cascades, as well as support reporting of Global AIDS Monitoring indicators for KPs (e.g. HIV prevalence, condom use, HIV testing coverage).

Patient Tracking & Treat All Monitoring: High levels of medication adherence are required to achieve virological suppression. Monitoring treatment adherence and patient outcomes is being prioritized to ensure clinicians have timely data to assist patients with achieving viral suppression. Disparate information systems and the absence of national unique identifier codes make monitoring the continuum of care challenging. PEPFAR currently provides TA link databases across clinic, laboratory, pharmacy and community outreach settings. In ROP17, these Master Patient Indexes will be operational at site level to provide patient level clinical and laboratory data. Use of these data to identify defaulters, poor adherence and refer patients for support is prioritized in ROP17. Investments in Jamaica will allow for routine collection of patient and system level data to identify and address barriers impacting retention and medication adherence. This will support activities in SO#1 which aim to improve the proportion of ART patients who achieve viral suppression.

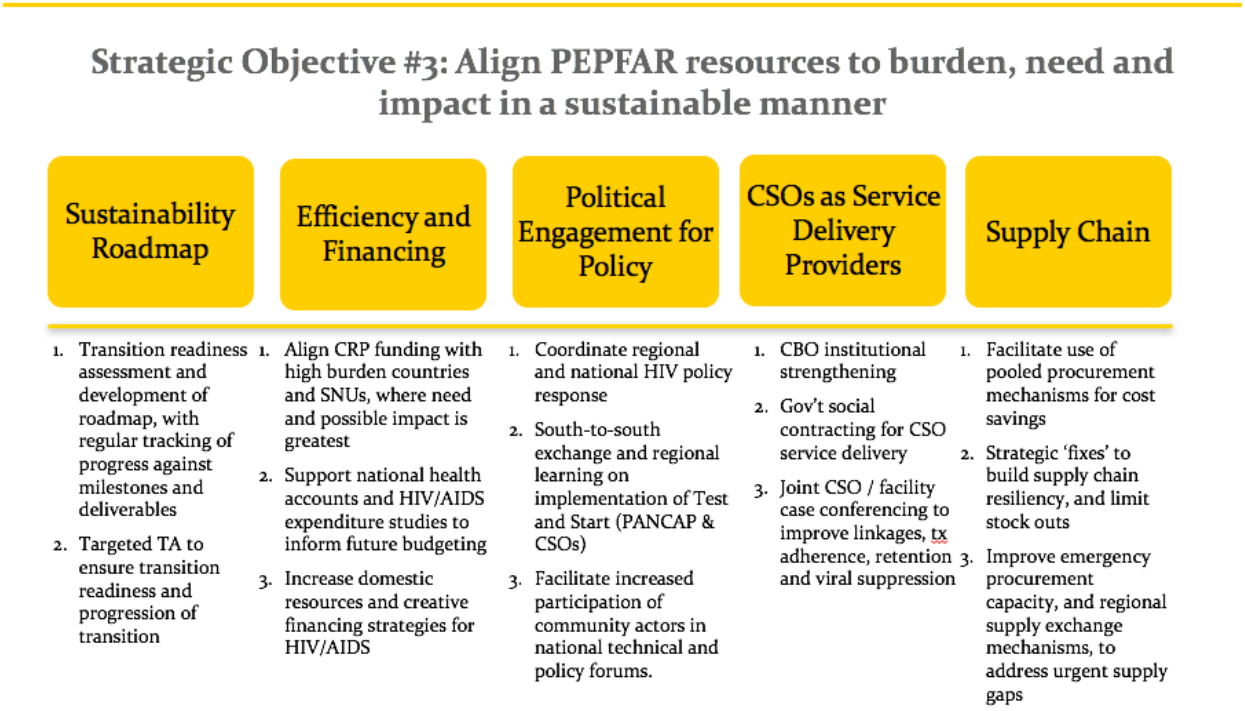
Data Use at Site, Sub-National and National Levels: Timely review and use of national and site level data will be prioritized in ROP17. Stigma and discrimination assessments are planned for Jamaica, to develop evidence based interventions and reduce barriers to healthcare uptake. In FY18, partners will provide site level TA in collection, analysis, and quarterly dissemination of quality HIV data, including use of data to develop HIV clinical cascades. These activities will support national planning and decision-making to ensure both external and domestic resources focus on activities that will achieve the greatest impact.

For SI investments to be sustained, donor supported activities must be transitioned to national budgets. The PEPFAR CRP will provide TA to MoHs to demonstrate the value of domestic investment in strategic information. These efforts will focus on ensuring that PEPFAR's support for staffing, systems investments and routine data reporting are transitioned.

3.1.3: Strategic Outcome #3: Align PEPFAR resources to burden, need and impact in a sustainable manner

Strategic Outcome #3 reflects the CRP focus on funding Jamaica's HIV/AIDS "Treat All" activities while simultaneously working with partner governments from Guyana, Suriname, Trinidad and Barbados to prepare and execute the transition from PEPFAR support. The CRP will invest approximately $3 million dollars, or 20% of the 2017 ROP budget on five priority areas including: developing sustainability and transition roadmaps; improving efficiency of budget allocations and

creative financing for HIVAIDS; facilitating political engagement for policy change; supporting civil society organizations as service delivery providers; and reinforcing supply chain systems.



Support Sustainability Roadmap and Transition Planning: The PEPFAR CRP team is making choices to strategically address the HIV/AIDS epidemic in the region, by investing resources in higher burden countries and SNUs. This requires progressively transitioning support out of lower-burden countries. To help countries prepare for decreased donor funding, PEPFAR will work with the Global Fund to support transition readiness assessments, particularly in Guyana, Suriname and Jamaica, which will be used to develop sustainability plans over the next one to two years. To build sustainability, PEPFAR will also support knowledge and lessons sharing, regional learning, and policy advocacy exchange forums through PANCAP and PAHO. Part of the strategy to consolidate and solidify gains will include efforts to install and reinforce formal mechanisms for NGOs to receive funding from host governments or other external donors, to continue to conduct critical community-based work.

Promote Efficiency in Financing: The CRP will build on its costing and financing work to prepare partner governments for transition within specific timeframes. Assistance will focus on maximizing the efficiency and impact of existing resources, mobilizing additional domestic resources, aligning domestic financing incentives for sustainable financing of KP CSOs, and establishing benchmarks to guide transition. The CRP will continue to work with partner governments to efficiently manage their national HIV/AIDS responses through establishing health accounts and increasing domestic resources for KP PLHIV service delivery at community and facility levels for Test and Start. Specifically, the CRP will assist governments to explore alternative and innovative financing strategies and to leverage the private sector for capital assets, cost optimization, technology and social services. This includes strengthening or establishing formal fiduciary mechanisms through which NGO/CBO entities receive funding directly from public and private sources. The importance of such a strategy cannot be underestimated in the Caribbean where high levels

of entrenched S&D does not facilitate sustainable financing of programs that ensure service and psychosocial support access by the KP most impacted by the epidemic.

Political Engagement for Policy: CRPs is working with governments, PAHO, the Global Fund and UNAIDS to assess the changes needed in policy and practice to accelerate implementation of Treat All. Costing and other studies are revealing the implications of Treat All on service demands, drug and commodity requirements and new roles/responsibilities for public and private sector providers, including critical actors such as KP CSOs in getting to 90-90-90 by 2020. The CRP will build on this foundation with support for essential policy reform and by facilitating the sharing of successful reform models and lessons learned across the region. A key strategy will be to help countries implement differentiated models of care across the treatment cascade and to further engage populations most impacted by the epidemic to extend appropriate and KP-friendly service delivery models beyond facilities into communities for increased impact. An essential outcome of CRPs work will be policy reform that facilitates earlier diagnosis and treatment, scale up of new high-impact service delivery models at community and facility levels and improved adherence and retention for virologic suppression.

A second approach CRP will use to accelerate implementation of Treat All will be support for south-to-south learning and exchange between Pan Caribbean Partnerships Against HIV/AIDS (PANCAP) members and KP CSOs. The CRP will build on successes achieved to date, by leveraging PANCAP's access to CARICOM political fora, including the CARICOM Heads of Government meetings, to secure regional cooperation from the highest-levels of government to collectively support ending AIDS in the Caribbean. The CRP will harness the momentum gained last year which secured the commitment of CARICOM Ministers of Health to prioritize cooperation in HIV/AIDS fiduciary efficiency gains, private sector solutions and accelerated learning from global examples of sustainable financing strategies. The CRP will similarly continue to support cooperation between National AIDS Program Managers and KP CSOs to synthesize and apply best practices and lessons learned for high impact and KP inclusive HIV/AIDS service delivery models that improve results across the cascade and accelerate implementation of Treat All.

CSOs as Service Delivery Providers: The CRP, through SO#1, is financing KP CSOs to assume new roles and greater responsibility for the national response in Jamaica and Guyana. In countries preparing for transition more rapidly from PEPFAR support, the CRP is focusing support through SO#3, on skills transfer and institutional strengthening of KP CSOs to facilitate sustainable engagement of these critical actors in achieving the 90-90-90 goal by 2020. This will involve development and implementation of specific technical capacity building plans to strengthen CSO ability to deliver high-quality and cost-efficient community services across the treatment cascade. The CRP will also support CSOs to build and maintain partnerships with facility service providers for joint case-management of KPLHIV and PLHIV, and to support their constituents' psychosocial and other support needs for successful adherence, retention and ultimately achievement d maintenance of viral suppression.

The CRP will work with partner governments and KP CSOs to identify and map these new roles and responsibilities into an institutional framework that will inform requisite policy reform for sustainable and expanded engagement in the HIV/AIDS response. Organizational strengthening will ensure that CSO improve business processes to increase public and other resources available to effectively account for and manage these resources for long-term viability as HIV/AIDS service providers. These investments in KP CSOs skills building and institutional systems will facilitate successful program management, improve effectiveness in responding to the main drivers of the

Caribbean HIV/AIDS epidemic and help to build trusted relationships needed to influence policy, practice and domestic resource allocations into the future

Supply Chain Support: The CRP will build upon past investments in procurement and supply chain management, and work with PAHO and the Global Fund to help countries achieve procurement efficiencies and facilitate the use of available pooled procurement mechanisms to obtain cost-savings. PEPFAR will invest in targeted TA and systems "fixes" to build the resiliency of SCM systems with a focus on minimizing stock-outs of test kits, ARVs and VL reagents. Targeted TA will establish mechanisms through which to source emergency procurements and move critical drugs/supplies within/ and across countries to address the most pressing supply gaps. Technical assistance will also drive procurement and supply management costs down while enabling existing systems to effectively absorb and distribute the requisite increases in commodities for Treat All.

3.2 Site level Investments

The PEPFAR CRP's site level support aims to demonstrate the success of innovative approaches with a focus on KP sexual health needs, including those who do not identify as KP that can be documented, replicated, scaled up and transitioned to partner governments - acting as 'catalytic models. The PEPFAR CRP is unique in its ability to add value by offering specific funding and TA to test proven models for layering KP-focused clinical services onto existing services (e.g. VICITS model). Activities are designed to influence how national AIDS programs expand access and use of HIV and AIDS services for more sustainable epidemic control. Selected PEPFAR priority sites are in high burden geographic areas that experience high patient volume. Site-level successes in these locations will have a direct influence on the governments' ability to establish the requisite policies, practices and financial investments necessary to reach the UNAIDS 90-90-90 targets by 2020.

Introducing the latest technology and best practices (e.g. webinars, quality improvement (QI) processes, and KP mentorships) will help to reduce barriers such as S&D among health care workers. This facility work is complemented by community-focused demand generation through improved HIV literacy, linkages to testing and treatment, peer support, and navigation to clinical services for improved uptake and retention. The CRP will also work to strengthen site-level data collection and information systems, procurement and supply chain logistics, and laboratory services.

The CRP will ensure that lessons learned at the site level are integrated into the institutional framework of countries so they can continue beyond PEPFAR support. In ROP 17, the CRP will focus on the institutionalization of QI systems and procedures, and ensure that QI plans are country context specific. The systems will account for the maturity of the site level QI teams, existing policies and programs, and needs determined by MOHs.

Facility-Level Strategies

PEPFAR CRP's strategic direction for facility-level support will increase treatment coverage and retention among KPLHIV/PLHIV. The team's approach will 1) increase access to facility-level PCT services among KPs; 2) improve retention (and medication adherence) among PLHIV/KPLHIV, and 3) strengthen the scale up of VL testing and counseling. To achieve these objectives, PCT strategies will support high quality SI, HSS, laboratory strengthening, and efforts to reduce S&D at priority care and treatment sites. Facility sites will be able to generate KP cascades to further define and develop national program responses in the out years. Increased site monitoring and assis-

tance to improve reporting at service delivery sites, and the integration of point of care testing at select HTC sites, will complement the prevention package of services. In addition, laboratory TA will support VL testing for ART uptake and strengthened capacity for HIV drug resistance.

Community Level Interventions
Available data indicate that approximately 25 percent of MSM have had a sexual relationship with a woman in the last year, (2014 regional CARIMIS survey), and do not identify as MSM, and are therefore extremely hard to reach. In general, males are less frequent users of public health services and are less likely than females to receive HIV-related education, information, or testing as part of a wellness or other health visits. For these reasons, community-level support and engagement, and active work within and among the social and sexual networks of men and young men is critical to reaching MSM and ensuring their access to prevention, care, and treatment services, as these may represent the majority of undiagnosed PLHIV. Support services will need to include community service providers who can also effectively reach, refer, and support non-identifying KP. Based on evidence of higher HIV rates and risky behavior between younger KP, as well as feedback from host governments indicating the need for a focus on youth, PEPFAR CRP's overall prevention and testing approach will intensify its focus on the most at risk and younger KP.

Community-Facility Collaboration Framework (CFCF)
A key component of the work of CBOs in each country is their collaboration with treatment sites to improve early diagnosis of HIV infection, early enrollment, and improved retention in HIV treatment and care, and enhanced medication adherence for clients. PEPFAR support for CBOs will emphasize strengthened collaboration with clinical facilities through regular coordination and case management meetings, placement of trained peer navigators and/or linkage coordinators in and around sites (where needed), and KP alliances to reduce barriers and increase use of HIV services. CBOs will support KPLHIV to manage their own care and treatment to attain and sustain viral suppression. Having a patient-centered approach historically improved the quality of interventions through enhanced care coordination between facilities and CBOs. The collaborative approach at these various levels (interagency; communities-facilities) will strengthen the capacity of CBOs to implement quality KP services.

3.3 Critical above-site systems investments for achieving sustained epidemic control

Above-site investments are a critical element of the PEPFAR CRP strategy to support sustainability, and are priority for the PEPFAR CRP as they permit targeted investments to have national and regional level impact. Above-site activities have been selected to address identified gaps and barriers to sustainable epidemic control,(included in activities to address SO #1, 2 and 3), and are in the areas of: Health Financing, Institutional Capacity Building, Laboratory Systems, Strategic Information Systems, and Supply Chain Management.

Institutional capacity building and policy change: PEPFAR CRP will prioritize the ongoing development and adaptation of national guidelines, policies and frameworks that promote Test and Start and assist with policy change, to ensure countries are implementing differentiated service delivery models, that will alleviate overburdened sites, help improve ART adherence and retention, and lead to cost savings and more efficient use of limited resources.

Through ROP 17 activities, the CRP will support enabling environments for key populations, which includes the implementation of non-stigma and discrimination policies towards KP at health care facilities, as well as in communities. The CRP will work with PANCAP to use the Stigma Index to measure efforts to reduce stigma and discrimination against KPs, and continue to

work with key decision makers as champions to promote the reduction of S&D in the region.

As donor funding decreases, PEPFAR CRP will support countries in the development and monitoring of national and regional strategic plans, as well as sustainability/transition plans that include innovative financing mechanisms. PEPFAR CRP will build the capacity of CSOs to participate in technical and decision-making forums, to advocate for ongoing funding of critical community-based activities, as part of the development of national and regional sustainability strategies.

Health Financing: As described in SO#3, PEPFAR CRP will support the development of funding models that are sustainable for Test and Start and will continue to work to engage Ministries of Finance and the private sector to explore creative strategies to mobilize additional domestic and external resources to sustain the HIV response beyond PEPFAR support. PEPFAR will also work with civil society organizations to develop plans for funding critical activities in the community, and to support their long-term sustainability, including the establishment of 'social contracting' mechanisms to allow host governments to fund CSOs for service provision.

Laboratory Systems Strengthening: As described in SO#1, PEPFAR CRP will support National Reference Laboratories to scale up VL testing, monitor HIV drug resistance and provide continuous quality assurance in laboratories providing critical diagnostics support throughout the continuum of care. The ROP 17 strategy is to build on the past years' laboratory achievements (including the accreditation of three regional laboratories) with a focus on VL scale-up and coverage through the implementation of the VL Active Scale-Up Strategy (VLASS). (detailed activities referenced in FOIT).

Strategic Information Systems Strengthening: As described in SO#2, PEPFAR CRP will support national monitoring of the HIV clinical cascade with a focus on building capacity to collect information specific to KP from sentinel surveillance data collected through VICITS. The objective will be to identify newly infected individuals and prioritize them for index testing and partner notification, with an expectation of increased yield. PEPFAR CRP will work with national and regional stakeholders to measure stigma and discrimination efforts, and to use data regularly for decision-making. This will include strengthening CSOs to understand, analyze and use HIV data for programming and advocacy.

Supply Chain Management Strengthening: As described in SO#3, PEPFAR CRP will provide targeted technical assistance to address key gaps in the supply chain by updating or developing regulations, strengthening mechanisms to procure high quality, lower cost commodities, and reinforcing national logistics management systems to reduce stock-outs. PEPFAR CRP support will improve logistical capacity to ensure uninterrupted supplies of HIV commodities in at health facilities as countries implement Test and Start and scale up VL testing. PEPFAR CRP will also continue to support the region by facilitating joint negotiation for procurement of essential HIV commodities at a lower cost by working with the PAHO and the Global Fund pooled mechanisms.

Above-site activities are complementary and synergistic with site level work, and PEPFAR CRP will leverages HSS investments to engage with stakeholders to influence policy discussions on how to achieve and sustain epidemic control in the Caribbean.

3.4: Expected High Level Achievements and Targets

Jamaica is categorized as a scale-up aggressive operating unit. Presently, 85% of PLHIV have been diagnosed with national ART coverage at the end of 2016 at 38%; and of those on treatment, 55%

were virally suppressed. By the end of FY 18, through the initiation of pre-ART patients and the return of lost patients, PEPFAR support aims to contribute to the national scale-up of ART coverage to 48%.

Through tailored activities in FY 18 and FY 19, PEPFAR will increase patient adherence to increase the number of patients who are virally suppressed. The ROP 17 investments will be used to intensify activities across that Continuum of Prevention, Care and Treatment to achieve viral suppression for 70% of PLHIV on treatment in FY 18 and 80% in FY 19. In FY 18, 14,650 PLHIV will be on treatment; 13,185 (90% of those currently on treatment) would have a VL test done. Of those on treatment, 10,255 or 70% would be virally suppressed. Support will include technical assistance to 10 parishes which will account for approximately 94% of persons living with HIV through 16 treatment facilities which account for 85% of persons.

Guyana at the end of 2015 had a national ART coverage of 58% of which only 12 % of those on treatment were virally suppressed due to the unavailability of consistent viral testing during 2015. Region 4 accounts for approximately 60% of the PLHIV population and 79% of persons currently on treatment, and is the only SNU selected for PPFAR support in Guyana and is categorized as scale-up: saturation. By the end of FY 18 PEPFAR aims to support the scale up ART coverage in Region 4 to 80%, with at least 80% viral suppression coverage among patients on treatment.

FY 18 Targets

Caribbean Region		SNU Prioritizations				
		Scale-Up: Saturation	Scale-Up: Aggressive	Sustained	Centrally Supported	Total *
HTC_TST	DSD	5,376	6,269	-	-	11,645
	TA	-	-	-	-	-
	Total	**5,376**	**6,269**	**-**	**-**	**11,645**
HTC_TST_POS	DSD	179	753	-	-	932
	TA	-	-	-	-	-
	Total	**179**	**753**	**-**	**-**	**932**
TX_NEW	DSD	818	-	-	-	818
	TA	-	2,550	112	65	2,727
	Total	**818**	**2,550**	**112**	**65**	**3,545**
TX_CURR	DSD	3,636	-	-	-	3,636
	TA	-	14,650	-	-	14,650
	Total	**3,636**	**14,650**	**-**	**-**	**18,286**
TX_RET	DSD	587	-	-	-	587
	TA	-	-	-	-	-
	Total	**587**	**-**	**-**	**-**	**587**
TX_PVLS	DSD	2,776	-	-	-	2,776
	TA	-	-	-	-	-
	Total	**2,776**	**-**	**-**	**-**	**2,776**
KP_PREV	DSD	3,268	5,142	-	-	8,410
	TA	-	-	-	-	-
	Total	**3,268**	**5,142**	**-**	**-**	**8,410**
HRH_PRE	DSD	-	-	-	-	-
	TA	-	-	-	-	-
	Total	**-**	**6**	**5**	**-**	**11**

may be greater than the sum of categories due to activities outside of the SNU prioritization areas outline

4.0 USG Management, Operations, and Staffing Plan to Achieve Goals

The PEPFAR CRP has a broad mix of technical, financial, and administrative staff distributed across agencies to implement core activities. This distribution was re-assessed based on the three new strategic objectives, and the new focus on Jamaica. Resources align to disease burden and priority countries as the regional programs move towards the transition to host nations of PEPFAR programs.

Caribbean Regional Program Coordinator's Office: There are five previously-approved full-time positions in the Coordination office (four in Barbados, one in Guyana, one in Jamaica). Given the focus on Jamaica, the Regional PEPFAR Coordinator position will move to Jamaica in summer 2017, but will continue to represent the program throughout the region. Hiring will begin for a Strategic Information Advisor in Jamaica to ensure coordination of reporting, data review and use, both interagency as well as with external stakeholders. The current Guyana SI Advisor is on leave, and plans are for the incumbent to continue part time upon return in fall 2017. The Coordinator's office will re-hire, on a time limited basis, for the currently vacant Program Management Specialist position in Barbados, which will include responsibilities to assist with transition planning outside of Jamaica, and be supported by the administrative assistant in Barbados. For FY17, the coordination office positions hired through USAID (all but the Coordinator) will be funded using applied pipeline.

Centers for Disease Control and Prevention: CDC staff work directly with MOHs and other partners to implement core activities along the HIV continuum of care. The Office is staffed by a Regional Director, Deputy Director and four teams: Strategic Information (SI), Management & Operations (M&O), Prevention Care and Treatment, and Laboratory. The prevention team supports the implementation of activities that will increase treatment coverage and improve access to quality services for KPs. The laboratory team provides TA to countries and partners to improve the quality and availability of diagnostic and monitoring services and systems to support core HIV prevention, treatment, and care interventions. The SI team provides direct TA to MOHs and partners to improve the availability and use of high quality data in the region. The M&O team, led by the Deputy Director, oversees the day-to-day management and operations of the CDC Office. Over the course of FY18, CDC will progressively shift the regional office from Barbados to Jamaica, to align human resources with the increased regional focus on Jamaica.

USAID Eastern and Southern Caribbean (USAID/ESC)*:* USAID/Eastern and Southern Caribbean (ESC) is not proposing any new positions in ROP 17. In ROP 17, USAID/ESC has decreased its management and operations (M&O) budget in response to the overall decrease in the Caribbean Regional PEPFAR Program budget. This decrease was achieved by eliminating a vacant Program Assistant position, a vacant Supply Chain and Logistics Project Management Specialist, and two vacant Senior Technical Advisors previously planned to be based in Trinidad and Tobago and Suriname.

USAID/Jamaica*:* The Staffing Plan for USAID Jamaica includes five full time positions in FY17. The proposed positions are a: 1) USPSC Senior HIV/AIDS Technical Advisor, 2) Local Hire Senior Project Management Specialist who manages the Government-To-Government agreement with the MOH and a crosscutting (GBV, SD and PHDP) policy development and capacity building

mechanism, 3) Local Hire Project Management Specialist who manages SI/SIMS activities and prevention and care capacity building mechanism, 4) Local Hire Monitoring and Evaluation Specialist concentrating on MER, SID and EA reporting, including providing technical assistance to partners and 5) Local Hire HIV Treatment Specialist providing treatment and care technical assistance to the MOH with implementing Test and Start. In addition, the team will be led by the new Health and Environment Office Chief, who will split her time between the two sectors. The Jamaica team has requested a USDH from USAID HQ in summer 2018, which is TBD.

Department of Defense: The U.S. DoD has two locally hired program staff who manage the key and priority populations programs regionally. There are no staffing changes expected this year, and DoD will be using pipeline funds to support the staffing positions.

Health Resources and Services Administration (HRSA): The HRSA program manages its programs from Headquarters (Rockville, MD) and does not have field staff in the Caribbean. Currently, one HRSA staff member participates from headquarters in the CRP and her salary is paid out of headquarters' funds, so there is no CODB funding request for HRSA.

APPENDIX A

A.1 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
US $1,896,534	**US $24,457,941**	**US $26,354,475**

Table A.1.1 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
HVOP	Other Sexual Prevention	$1,477,405
HVCT	Counseling and Testing	$1,005,905
HBHC	Adult Care and Support	$4,313,798
PDCS	Pediatric Care and Support	$53,653
HTXS	Adult Treatment	$5,353,836
PDTX	Pediatric Treatment	$124,497
HLAB	Lab	$1,780,500
HVSI	Strategic Information	$2,026,560
OHSS	Health Systems Strengthening	$2,708,526
HVMS	Management and Operations	$7,509,795
TOTAL		**$26,354,475**

A.2 Costing / Budgeting Analysis and Justification

The PEPFAR Caribbean team received expenditure analysis results that were reviewed jointly during the ROP 17 Regional Retreat, and served as a basis for costing discussions throughout the ROP development process. Each TWG and agency analyzed unit expenditures, where appropriate and applicable, and reviewed data using the data navigation tools, to identify outliers and determine a foundation from which to begin activity-level budgeting.

The team worked closely with the Caribbean EA Advisor to determine the best unit expenditures (UEs) for specific mechanisms, based on the FY 16 EA data and expected changes to the programs. Based on in-depth reviews with each activity manager and the Caribbean EA Advisor for each implementing partner, it was decided that EA data would be challenging to apply for effective budgeting due to major programmatic shifts in program scope between FY 16 and FY 17 in-

cluding a stronger technical focus on increasing yield, intensifying linkage to treatment, and psychosocial support for adherence and retention with a focus on KP. As such, the CRP team often used lump sum budgeting based on traditional US government cost estimate tools and procedures and used EA data as one data point in several to finalize implementing partner and activity budgets. To determine the activity level budget, the team used FY 17 budget levels and spending data from Implementing Partner reports and the EA. The EA was used to determine proportionality of spend on various activity categories. Further adjustments were made to accommodate increased emphasis on activities what would impact treatment initiation, retention in care and viral suppression.

In a few instances where direct service delivery is being implemented, and results are more closely linked with investements, an in-depth analysis of the unit expenditures was utilized. An example from high volume treatment sites in Guyana can be found below with detailed calculations. The team also undertook a process to estimate the cost of laboratory support activities. During ROP 15 the PEPFAR CRP fully Accredited 3 labs (Jam, Bar, Bah) to international standards, and 3 others attained partial Accreditation. Based on the EA 16 report for the Lab Implementing partner, a unit expenditure for Laboratory Strengthening activities was calculated for Jamaica, Suriname, Trinidad and Barbados (Column E). This cost was multiplied by the proposed amount of sites/activities planned for ROP 17 to determine an estimated funding allocation needed to provide further Lab strengthening interventions including Vl scale up, Lab Quality improvement, RTQII, Proficiency testing and HIV Drug Resistance support (Column G). Based on these estimates a proposal is being made for ROP 17 support as identified in column H & I. The total allocation for Barbados is higher than the calculated estimate because the MOH provides regional referral services for VL testing. This support will be transitioned to the MOH by the end of the 2 year ROP. The amounts proposed in column H are for the Implementing partner and column I consist of the amounts allocated to the MOH. When totaled they give the full ROP 17 proposal per country.

A	B	C	D	E	F	G	H	I
Country	EA reported lab strengthening and Accreditation expenditure	EA reported total Lab expenditure	# Lab sites FY 16/FY 17	UE by Lab site	#Lab/PT sites for ROP 17	Calculated Lab Activities ROP 17	Proposed 1 yr ROP 17 Funding (IP)	Proposed 1 yr ROP 17 Funding (MOH)
Jamaica	$197,684.66	$286,894	3	$65,894.89	10	658,948	$525,500	$100,000
Suriname	$145,868.00	$182,335	3	$48,622.67	4	$194,490	$150,000	$18,000
Trinidad	$145, 868.00	$182,335	2	$72,934.00	5	$364,670	$230,000	$100,000
Barbados	$22,877.60	$28,597	1	$22,877.60	2	$45,755	$61,000	$60,000

Davis Memorial Hospital (PUSH Mech ID 18406) Care and Treatment Unit Rxpenditure Calculations			
Cost Category	**FY 15 Actual Expenditure**	**Adjustment - Expenditures not based on unit calculation**	**Adjusted Expenditure**
Personnel	154,802	(97,993)	56,809
Non-ARV Drugs & Reagents	6,682		6,682
Travel & Transport	874		874
Other Recurrent Expenditures	13,846		13,846
Program Mgmt	64,557	(64,557)	-
HSS	12,459		12,459
Strategic Information	75,976		75,976
Total Cost	**329,196**	**(162,550)**	**166,646**
Care & Treatment Split:			
Care	19,003.00		9,620
Treatment	310,193.00		157,026
Number of patients - Treatment	1,451		1,451
EA Unit Expenditure - Treatment	213.78		**108.22**

Davis Memorial Hospital (PUSH Mech. ID 18406) Testing and Counseling Unit Rxpenditure Calculation			
Cost Category	**FY 15 Actual Expenditure**	**Adjustment - Expenditures not based on unit calculation**	**Adjusted Expenditure**
Personnel	6,721		6,721
Travel	167		167
Program Mgmt	18,445	(8,607)	9,838
Total Cost	**25,333**		**16,726**
Number of tests	1,609		1,609
EA Unit Expenditure	15.74		**10.40**

Davis Memorial Hospital Clinic (PUSH Mech. ID 18406) ROP 17
Target Based Budget

Program area	EA Unit Expenditure	Adjusted Unit Expenditure	ROP 17 Target	Total
Treatment (Art)	213.78	108.22	1,745.00	188,842.77
Testing (HTC)	15.74	10.40	2,405.00	25,000.64
Sub-Total (based on Unit expenditure)				**213,843.41**
Lump sum - Salaries, benefits and other expenditures not based on Unit Expenditure				171,157.00
SI (Data collect and quality improvement)				25,000.00
Adduitional support for lost to follow up				15,000.00
Total ROP 17 Funding Need				**425,000.41**

ROP 17 Funding request by Budget Codes	
HBHC	50,000
HTXS	225,000
PDCS	30,000
PDTX	70,000
HVSI	25,000
HVCT	25,000
	425,000

APPENDIX B

Focused Outcome and Impact Table (FOIT), presented as a separate excel worksheet

Focused Outcome and Impact Table (FOIT) Overview
Caribbean Region

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Outcome #1: Increase Treatment coverage in Jamaica with a focus on Key Populations so that 75% of diagnosed PLHIV and KPLHIV are on treatment and 80% of PLHIV and KPLHIV on ART achieve viral suppression by the end of FY 19.							
Service delivery and quality improvement: key populations	Innovative prevention and testing services including social network tracing among KP and males in STI care	90% of KP prev annual target for Jamaica is reached by end of FY18	90% of KP prev annual target for Jamaica is reached by end of FY19	KP_PREV_DSD, HTC_TST_DSD			$1,015,000
Service delivery and quality improvement: key populations	Establish mobile clinic targeting KPs with a package of care and treatment services	One mobile clinic is fully staffed and functional and servicing KP	One mobile clinic is fully staffed and functional and servicing KP				$650,000
Service delivery and quality improvement: key populations	Demand creation for PCT services among KPs	4,916 KP's reached with preventive interventions	5,408 KP's reached with preventive interventions	KP_PREV_DSD			$300,000
Service delivery and quality improvement: key populations	Provide TA to develop a tool to address internal and intra-community S&D within the MSM community	Pilot interventions developed and implemented at one (1) site/priority location	Interventions refined and expanded at two (2) or more sites/priority locations				$75,000
Service delivery and quality improvement: key populations	Strengthen and expand care/treatment services, inluding the same day initiation, differentiated models of care	(1) 14,650 persons currently on ART (2) 5,993 persons receiving HTC Services (3) 2,500 persons newly placed on treatment	(1) 16,115 persons currently on ART (2) 6,592 persons receiving HTC Services (3) 2,750 persons newly placed on treatment	HTC_TST_DSD, TX_NEW_DSD, TX_CURR_DSD			$2,830,000
Service delivery and quality improvement: key populations	Scale up access to treatment and support serivces and referrals through Health and KP Peer Navigators in 12 sites	226 number of KPs reached with the minimum package of prevention services	249 number of KPs reached with the minimum package of prevention services	KP_PREV and DSD			$535,000
Service delivery and quality improvement: key populations	Private clinician driven PrEP pilot	PrEP pilot implemented	Report on PrEP pilot results developed	PREP_NEW			$50,000
Service delivery and quality improvement: key populations	Develop support services including IECs, web-based support, etc.for self-testing	Self-tested pilot implemented	Report on self-testing pilot results developed				$50,000
Systems: Health workforce (including CHWs)	Sensitization of HCW in the comprehensive package of services for KP with a focus on STI service providers	Four (4) Regional Health Authorities sensitized in the appropriate package(s) of prevention, care and/or treatment services	Four (4) Regional Health Authorities sensitized in the appropriate package(s) of prevention, care and/or treatment services				$275,000
Service delivery and quality improvement: key populations	Integrate two anal health service facilities and one transgender health service facility in Jamaica	Screening and treatment protocols developed, training provided to relevant HCWs	80% of patients at the two pilot sites screened for ano-genital health				$185,000
Service delivery and quality improvement: key populations	Support novel community-based, comprehensive HIV prevention services for younger KP and link KP-PLHIV.	(1) 3,268 (89%) of KP PLHIV are reached with the minimum package of HIV prevention services (2) 50% of KP PLHIV identified are successfully referred to treatment	(1) 3,595 (98%) of KP PLHIV are reached with the minimum package of HIV prevention services (2) 75% of KP PLHIV are referred to treatment	HTS_TST_DSD	Program Indicator	TX_LINKAGE	$330,000
Service delivery and quality improvement: key populations	Targeted activities to address HIV prevention, communication, and/or education among at-risk youth or KPs in each country	Between 1-2 grants are awarded in Barbados, 1-2 in Suriname and implemented within FY18	Between 1-5 grants awarded in Barbados and implemented within FY19				$50,000
Service delivery and quality improvement: key populations	S&D monitoring at public health facilities and community sites for KP in order to improve care and treatment services	Four (4) facilities that are implementing the quality improvement scorecard system	Eight (8) facilities that are implementing the quality improvement scorecard system				$80,888
Service delivery and quality improvement: key populations	Sensitize HCW at 3 treatment sites to reduce S&D; TA to strengthen S&D systems; and identify and refer GBV cases at 12 sites	Three (3) health facilities sensitized in a comprehensive package to reduce stigma and discrimination. PLHIV Leaders deployed in four (4) Regional Health Authorities to support treatment and care.	Three (3) health facilities sensitized in a comprehensive package to reduce stigma and discrimination. PLHIV Leaders deployed in four (4) Regional Health Authorities to support treatment and care.				$529,928

Focused Outcome and Impact Table (FOIT) Overview
Caribbean Region

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Service delivery and quality improvement: key populations	Sensitize HCW at 9 treatment sites to reduce S&D, through with JFLAG (CSO)	Sensitization trainings on stigma and discrimination are completed in all 9 treatment sites. Baseline scores using stigma index are collected among all HCWs participating in the training.	Scores on the stigma and discrimination index tools indicate that sites are 90% or more 'stigma and discrimination free'				$100,000
Service delivery and quality improvement: key populations	Support for Treat All in Jamaica	The revision of national treatment guidelines is completed and guidelines are disseminated in all 10 parishes support by PEPFAR	Treatment guidelines are being implemented fully and correctly in all 26 treatment sites in Jamaica (verified by SIMS visits)	TX_NEW	TX_RETURN		$200,000
Service delivery and quality improvement: key populations	Implement the MOPH-led VICITS strategy to improve services for KPs. Re-engage a substantial number of patients LTFU using innovative strategies.	Increase the number of NCTC registered clients on ART to 85%. Decrease number of clients LTFU at NCTC by 60%.	Increase the number of NCTC registered clients on ART to 95%. Decrease the number of clients LTFU at NCTC by 85%.	HTC_DSD;TX_NEW; TX_CURR; TX_RET; TX_VIRAL			$217,296
Service delivery and quality improvement: general population	Train and mentor QI teams to utilize CQI tools to identify barriers to high quality care and treatment and to support implementation of QI plans	(1) QI teams participate in learning sessions, webinars, and site visits (2) 100% of participating facilities have identified and tested change concepts to address barriers (3) QI staff and roles are identified	QI roles are documented for sustainability	TX_PVLS_TA	QI_SITE		$307,000
Service delivery and quality improvement: general population	Increase ART enrollment, VL tesing and suppression: support QI teams to test changes related to ART readiness, adherence, retention, and differentiated care	All participating QI teams conduct at least one test of change addressing differentiated models of care to improve ART readiness, adherence, retention, VL testing and/or suppression, as appropriate	QI teams document results of successful changes and make them standard practice	TX_PVLS_TA	QI_SITE		$300,000
Systems: Health workforce (including CHWs)	Support UWI diploma in the management of HIV infection scholarships for priority site HCWs	Ten (10) HCWs from Jamaica, Trinidad, and Suriname participate in the UWI postgraduate Diploma in the Management of HIV Infection course	Ten (10) HCWs from Jamaica and Suriname participate in the UWI postgraduate Diploma in the Management of HIV Infection course	HRH_PRE			$59,400
Service delivery and quality improvement: key populations	Support patients to develop CaReQIC Action Strategy Team (CAST), which institutionalizes patient engagement in QI activities and reduces HCW S&D	CaReQIC Action Strategy Team (CAST) is piloted in some countries and strengthened in others	Patient engagement in QI is institutionalized	TX_PVLS_TA	QI_SITE		$93,000
Service delivery and quality improvement: general population	Build capacity for clinical care and treatment through in-person and distance consultation, mentoring and training; pilot a telementoring program	Telementoring program is established	Priority SNUs participate in telementoring program	TX_PVLS_TA			$292,800
Service delivery and quality improvement: key populations	Build the practical skills of HCWs to provide comprehensive care & treatment for KPs through simulated patient preceptorships	All priority SNUs have clinicians trained in KP specific care and treatment	All priority SNUs have clinicians and nurses trained in KP specific care and treatment				$270,000
Systems: Health workforce (including CHWs)	S&D reduction training for military HCW	Training completed for 75% of HCW in the military					$1,000
Systems: Governance (including policy)	Update military HIV policy to include a S&D-free policy and practices	Military policy updated and approved					$0
Service delivery and quality improvement: key populations	Pilot the MOH-led VICITS strategy to improve services for KPs	VICITS model implemented; fully implemented sentinel surveillance system	KP clinical site data available for program monitoring by MOH	TX_NEW			$35,000
Service delivery and quality improvement: key populations	Blitz\fast track return of patients LTFU for treatment, institutionalize RTC process, enhance retention and partner tracing of returned patients	Support LTFU Blitz activity at 1 facility	Support LTFU Blitz activity at 1 facility	TX_NEW	TX_RETURN		$35,000
Service delivery and quality improvement: key populations	Blitz\fast track return of patients LTFU for treatment, institutionalize RTC process, enhance retention and partner tracing of returned patients	Support LTFU Blitz activity at one (1) facility	Support LTFU Blitz activity at one (1) facility	TX_NEW	TX_RETURN		$125,000

Focused Outcome and Impact Table (FOIT) Overview
Caribbean Region

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Service delivery and quality improvement: key populations	Technical assistance support to implementation of VICITS, with a focus on viral load counseling/medication adherence	VICITS model implemented; fully implemented sentinel surveillance system	KP clinical site data available for program monitoring by MOH	TX_NEW			$22,000
Service delivery and quality improvement: key populations	Blitz\fast track return of KP patients LTFU for treatment, institutionalize RTC process, enhance retention & partner tracing with returned patients	Support LTFU Blitz activity at 2 facilities	Support LTFU Blitz activity at 2 facilities	TX_NEW	TX_RETURN		$164,000
Strategic Outcome #2: Improve data access, quality, particularly for key populations							
Service delivery and quality improvement: key populations	Build KP CBO staff capacity to conduct SOGI training for HCWs to address & respond to S&D in the community & service sites	(1) 100% of CBO staff are trained by IP staff (ToT) (2) CBO staff train 50 health care workers in SOGI	(1) 100% of CBO staff are trained by IP staff (ToT) (2) 100% of participating KP-friendly service providers have improved scores on S&D monitoring index (developed by LINKAGES in ROP16) (3) CBO staff train 75 health care workers in SOGI	N/A			$55,000
Service delivery and quality improvement: key populations	Support CBOs to conduct screening for GBV and make the appropriate referrals	(1) 100% of KPs receiving services are screened for GBV (2) 100% of KPs reporting GBV are referred for supportive services	(1) 100% of KPs receiving services are screened for GBV (2) 100% of KPs reporting GBV are referred for supportive services	N/A			$55,000
Systems: Laboratory	HIV DR testing and capacity building (QA/QI, QC, TB, VL, Biosafety)	At least 50% of the countries are able to access and use routine HIV DR testing	All CRO PEPFAR supported countries are able to access routine HIV DR testing and use data for patient management				$65,000
Systems:Laboratory	Viral Load Active Scale - up Strategy (VLASS) to improve access and coverage to viral load testing & counseling using innovative strategies	At least 80% of patients on ART had at least one (1) VL test result per year	At least 90% of patients on ART had at least one (1) VL test result per year				$770,000
Systems: Laboratory	Viral Load Active Scale - up Strategy (VLASS) to improve access and coverage to viral load testing & counseling using innovative strategies	At least 80% of patients on ART had at least one (1) VL test result per year	At least 90% of patients on ART had at least one (1) VL test result per year				$160,000
Systems: Laboratory	Continuous quality improvement and strengthening of the lab technical capacity	Lab attains Tier 3 level of the Caribbean LQMS-SIP	Lab is fully accredited	Lab_CQIPT			$75,000
Systems: Laboratory	HIV Drug Resistance testing and lab interconnectivity	All treatment sites have access to HIV DR testing	all treatment sites have access to HIV DR testing				$75,000
Systems: Laboratory	Establish in country capacity for HIV DR testing including Surveillance protocol	At least 50% of the countries are able to access and use routine HIV DR testing	All CRO PEPFAR supported countries are able to access routine HIV DR testing and use data for patient management				$100,000
Systems:Laboratory	Strengthen HIV related laboratory systems and services for KP management including lab accreditation, RTQII	Three labs achieve Tier 1 of the LQMS-SIP, 95% PT pass rate	Three labs achieve accreditation, 99% PT pass rate	Lab_CQIPT			$535,500
Systems: Strategic Information	Implement electronic data reporting system to support data sharing between member states and CARPHA	Electronic data system with HIV module rolled out to Tier I & II countries by December 2017	Jamaica, Trinidad, and Jamaica report data for agreed HIV indicators using electronic reporting system by September 2019				$213,000
Systems: Strategic Information	Support use of technology to monitor treatment adherence and patient tracking	Pilot initiated in Jamaica by June 2018	Pilot completed by December 2019				$600,000
Systems: Strategic Information	Support training, routine (quarterly) analysis and dissemination of national and subnational data to review progress with fast track targets and implementation of treat all	100% of countries conduct annual review of progress with fast track /2020 targets	100% of countries conduct annual review of progress with fast track /2020 targets				$45,000

Focused Outcome and Impact Table (FOIT) Overview
Caribbean Region

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Strategic Information	Support training, routine (quarterly) analysis and dissemination of national and subnational data to review progress with fast track targets and implementation of treat all	100% of countries conduct annual review of progress with fast track /2020 targets	100% of countries conduct annual review of progress with fast track /2020 targets				$270,000
Systems: Strategic Information	Implement sentinel surveillance to support VICITS implementation with protocol development, purchase of software and hardware, clinic-level monitoring and support for analysis and use of data	At least 1 sentinel surveillance site established by September 2018.	VICITS sites routinely report and use sentinel surveillance data by September 2019				$500,000
Systems: Strategic information	Support implementation and staff training for roll out of electronic data management platforms (UIC/DHIS in Jamaica)	UIC rolled out and operational in 15 out of the 25 treatment sites in Jamaica	UIC rolled out and fully operational in all 25 treatment sites in Jamaica				$80,000
Systems: Strategic information	Operational assessment to identify barriers to/across the Co PCT and validate best approaches for providers to collect KP data in service delivery settings	Assessment conducted and report finalized	Assessment conducted and report finalized				$15,000
Systems: Strategic information	Operational assessment to identify best approaches for providers to collect KP data in service delivery settings	Assessment conducted and report finalized	Assessment conducted and report finalized				$15,000
Systems: Strategic information	Support to conduct Stigma Index	Study conducted and report finalized					$0
Service delivery and quality improvement: general population	Conduct site-based training and webinars to develop staff capacity for data collection, analysis, and use for quality improvement	100% of QI team members are knowledgeable regarding what data are available at their facility, the methods for collection and how to use these data	Routine data are collected and used for quality improvement activities by 100% of facility QI teams	TX_PVLS_TA	QI-SITE		$162,500
Service delivery and quality improvement: general population	Support MOH and regions to identify and use a core set of Quality of Care indicators for HIV	List of quality of care indicators identified	Quality of care indicator reports are used as part of the MOH's QI framework				$37,500
Systems: Strategic information	Conduct a study to inform and support S&D reduction efforts at priority sites	Baseline research conducted and report completed	Post-intervention research conducted and report completed				$200,000
Systems: Strategic Information	Implement sentinel surveillance to support VICITS implementation with protocol development, purchase of software and hardware, clinic-level monitoring and support for analysis and use of data	At least 1 sentinel surveillance site established by September 2018.	VICITS sites routinely report and use sentinel surveillance data by September 2019				$61,000
Systems: Strategic Information	Support collection of risk factor for KPs, including SOP development and using mhealth/e-health platforms to improve collection of sensitive (behavioral) data	80% completeness of risk factor data at supported sites by Sept 2018	Site-level KP cascades available for supported sites by Sept 2019				$100,000
Systems: Strategic Information	Implement sentinel surveillance to support VICITS implementation with protocol development, purchase of software and hardware, clinic-level monitoring and support for analysis and use of data	At least 1 sentinel surveillance site established by September 2018.	VICITS sites routinely report and use sentinel surveillance data by September 2019				$80,000
Systems: Strategic Information	Implement sentinel surveillance to support VICITS implementation with protocol development, purchase of software and hardware, clinic-level monitoring and support for analysis and use of data	At least 1 sentinel surveillance site established by September 2018.	VICITS sites routinely report and use sentinel surveillance data by September 2019				$75,000
Systems: Strategic Information	Implement sentinel surveillance to support VICITS implementation with protocol development, purchase of software and hardware, clinic-level monitoring and support for analysis and use of data	At least 1 sentinel surveillance site established by September 2018.	VICITS sites routinely report and use sentinel surveillance data by September 2019				$45,000
Systems: Strategic Information	Support implementation for linkage of electronic data management platforms (DHIS2, HMIS) inc private sector	EMR implementation plan developed by September 2018	50% of targeted sites use EMR for data management in September 2019				$400,000
Systems: Strategic Information	Support implementation for linkage of electronic data management platforms (DHIS2, HMIS) inc private sector	EMR implementation plan developed by December 2017	50% of targeted sites use EMR for data management in September 2019				$100,000

Focused Outcome and Impact Table (FOIT) Overview
Caribbean Region

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Outcome #3: Align PEPFAR resources and staff to the countries and sub-national units (SNUs) with the greatest disease burden, need, and impact, in a sustainable manner							
Systems: Institutional Capacity Building	Support capacity building towards successful transition of site level activities to indigenous CSOs	Documentation tools and policies developed to improve quality assurance outcomes for targeted KP services					$110,000
Systems: Supply chain and essential medicines	Support supply chain logistics and systems for Test and Start, including increasing efficiencies for emergency procurement	1 emergency procurement system established per country; Procurement and supply management efficiencies gained based on country specific bottlenecks	Benchmarks noted in YR 1 will be accomplished over the two year period	N/A			$412,660
Systems: Supply chain and essential medicines	Support supply chain logistics and systems for Test and Start, including increasing efficiencies for emergency procurement	An action plan to address emergency procurment issue is developed and implemented by end FY 18		N/A			$100,000
Service delivery and quality improvement: key populations	Develop national policies aligned with WHO guidelines including differentiated models of care and KP friendly services	All supported countries develop national policies with differentiated model of care by September 2018	Differential models of care implemented at all PEPFAR supported sites by September 2019				$100,000
Service delivery and quality improvement: general population	Collaborate with MOHs, RHAs, and SNUs to develop QI sustainability plans at the appropriate levels	National, regional or site level QI plans drafted	QI plan is finalized				$100,000
Systems: Health Financing	Establish health accounts and increase domestic resources for KP PLHIV service delivery at community and facility levels for Test and Start	(1) Resource needs and expenditure analyses of HIV prevention programs conducted per country (2) Outline of dashboard indicators is populated with one year of data; Crosswalk of government budget and SHA 2011 codes with focus on HIV spending (3) One policy brief developed with results of 2015/2016 Health Accounts (HA) estimation per country (total: 5)	(1) Establish and train government HA team in HA data collection, analysis and use per country (2) Employ a mechanism for regular health economics data collection for CSOs, employers and insurance for each country	N/A			$186,395
Systems: Health Financing	Establish and strengthen formal mechanisms for non-gov entities to receive funding directly from gov & non-gov sources for KP PLHIV service delivery	(1) Conduct one feasibility study per country (total: 4) to identify mechanisms (e.g., trust fund, government contracting mechanism, etc.) through which to fund non-governmental entities (e.g. CSOs, private physician networks) (2) Develop one policy brief of the costs and benefits of government funding of CSO-provided HIV services per country (total: 4)	One mechanism per country is established or strengthened to fund non-government provision of HIV services by the end of ROP18	N/A			$186,395
Systems: Governance (including policy)	Support and monitor government and joint donor sustainability/transition plans through TA	(1) In each country, the government/MOH acquires a budget allocation line item to fund non-governmental entities (e.g. CSOs, private physician networks) (2) Milestone(s) of government sustainability and/or transition plans achieved on schedule (3) MOH & MoF training on the MOH/MoF toolkit, budgeting and budget-tracking for health in each country is conducted	(1) The government/MOH effectively uses the MOH/MoF toolkit (2) The government/MOH effectively uses new or improved techniques for budgeting and tracking HIV spending in each country (3) Milestone(s) of government sustainability and/or transition plans are achieved on schedule	N/A			$186,394

Focused Outcome and Impact Table (FOIT) Overview
Caribbean Region

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Governance (including policy)	Enhance knowledge generation, sharing and learning among PANCAP members & CSOs for accelerated implementation of Test and Start	(1) Develop and disseminate national and regional Test and Start best practices for PANCAP members including tools for sharing knowledge within the organization and/or with members	(1) KM outputs around Test and Start are utilized at the national level as measured by a user survey for selected KM outputs. Target: 80% of PANCAP members rate as satisfied with the usability and content relevance of knowledge outputs disseminated to them (2) Conduct capacity building trainings and mentoring sessions (face to face and virtual) by K4Health for PCU staff, by topic (target is 8)	N/A			$350,000
Systems: Governance (including policy)	Coordinate regional and national policy response to HIV/AIDS among member states	(1) Develop national and regional collaboration, learning, and adapting agendas supporting the scale up and sustainability of the overall KP HIV response (2) Three (3) regional policy recommendations are endorsed by executive board and COHSOD to facilitate operationalization of national responses to achieve the 2020 targets (3) Sustainably scale up two (2) programs for the overall KP PLHIV response according to the national and regional agendas	(1) Develop joint national and regional learning programs and strategies (2) Develop policy recommendations to assist countries to achieve the targets for Test and Start	N/A			$200,000
Other: specify in activity description	Strengthen CBO institutional systems to enable successful program management and improve effectiveness in responding to HIV/AIDS	TBD	TBD	N/A			$200,000
Other: specify in activity description	Support CBOs to provide innovative community-based, comprehensive HIV prevention services for younger KP and link KP-PLHIV.	(1) Supported CSOs achieve 75% of KPs reached in the community with referral and linkage to HIV testing (2) 50% increase in MSM aged 15-19 reached/identified through chain referral networking and social media strategies	Activity expected to end for Barbados after YR1, scale down further for Trinidad and for Suriname				$623,810
Other: specify in activity description	Support clinical and CBO partners to implement differential models of HIV clinical and psychosocial care for KP PLHIV	(1) Supported CSOs will link 100% of newly diagnosed KP PLHIV to community care services when needed (2) 90% of KP PLHIV that are receiving LINKAGES peer navigation services are referred and enrolled in treatment (3) 50% of KP PLHIV identified as LTFU by CSOs are reengaged into care by peer navigators	Activity expected to end for Barbados, scale down further for Trinidad and continue for Suriname	Program Indicator	CARE_COMM		$779,762

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Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Other: specify in activity description	Build capacity of CBO staff to respond to S&D within their communities and in facilities for increased access to friendlier KP services	(1) CSOs are strengthed so that 100% of participating KP-appropriate HIV service facilities have acceptable or improved scores on S&D monitoring index (developed in ROP16) as measured by KP and provider assessments (2) 100% of HIV service facilities with mechanisms which include KP representation for reviewing delivery of sensitive services to KPs	Activity expected to end for Barbados, scale down further for Trinidad and continue for Suriname				$77,976
Other: specify in activity description	Support KP CBOs to conduct GBV and human rights violation response activities	(1) 100% of LINKAGES-supported KP CBO staff are trained to effectively screen and provide GBV services and/or appropriate referrals (2) 100% of KPs accessing services are screened for GBV (3) 100% of KPs reporting GBV are referred for supportive services	Activity expected to end for Barbados, scale down further for Trinidad and continue for Suriname				$77,976
Systems: Governance (including policy)	Support and monitor government and joint donor sustainability/transition plans through TA	(1) Milestone(s) of government sustainability and/or transition plans achieved on schedule (2) MOH & MoF training on the MOH/MoF toolkit, budgeting and budget-tracking for health in each country is conducted	(1) The government/MOH effectively uses the MOH/MoF toolkit (2) The government/MOH effectively uses new or improved techniques for budgeting and tracking HIV spending in each country (3) Milestone(s) of government sustainability and/or transition plans are achieved on schedule	N/A			$0
Systems: Strategic Information	Strategic Information investments are shifted from special studies to strengthening the quality and timeliness of data in routine data systems	PEPFAR's investment in special studies (e.g. bio-behavioral surveys, cost analyses) are limited to Tier I countries only and conclude by September 2019	83% of PEPFAR of priority countries report timely (< 2 year old) key population (MSM, FSW), facility, age, and sex disaggregated clinical cascade data by September 2019				$0
Systems: Strategic Information	Transition PEPFAR supported technical staff to the MOH payroll (e.g., strategic information officers, epidemiologists, M&E staff)	100% of Tier I and II countries have dedicated strategic information staff by December 2017	100% of PEPFAR staff in Tier I countries transitioned to MOH payroll by December 2019				$0
Systems: Health Financing	PUSH staff participates in MOPH trainings,care&treatment oversight committee,MOPH onsite quality improvement activities and pediatric comanagement	Increased collaboration leading to co management of pediatric clients, quality HIV management, reduced LTFU at MOPH sites	Increased collaboration leading to co management of pediatric clients, quality HIV management, reduced LTFU at MOPH sites				$0
Service delivery and quality improvement: key populations	PUSH will implement Treat All strategy and differentiated models of HIV care resulting in six (6) months ARV supply for stable clients and fewer CD4	(1) 50% increase in the number of clients with six months prescription refill schedule (2) 50% reduction in routine CD4	(1) Further 30% increase in the number of clients with six months prescription refill schedule. (2) Further 50% reduction in routine CD4				$0
Service delivery	Work closely with PUSH sites on continued collaboration with MOPH to ensure sustainability of PUSH activities beyond PEPFAR	Maintain support from MOPH for ARVs, STI/OI medication, HIV rapid test kits, viral load and CD4 (when indicated) tests at PUSH sites	Ensure 100% support from MOPH for ARVs, STI/OI medication, HIV rapid test kits, viral load and CD4 (when indicated) tests				$0

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Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Health Financing	USG Transition plan developed and implemented over one - two years in Barbados, Trinidad, Guyana and Suriname for USG program activities	USG program transition plan developed and adopted in collaboration with external stakeholders by SAPR due date in FY18	At least 90% of USG transition plan activities implemented by the end of FY19				$0