HIV/AIDS in the Caribbean Region: A Multi-Organization Review

Final Report

By a review team from
DFID, WHO/PAHO, GFATM, UNAIDS Secretariat and the World Bank
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ACRONYMS

ART  Antiretroviral Treatment
ARV  Antiretroviral
CAREC  Caribbean Epidemiology Center
CARICOM  Caribbean Community and Common Market
CBO  Community Based Organizations
CCM  Country Coordination Mechanism
CHRC  Caribbean Health Research Council
CRN+  Caribbean Regional Network of People Living with HIV/AIDS
CSO  Civil Society Organization
CSW  Commercial Sex Worker
DFID  Department for International Development
FBO  Faith Based Organizations
GFATM or GF  Global Fund to Fight AIDS, TB, and Malaria
GTT  Global Task Team
IDB  Inter-American Development Bank
M&E  Monitoring and Evaluation
MAP  Multi-Country HIV/AIDS Program
MOH  Ministry of Health
MSM  Men who have Sex with Men
NAC  National HIV/AIDS Council or Commission
NAS/NAD  National HIV/AIDS Secretariat or Directorate
NGO  Non-Governmental Organization
NSP  National Strategic Plan
OECS  Organization of Eastern Caribbean States
PAHO  Pan American Health Organization
PANCAP  The Pan Caribbean Partnership Against HIV/AIDS
PCU  Project Coordination Unit
PEPFAR  US President’s Emergency Plan for AIDS Relief
PLWHA  People Living with HIV/AIDS
PPS  Pharmaceutical Procurement Services
STI  Sexually Transmitted Infection
TWG  Technical Working Group
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNDP  United Nations Development Program
UWI  University of West Indies
WB  World Bank
WHO/PAHO  World Health Organization/Pan American Health Organization
EXECUTIVE SUMMARY

A team from five international organizations carried out a review of the HIV/AIDS program in the Caribbean Region in September/October 2005 at the request of the World Bank Country Director for the Caribbean Region and Sector Director for Human Development for the Latin America and Caribbean Region. The review was carried out with the support of the World Bank’s Global HIV/AIDS Program.

The Caribbean Region has the highest HIV prevalence in the world outside Africa. An estimated 440,000 individuals are HIV positive or a mean prevalence rate of 2.3 percent for adults aged 15 to 49, with a range from 1.5 to 4.1 percent. AIDS is the leading cause of death in that age group. There is still little hard evidence on the HIV/AIDS epidemic and considerable uncertainty about its possible future course. The epidemic remains hidden from view, due in large part to strong stigma and discrimination within the Region. In some countries HIV/AIDS is considered a health threat but not a major development threat despite its potential impact on their economies.

National HIV/AIDS programs are primarily focused on the health sector response. Treatment is being scaled up with less attention being paid to prevention and care, to the multi-sector response and the meaningful engagement of civil society. A systematic effort to apply the “Three Ones” principles is underway in some countries. For most countries, however, national strategies, M&E systems and organizational and governance structures are weak. This is not due to a lack of political will but to weak institutional and human capacity. The Regional response through PANCAP and other regional agencies has great promise which is yet to be fully realized. External funding exceeds $460 million for the Region, but World Bank and Global Fund financed programs have been slow to implement. There are good examples of effective implementation and national commitment that can form the basis of an accelerated response.

Recommendations from the Review team from DFID, the Global Fund, WHO/PAHO, UNAIDS Secretariat and the World Bank are grouped into three clusters.

Priority attention for the national response includes (i) restoring a strategic balance in national programs with intensified focus on prevention, (ii) launching a concentrated attack on stigma and discrimination through better analysis communication strategies and legal action, (iii) adopting simple, low-tech M&E systems to support interventions based on evidence, (iv) enhancing local capacity through innovative, collaborative means rather than increases in numbers of staff, and (v) simplifying implementation processes, especially for smaller states.

The Regional response should be invigorated by improving the capacity of PANCAP and other regional agencies to coordinate the regional response and to serve national programs more effectively.

The international response should: (i) develop a strategy for financial sustainability of the HIV/AIDS program over the medium term, (ii) consolidate donor harmonization on the ground in at least two countries on procurement, financial management, progress reporting, disbursements, program oversight and implementation support , and (iii) encourage greater collaboration among UN agencies with the UNAIDS Secretariat taking the lead.
I.  INTRODUCTION

1.  In September/October 2005, a review team from five international organizations carried out a review of the HIV/AIDS program in the Caribbean Region.

2.  The Review team consisted of Rosemary Barber—Madden and Heather Royes, UK Department for International Development (DFID); Jessie Schutt-Aine and Wolfgang Munar, Global Fund to Fight AIDS, TB and Malaria (Global Fund); Regine Meyer, Pan American Health Organization (PAHO); Miriam Maluwa and Kristan Schoultz (UNAIDS Secretariat); Willy De Geyndt, Nadeem Mohammad, Elizabeth Mziray and Ahmadou Moustapha Ndiaye, World Bank; and Daniel Ritchie (Chair). Joe Valadez (World Bank) contributed to the Final Report.

3.  The Review was the first undertaken since completion of the Global Task Team report of June 2005 on improving AIDS coordination among multilateral institutions and international donors, and the recommendations in this Report are fully consistent with its directions. The current review is the first in which international and bilateral donors have collaborated together on a review of an HIV/AIDS program in the Caribbean.

Objectives

4.  The goals of the Caribbean HIV/AIDS Review were to (i) assess the response to the HIV/AIDS epidemic at the national, regional and international levels, and (ii) recommend measures to enhance the effectiveness of the response at all levels.

5.  Prompted initially by the World Bank’s concern about the slow implementation of its portfolio of ten projects, the Review examined both the World Bank-funded projects and also the international support in the Caribbean Region and collaboration among partners. The recommendations of this report relate not only to the World Bank program but to the overall response to the epidemic by national programs and by regional and international partners. The Terms of Reference for the Review are attached (Annex 1).

Approach and Methodology

6.  The Review was carried out through:

- document reviews related to (a) the epidemic in the Region, (b) the World Bank-financed projects (project appraisal documents and supervision reports), (c) other donor programs (DFID, Global Fund, the US President’s Emergency Plan for AIDS Relief--PEPFAR), (d) the recent Global Task Team Report on improving the multi-lateral response and (e) national responses (Strategic Plans, Operational Manuals, annual work plans).

- A brainstorming session among representatives of national AIDS programs, project implementation units and donors. The Review team plus Jane Armstrong (DFID), Keith Hansen and Mary Mulusa (World Bank) joined representatives from seven national programs in St. Lucia on September 26 and 27, 2005.
• Field visits from September 28 to October 8 by team members (in three separate groups) to eight countries with World Bank-financed projects—Barbados, Dominican Republic, Grenada, Guyana, St. Lucia, St. Kitts and Nevis, St. Vincent and the Grenadines and Trinidad and Tobago. (The team was unable to visit Jamaica). Team members met with PANCAP staff at its headquarters in Guyana and with PANCAP’s “core partners” in Trinidad. A list of the team members and the countries visited is attached.

• Interviews in Washington, DC and in the field with over 200 individuals concerned with HIV/AIDS, and

• Joint development of conclusions and recommendations and preparation of the Final Report by the core team in Washington, DC, October 10-14, 2005.

7. The Final Report reflects a full consensus of the core team members on the critical issues and the road ahead. The team members participated in their individual capacity and the recommendations are those of the team and not the organizations from which they come.
II. THE CONTEXT

The Region

8. The HIV/AIDS epidemic in the Caribbean region continues to be driven by complex behavioral, socio-cultural, equity, historical, political and economic issues, particularly the human mobility throughout the Caribbean, between the region and other geographic areas including migration and tourism which brings more than 20 million visitors each year.

9. The Caribbean region is heterogeneous in terms of its political, economic, cultural and ethnic, religious and linguistic characteristics, which present complex challenges to the response to AIDS. The region is multiethnic and culturally diverse, with many languages—Spanish (spoken by more than 60% of the population), French (20%), English (16%), with the remaining speaking Dutch and Creole.

10. The population of the region is approximately 39 million people, with mainland states (Belize, Guyana and Suriname), and island states that vary in size, ethnicity and religion. Population size in the island states varies from smaller island states such as Anguilla with 8,000 and Cayman Islands with 35,000 to Haiti with 8 million and Cuba with 11 million inhabitants. While the majority of the population is of African descent, there are also people of European and Asian ancestry, as well as indigenous populations such as Carib, Arawak, Garifuna and Taino peoples. The Caribbean peoples are also from diverse religious backgrounds—Christian, Hindu, Muslim and others.

11. The economies of the Region are generally fragile, especially the smaller states, with historical reliance on primary commodities such as bananas and sugar whose international markets are in flux, and tourism, the major foreign exchange earner for many countries, which has been volatile in recent years. The Region is also highly indebted, with external public debt over 100% of GDP in several countries.

The HIV/AIDS Epidemic

12. The Caribbean Region has the highest HIV prevalence outside of Africa. About 440,000 individuals are estimated to be infected.

<table>
<thead>
<tr>
<th>Adult (15-49) HIV prevalence rate</th>
<th>2.3% (range: 1.5-4.1%)</th>
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</thead>
<tbody>
<tr>
<td>Adults and children (0-49) living with HIV</td>
<td>440,000 (range: 270,000-780,000)</td>
</tr>
<tr>
<td>Women (15-49) living with HIV</td>
<td>210,000 (range: 120,000-380,000)</td>
</tr>
<tr>
<td>Adults and children newly infected with HIV in 2004</td>
<td>53,000 (range: 27,000-140,000)</td>
</tr>
<tr>
<td>Adults and child deaths due to AIDS in 2004</td>
<td>36,000 (range: 24,000-61,000)</td>
</tr>
</tbody>
</table>

Source: UNAIDS, 2004 Fact Sheet

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1 For the purposes of this review, members of PANCAP are used as the definition of “the Region.” They include: Barbuda, The Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Montserrat, Netherlands Antilles, Puerto Rico, St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, Suriname, Trinidad & Tobago, Turks & Caicos Islands and the US Virgin Islands.
13. Out of fifteen high prevalence countries outside of Africa, eleven are in the Caribbean region.

### Top 15 HIV/AIDS Prevalence Countries (end 2003)

**Percent of population 15-49 years old with HIV/AIDS**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Country</th>
<th>% of Population</th>
<th>Rank</th>
<th>Country</th>
<th>% of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Swaziland</td>
<td>38.8</td>
<td>1</td>
<td>Haiti*</td>
<td>5.6</td>
</tr>
<tr>
<td>2</td>
<td>Botswana</td>
<td>37.3</td>
<td>2</td>
<td>Trinidad and Tobago*</td>
<td>3.2</td>
</tr>
<tr>
<td>3</td>
<td>Lesotho</td>
<td>28.9</td>
<td>3</td>
<td>Bahamas*</td>
<td>3.0</td>
</tr>
<tr>
<td>4</td>
<td>Zimbabwe</td>
<td>24.6</td>
<td>4</td>
<td>Cambodia</td>
<td>2.6</td>
</tr>
<tr>
<td>5</td>
<td>South Africa</td>
<td>21.5</td>
<td>5</td>
<td>Guyana*</td>
<td>2.5</td>
</tr>
<tr>
<td>6</td>
<td>Namibia</td>
<td>21.3</td>
<td>6</td>
<td>Belize*</td>
<td>2.4</td>
</tr>
<tr>
<td>7</td>
<td>Zambia</td>
<td>16.5</td>
<td>7</td>
<td>Honduras*</td>
<td>1.8</td>
</tr>
<tr>
<td>8</td>
<td>Malawi</td>
<td>14.2</td>
<td>8</td>
<td>Dominican Republic*</td>
<td>1.7</td>
</tr>
<tr>
<td>9</td>
<td>Central African Rep.</td>
<td>13.5</td>
<td>9</td>
<td>Suriname*</td>
<td>1.7</td>
</tr>
<tr>
<td>10</td>
<td>Mozambique</td>
<td>12.2</td>
<td>10</td>
<td>Thailand</td>
<td>1.5</td>
</tr>
<tr>
<td>11</td>
<td>Tanzania</td>
<td>8.8</td>
<td>11</td>
<td>Barbados*</td>
<td>1.5</td>
</tr>
<tr>
<td>12</td>
<td>Gabon</td>
<td>8.1</td>
<td>12</td>
<td>Ukraine</td>
<td>1.4</td>
</tr>
<tr>
<td>13</td>
<td>Côte d'Ivoire</td>
<td>7.0</td>
<td>13</td>
<td>Myanmar</td>
<td>1.2</td>
</tr>
<tr>
<td>14</td>
<td>Cameroon</td>
<td>6.9</td>
<td>14</td>
<td>Jamaica*</td>
<td>1.2</td>
</tr>
<tr>
<td>15</td>
<td>Kenya</td>
<td>6.7</td>
<td>15</td>
<td>Guatemala*</td>
<td>1.1</td>
</tr>
</tbody>
</table>

(*) Caribbean countries

14. According to UNAIDS, the epidemic in the Region is predominately characterized by heterosexual transmission, increasingly female and increasingly young:

- In 2004 in the Region, an estimated 53,000 people were newly infected with the virus, about 36,000 people died of AIDS. HIV prevalence varies widely among Caribbean countries, with 5.6% in Haiti to 0.1% in Cuba.

- Overall, Caribbean countries have the highest HIV-infection levels among women in the Americas and AIDS has become the leading cause of death among adults aged 15–44 years. In Haiti, life expectancy at birth in 2010 is projected to be 10 years less than it would have been without AIDS.
• In Latin America and the Caribbean, HIV transmission is occurring largely through heterosexual intercourse (almost two thirds of all AIDS cases to date are attributed to this mode of transmission).

• The number of new HIV infections among women in the Caribbean now outstrips that among men. Latest estimates suggest that roughly as many women as men are now living with HIV in this region. According to a population-based survey carried out in 2002, women younger than 24 years in the Dominican Republic were almost twice as likely to be HIV-infected compared with their male peers.

• Haiti continues to have more than half of all people living with HIV in the Caribbean: some 280,000 at the end of 2003. Recent behavioral surveillance has shown that a significant proportion of the country’s largely young population (about 60% of which is under 24 years) is sexually active and having unprotected sex and the survey showed that 18% of urban women in their late teens had been pregnant at least once.

• In 2004, about 5,000 people were receiving anti-retroviral therapy (ART) in the nine countries with World Bank-funded projects and Haiti, accounting for about 10 percent of the population needing treatment. Treatment is expanding rapidly in 2005.

• There are indications that HIV infection levels are dropping, for reasons that are not yet clear. In the Bahamas, for example, HIV prevalence among pregnant women fell from 4.8% in 1993 and 3.6% in 1996 to 3% in 2002. In Guyana, the Ministry of Health reports reductions in infection of commercial sex workers from 45% in 1997 to 25% in 2005, and of miners from 11% to 4%. In Barbados, new HIV diagnoses among pregnant women dropped substantially between 1999 and 2003, from 0.7% to 0.3%. In Santo Domingo, Dominican Republic, HIV prevalence among 15–24 year-old pregnant women—which can offer a hint of recent infection rates—has declined from around 3% in 1995 to below 1% in 2003.

• Cuba has very low HIV prevalence, only about 0.1%, and Cuban doctors are active throughout the Caribbean working on HIV and a broad range of health issues. However, a sharp increase in newly reported HIV cases has occurred in Cuba since the late 1990s, with the annual number of reported new cases growing almost five-fold between 1995 and 2000.

Vulnerability

15. Understanding HIV/AIDS in the Region is hampered by underreporting. Although a number of studies at regional and national levels have been conducted with vulnerable sub groups, availability and quality of data about the beliefs and practices of sub groups in the population at country level are limited. This limits understanding of the real dimensions of the epidemic within countries, and may underestimate the epidemic in the Caribbean. Also, ARV treatment programs are at various stages of development ranging from initiation in 2005 (St. Lucia) to programs said to be providing third, fourth or fifth generation ARV drugs (Barbados) challenging countries and donors to take extreme care in projecting the course of the epidemic in the region.

16. While data on gender distribution based on reported cases are available by country, the actual understanding of the gender dimension and design of an appropriate response has not been fully realized thus far. This is particularly important considering that HIV/AIDS is becoming more prevalent among young people; particularly young women aged 15 to 19, although data are not
reliable. Yet interventions are not directed to the values, mores, sexual practices, and reproductive health needs of today’s youth. Similarly, interventions do not generally address the uneven power relationships between men and women.

17. Despite the unreliability of data for the region, there is some indication that male-to-male transmission has declined since the start of the epidemic. However, it bears noting that there is a high degree of stigma against men having sex with men (MSM) producing strong social, cultural and legal discrimination against this group. This has likely contributed considerably to under-reporting. Recent studies report that there are large centers of commercial sex workers in the Caribbean located in Curacao, the Dominican Republic and the Bahamas. Migration both within the Caribbean and from outside the Caribbean, is encouraging a new population of sex workers on demand.
III. THE NATIONAL RESPONSE

The General Response

18. Typically, countries in the region have based their national responses on a set of regionally agreed guidelines and priorities for action as set out in the Caribbean Regional Plan of Action, developed as an outcome of the Caribbean Regional Conference of September 2000. As a result, most National Strategic Plans (NSPs) embrace a comprehensive approach which includes: a) prevention; b) care and treatment; and; c) institutional development, management and coordination (including M&E). Very few countries have translated their plans into rolling, results-oriented action frameworks.

19. Generally, NSPs in the region call for an enhanced multi-sectoral approach, to be coordinated by high-level national coordinating bodies. All countries visited by the review team have established national coordinating commissions or councils usually established under the auspices of the office of the Prime Minister or President and generally supported by secretariats whose responsibility is to coordinate action on a day-to-day basis. However, with few exceptions, there is a lack of clarity regarding the roles and responsibilities of the various government entities involved in the national response. The relationship between the coordinating entities and Ministries of Health appears to be particularly problematic in this regard. In addition, in several cases, the secretariats to the coordinating entities appear to be acting as implementers, rather than coordinators, of the national response and different donors use different implementation mechanisms.

20. All of the region’s NSPs embrace implementation strategies which include the broad engagement of civil society and key line ministries. In practice, however, most countries place the highest priority on health sector strengthening and interventions, and the establishment of systems to support treatment access. In some countries such as the Dominican Republic and Haiti Civil Society Organizations (CSOs) are well organized but smaller countries tend to have less developed CSOs with limited implementation capacity to respond to HIV/AIDS. In the area of prevention, most plans prioritize selected vulnerable groups (generally including youth, CSW, MSM, prisoners, and people living with HIV/AIDS--PLWHA) in addition to the sensitization of the general public and health sector prevention activities; however, not many countries have moved beyond awareness-raising for the general public toward a more focused approach on vulnerable population groups.

Six Overarching Issues

21. At the brainstorming session in St. Lucia on September 26 and 27, 2005, participants from six countries and the PANCA Secretariat were asked to identify the most significant challenges their programs faced in responding to the HIV/AIDS epidemic. There was a strong consensus around six issues:

- the lack of strategic balance among prevention, care and treatment in their programs,
- the difficulties in developing an effective monitoring and evaluation system,
- the barriers to an effective response posed by strong stigma and discrimination against vulnerable populations and people living with HIV/AIDS,
• complex implementation arrangements required by donors such as the World Bank and the Global Fund as well as their own domestic procedures,

• longer-term financial and human capacity sustainability of the programs and the ethical issues surrounding universal access to treatment and prevention if funds become more scarce in the future, and

• the need for real harmonization among donors on the ground in the spirit of the “Three Ones.”

22. Each of these challenges is elaborated below.

(a) Strategic Balance

23. Participants in the St. Lucia brainstorming worried that their programs had become imbalanced. With the arrival of significant funding for treatment prevention programs were receiving less attention and line ministries and civil society organizations were not being engaged.

24. Programs in the Caribbean have been predominantly health sector-oriented. Ministries of Health have generally been responsible for execution of World Bank projects and have generally received the largest share of funding. Perhaps as a result, the health sector appears to have made good progress in many countries. Key health sector staff are generally in place, activity is being scaled up, and the procurement of equipment and supplies (condoms, lab supplies, STI drugs) has been undertaken, even though the procurement process is often very slow for even the most basic of items, due to bottlenecks caused by government bureaucracy and/or unclear and often lengthy procurement processes.

25. Perhaps as a result of the priority given to the health sector, multisectoral engagement is still quite limited, though progress has been made in this area in some countries. However, in several countries the World Bank project disbursements for line ministries have been hampered due to highly bureaucratic procedures within governments or overly-rigid interpretations of World Bank procedural regulations by local authorities.

26. Line ministries also experience human resource challenges. Focal points in ministries generally undertake their AIDS activities in addition to their regular ministry portfolios, and are therefore additionally burdened by their AIDS responsibilities. Progress in the line ministries is thus often a reflection of individual motivation rather than of overall institutional commitment HIV/AIDS is rarely a line item in the national budget. If it is, it is normally in the budget of the health sector but almost never in the allocations to line ministries.

27. Perhaps also due to the priority given to treatment and care in the health sector, the potential of civil society to make an important contribution to prevention (and to some extent mitigation) has not been realized. Though CSOs have been active across the region for some time, their efforts have been severely hampered due to insufficient resources and capacity limitations. Very few countries have engaged in a public process for civil society engagement (i.e. calls for proposals), and few effectively utilize the available World Bank project resources to support civil society initiatives. CSOs in the region express their need for more and better information about regional programs, capacity development opportunities, and more predictable and longer-term
financing. In addition, national programs do not appear to offer the coordination support necessary to effectively organize the civil society contribution to national responses.

(b) Monitoring and Evaluation

28. Participants in the St. Lucia brainstorming recognized that their local programs had been designed and implemented without the benefit of hard evidence on the epidemiology of HIV/AIDS, the most vulnerable populations, behaviors and other critical factors. They also recognized the potential importance of monitoring and evaluation systems for generating evidence, but they almost despaired at the apparent magnitude of the task, the over-ambition of donor proposals for data collection (such as sophisticated IT platforms) and the sometimes overwhelming demands of different donors for information. With limited experience in dealing with international agencies, they were hard-pressed to manage the process and direction.

29. At the moment, M&E capacity is weak throughout the Caribbean. However, most NACs and MOHs are aware of their weaknesses and want to build their capacity. Both national health system managers and international agencies have underestimated their capacity and the effort (including technical assistance) needed to collect recurrent output or outcome M&E information.

30. Most MOHs have limited capacity and experience in quantitative data collection. They collect basic service statistics from hospitals and health centers, and there have been limited efforts to collect population-based survey information.

31. There is greater experience in the area of epidemiological surveillance. However, these systems tend to be imported and provided with a substantial amount of external technical assistance. Surveillance also is a highly specialized vertically organized information system, as compared with program M&E systems with many elements and requires the participation of several layers of personnel in the health system.

32. External funders have imposed new requirements on this limited resource base, requiring data on outputs and results as a condition of funding (the Global Fund) and process indicators from organizations like the World Bank. When aggregated, the demands are simply not possible to meet and the countries have difficulty prioritizing which to eliminate. St. Vincent and the Grenadines has been asked to monitor 191 indicators, Guyana 169.

33. A positive step forward in the Caribbean has been a recent agreement among regional and international organizations on a common approach for providing M&E technical assistance. At the country level, such as in Guyana, donors are adopting a common set of about 45-50 indicators.

(c) Stigma and Discrimination

34. Stigma and discrimination represents the single greatest obstacle to an effective national response, but most programs have not yet found ways to address the problem effectively.

35. Stigma and discrimination makes it difficult for infected persons to come forward for testing, treatment and care, for vulnerable groups to be reached, for politicians to speak out publicly, and for laws against discrimination, where they do exist, to be enforced. The epidemic is still largely underground, reflecting a stage in some countries where Africa was a decade ago and thus, increasing the danger of hidden eruptions or flashpoints that could have been predicted and perhaps avoided.
36. Discrimination in the workplace, schools and even health care facilities is still present despite efforts such as workplace policies and government regulations. The problem is especially troubling in the health sector, where health workers may still be uncomfortable in dealing with people living with HIV/AIDS, and where breaches of confidentiality continue to occur.

37. The legal framework of the English-speaking Caribbean actually perpetuates stigma and discrimination against some high risk groups, particularly MSMs and CSWs. Homosexual behavior is illegal in every country visited as is prostitution. Nevertheless, there are growing signs of recognition of the consequences of such legislation. The Bahamas recently decriminalized homosexual behavior and a more inclusive attitude toward PLWHAs was described in most—but by no means all—countries.

38. At the same time, significant barriers remain. One relates to the “age of consent” among adolescents. There is often a contradiction between law and practice, since many young people below the age of consent are sexually active but can be legally refused information, services or products, leaving them in some cases, at risk and unable to access the necessary information.

39. Positive work has been done in most of the countries on discrimination in the workplace and in reviewing the legislative framework. Unions and some employer associations are sensitizing their members to negative effects of discrimination against those who are HIV positive. ILO is helping draft legislation on discrimination in the workplace. Since 2002, PANCAP has worked with the Canadian HIV/AIDS Legal Network to assist governments in the region and in 2003, the Global Fund approved proposals that included bolstering current law reform efforts.

(d) Implementation Arrangements and Processes

Institutional arrangements

40. Participants in St. Lucia reported an array of arrangements for managing their national HIV/AIDS programs. Many of these arrangements were required by external donors such as the World Bank and the Global Fund. In most cases, they had led to lack of clarity of roles and responsibilities, confusion and conflict and continued to do so in several countries.
41. The chart below illustrates the inherent complexity. All World Bank projects required a high level body to approve, oversee and guide a National HIV/AIDS Program. These were typically called the National AIDS Commission (NAC), consisting of representatives of government, the civil society, PLWHAs, donors (in some cases) and other stakeholders. The NAC was to serve as the supreme body for managing the national response. In seven of the nine countries with a World Bank-funded project, the Prime Minister or President serves as Chairman. The NAC is typically served by a NAC Secretariat. In most African countries, the NAC Secretariats are the principal implementing or coordinating agency for the NAP.

42. The Global Fund created a separate high-level body to oversee and manage its activities at the national level. Country Coordinating Mechanisms (CCMs) were established to develop and approve national plans for submission to the GF. Membership was similar, but not identical, to the NAC.

43. Not only was the governance structure different, but implementation arrangements differed both between the GF and the World Bank and sometimes among World Bank projects in different countries. Project coordination and execution for World Bank-funded projects lies normally within the Ministry of Health. In some cases, however, the implementation responsibility lies outside the MOH and procurement and financial management are in some cases the responsibility of a Project Implementation Unit in the Ministry of Finance.

44. The Global Fund designates a Principal Agent to oversee its project. In some cases it is the MOH, but in others it is the United Nations Development Program (UNDP) or a private firm.

45. In addition to this complex institutional arrangement, early World Bank financed projects were designed around thematic areas (prevention, treatment and care, capacity building) rather than by implementing agency (CSOs, Line Ministries, MOH), which added to the problems of overlapping roles and uncertain responsibility and accountability. More World Bank funded recent projects are structured by implementing agency.
Implementation arrangements

46. Implementation arrangements have also proven to be problematic. Most externally-funded projects did not adequately address the constraints of smaller countries in following the rules designed for much larger states. Understanding and following procurement guidelines, financial reporting, progress reporting, auditing and other aspects have been time-consuming and costly and often beyond the capacity of small offices.

47. Some countries pre-finance expenditures eligible for World Bank financing through the regular government budgetary system. In such cases, planning, approval, financing and documentation of expenses require compliance with both the Bank and government procedures resulting in parallel reporting mechanisms. Line ministries carry out activities using government funds allocated in their budgets. They have little incentive to document and report their expenditures to the NAS or the PCU since they are already justifying their budgeted expenditures as a matter of government procedures. However the NAS or PCU need the documentation to be able to claim reimbursement. This results in very slow disbursement of the Bank funds.

48. Project Operations Manuals were required by the World Bank but are of uneven quality and are not widely distributed or referred to in any of the countries visited. Key implementation institutions including line ministries, civil society organizations and the health ministry staff are not familiar with the guidelines. The key aspect of 'how to' is missing from the project operations manual. Most project operations manuals are not explicit about how CSO can apply for funds, the approval process, what is needed in a proposal, its format, and reporting requirements.

(e) Harmonization among Donors

49. Country representatives at the St. Lucia workshop noted the good fortune of a significant flow of external resources but were concerned about their ability to manage such flows and deal with as many as eight donors and agencies working on HIV/AIDS.

50. The potential inflow of $460 million represents a significant influx of financial resources, in a comparatively short period of time, to relatively small island-states. The three principal funders are the Global Fund, the World Bank and the US President’s Emergency Plan for AIDS Relief (PEPFAR). As indicated below, the programs are operating in several countries at the same time.

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>World Bank</strong></td>
<td>US$117.65 Million over 5 years (mix of loan and grant)</td>
<td>Barbados, Dominican Republic, Grenada, Guyana, Jamaica, St. Kitts &amp; Nevis, St. Lucia, St. Vincent &amp; Grenadines, Trinidad &amp; Tobago, PANCAP</td>
</tr>
<tr>
<td><strong>US Government</strong></td>
<td>US$120.9 Million grant over 2 years (2004, 2005 only)</td>
<td>Dominican Republic, Guyana, Haiti, Jamaica, Regional</td>
</tr>
<tr>
<td><strong>The Global Fund</strong></td>
<td>US$225.176 Million grant over 5 years</td>
<td>Belize, Cuba, Dominican Republic, Guyana, Haiti, Jamaica, Suriname, OECS, PANCAP, CRN+</td>
</tr>
</tbody>
</table>
51. The review team identified challenges of harmonization and alignment in every country. On the financing side, donor financing—particularly the World Bank and Global Fund—is not aligned with country budget cycles and systems. Despite an explicit interest in harmonization and alignment, they are still focused on financing projects rather than broader national programs. The governance arrangements, on the other hand, tend to be fragmented due to the superimposition of the national AIDS authorities and the Country Coordinating Mechanism of the Global Fund. These duplicate mechanisms increase costs (and in smaller countries often involve the same people). Financial reporting and audit reports, disbursement requests and regular reporting follow donor-defined timelines and procedures rather than national ones. Pre-execution assessments and appraisals for fiduciary and implementation arrangements are often duplicated. There are examples in the Region of effective, country-driven harmonization among donors, such as in Guyana where the WB, GF (and IDB’s health program) share a common implementation unit, common procurement guidelines, a single audit for all projects and a harmonized financial reporting system. Such a model should be replicated, but it takes local leadership and commitment.

(f) Sustainability and Human Capacity

52. Participants in the brainstorming session were concerned about the sustainability of the national response in two respects: (i) financial sustainability and affordability; and (ii) human resource capacity.

53. The significant increase in international funding has enabled national programs to scale up their prevention, care and treatment programs dramatically. However, only a few countries such as Barbados, Trinidad and Tobago and St. Kitts and Nevis are using domestic resources to support their national programs. Others depend entirely on external funding. (In developing countries as a whole, about a quarter of HIV/AIDS expenditures are funded from domestic resources).

54. National programs have generally not estimated the potential cost of their programs beyond the current year. Estimation is admittedly difficult given the limited information on the number of infected or affected individuals and the potential demand for ART. Consequently, there is no regional estimate of the potential financial burden to the health system in applying the policy articulated recently by the G8 countries of “universal access”. Countries are still essentially “flying blind” both in the epidemiology of the disease and its potential cost.

55. Moreover, future funding from international sources is uncertain. Under current policy, countries classified as upper middle income under the World Bank classification system are not eligible for Global Fund financing. Therefore, only Cuba, the Dominican Republic, Haiti, Guyana, Jamaica and Suriname are eligible to apply for future rounds of Global Fund grants. Belize and the OECS countries will no longer qualify for funding. Six of the ten World Bank-funded projects will be closing in the next two years. The only two PEPFAR focus countries in the region are Guyana and Haiti.

56. This uncertainty raises both ethical and practical issues. As an ethical issue, the participants in the St. Lucia brainstorming asked how countries can offer testing and promise of “universal access” to treatment while funds are available if they will be unable to afford continuing such treatment once those funds have been exhausted. What are the moral, ethical, health (and political) consequences of scaling up today only to have to scale down tomorrow?
57. The related question was how countries are going to sustain the HIV/AIDS program on their own when 90% of PLWHAs in the region needing treatment are still not getting it. The epidemic is almost certain to demand more of the national health budget in the future as more and more individuals come forward and the eligibility for treatment expands (as recently in Guyana where the CD4 count cut-off point for eligibility has been raised from 200 to 350, adding about a third to the population of eligible recipients).

58. There is also a current crisis of lack of skilled manpower. Like other parts of the world, most Caribbean countries lack the skilled manpower to staff a full program of prevention, care and treatment. However, it is not so much the absence of the skills as the shortage of people. The individuals met by the Review team working in PCUs, clinics and VCT centers were usually well-qualified and motivated. But there were simply not enough of them. In Guyana, a pharmacist at a clinic said that 95% of the 53 students who graduated with him in 1999 have left the country. The St. Kitts NAC Secretariat is two people. The Review team estimates that less than 200 people in the eight countries visited are working full-time on HIV/AIDS.

59. Some donor funded programs (and some PCUs) are paying premiums to attract individuals, having the perverse effect of “capacity depletion” in the public services responsible for responding to the epidemic. Training programs are often preparing students for migration out of the country. The shortage of skilled staff, next to the effects of stigma and discrimination, is the single greatest obstacle to an effective response and has been aggravated by the donor approach to “poaching” staff to manage their own projects.

60. In brief, the national responses were guided by regional priorities for action and embraced a comprehensive approach. The health sector ministries have responded appropriately but other ministries and civil society organizations have been slow to come on board. Stigma and discrimination and human resource capacity are the key limiting factors to making rapid progress. M&E capacity in general is weak throughout the region. The dramatic increase in donor funds in the past two years necessitates urgent donor harmonization of programs, budget cycles and fiduciary management in each country.
IV. THE REGIONAL RESPONSE

61. The Caribbean has many regional bodies, including those dealing with HIV/AIDS, such as The Pan Caribbean Partnership against HIV/AIDS (PANCAP), established in 2001, the Caribbean Epidemiology Center (CAREC), the Caribbean Health Research Council (CHRC), the Caribbean Regional Network for People Living with AIDS (CRN+), the Organization of Eastern Caribbean States (OECS) and others. These organizations offer a potentially critical resource for building capacity, raising resources, providing technical support and promoting strong national responses given the diversity of the Region and the presence of many small countries. Two of the more important groups are described below.

PANCAP

62. The Pan Caribbean Partnership against HIV/AIDS (PANCAP) was created in February 2001 to address the HIV/AIDS epidemic in the region and was launched in Barbados at a meeting of Heads of State and Government of the Caribbean Community and Common Market (CARICOM) countries. PANCAP is not a legal entity; it is a CARICOM program and hence depends on CARICOM for signing authority on all matters. The Partnership has real promise however as it brings together governments, regional institutions, the international community, the private sector and civil society to achieve a more vigorous response to the epidemic at the national and regional levels.

63. CARICOM/PANCAP has been a strong advocate of HIV/AIDS programs and has raised awareness in the region of the potentially devastating social, human and economic impact of the epidemic. It has successfully mobilized financial resources of about $40 million from multilateral and bilateral organizations to sustain its operations and it has the power to convene all relevant institutions.

64. However, most member countries do not perceive the value-added of PANCAP, thereby diminishing its authority and credibility. A number of reasons account for the less than satisfactory performance of PANCAP to date. Staff shortages and a lack of technical and program management skills have thwarted fulfilling core functions of providing leadership, being proactive and ensuring a collective vision, and especially responding to requests of national programs. It has been a successful fundraiser for itself but not for member countries.

65. PANCAP is financed by international donors. Its long term sustainability will depend on the willingness of the CARICOM member countries to make contributions and that willingness will be a function of their perception of PANCAP adding value to their national programs. At the moment, PANCAP is not coordinating the M&E effort and does not aggregate regionally the progress made by the national programs and the impact of the national efforts in preventing and controlling the epidemic. PANCAP must ensure that political pronouncements by Heads of State translate into a supportive national environment that reaches lower political levels, especially Parliaments, where laws, regulations and policies to combat stigma and discrimination are defined and legislated and that also reaches the public sector government structures with its line ministries that decide on resource allocations, on recruitment and training of staff, on promoting prevention programs, on access to
free medicines, on entering into contracts with civil society. PANCAP should advocate issues that are politically sensitive and too controversial to be brought up by national governments.

**Organization of Eastern Caribbean States (OECS)**

66. The Organization of Eastern Caribbean States (OECS) is a loose federation of nine countries with about half a million inhabitants headquartered in Saint Lucia. Four of the nine countries have World Bank financed HIV/AIDS projects and six countries have a multi-country Global Fund contribution of US$ 10.2 million approved in 2005.

67. The OECS countries have small populations, economies are fragile and based on tourism and single crop exports, and they are highly vulnerable to natural disaster. The national responses have developed slowly primarily related to a lack of data on the epidemic and its behavioral aspects and to the limited management capacity of government and civil society to respond adequately. Capacity to carry out effective programming is limited by the small country size, mobility of the population, in particular out migration of qualified staff, and high cost of conducting business since most equipment and medical supplies must be imported.

68. One promising regional initiative is the common purchasing arrangement for pharmaceuticals, The Pharmaceutical Procurement Service (PPS) is a regional procurement agent for pharmaceuticals and perishable medical supplies set up for OECS countries and is judged to be a good practice. The Policy Board of OECS/PPS consists of the Ministers of Health of the nine countries and the Director General of OECS. Pooled purchasing for the region improves the negotiation power to lower prices for ARVs. The PPS is also responsible for quality assurance, forecasting demand and distribution. The PPS can only negotiate lower prices and sustain its operations if all OECS countries procure through the PPS and do not undermine the collective pooling process. Some countries are reluctant to pay the 13% (recently reduced from 15%) administrative fee, which, according to the PPS includes the costs of quality assurance and testing the pharmaceuticals. Specific provisions were made under the projects in St. Kitts and Nevis, Grenada, St. Lucia and St. Vincent and the Grenadines to support the purchase of drugs and other medical supplies under pooled arrangement of the PPS.

69. In brief, a coordinated and integrated regional response is essential in the Caribbean given the many small countries and the heterogeneity of the region. Many regional bodies exist among which PANCAP and the OECS are the largest and have the most promise for building capacity and supporting national responses.
V. THE INTERNATIONAL RESPONSE

70. Bilateral aid agencies and international non-governmental organizations have been engaged in fighting the HIV/AIDS epidemic in the Caribbean for some time. It was only in 2000, however, that the major multi-lateral organizations became committed to supporting the Region.

71. The World Bank initiated the Multi-Country HIV/AIDS Program (MAP) for the Caribbean Region in September 2000 at a regional meeting in Barbados organized by the World Bank and Government of Barbados with support of CARICOM, UNAIDS Secretariat and PAHO. At the time, the World Bank pledged US$155 million. Its financial support and leadership helped raised awareness of the epidemic at the political level and encouraged heads of state to speak out publicly on the issue.

72. The first three approved projects were Barbados (US$15.2 million), the Dominican Republic (US25.0 million) in FY 2001 and Jamaica (US$15 million) in FY 2002. Seven more projects were funded during the next three fiscal years to reach an estimated commitment of US$117.65 million over a five year period, as indicated below:

<table>
<thead>
<tr>
<th>Country/Organ.</th>
<th>FY Approved</th>
<th>Amount (US$m)</th>
<th>Amount Disbursed 10/05</th>
<th>% Disbursed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barbados</td>
<td>FY01</td>
<td>15.2</td>
<td>8.3</td>
<td>55</td>
</tr>
<tr>
<td>Dominican Rep.</td>
<td>FY01</td>
<td>25.0</td>
<td>9.2</td>
<td>37</td>
</tr>
<tr>
<td>Jamaica</td>
<td>FY02</td>
<td>15.0</td>
<td>3.9</td>
<td>26</td>
</tr>
<tr>
<td>St. Kitts &amp; Nevis</td>
<td>FY03</td>
<td>4.05</td>
<td>0.3</td>
<td>7</td>
</tr>
<tr>
<td>Grenada</td>
<td>FY03</td>
<td>6.0</td>
<td>0.4</td>
<td>7</td>
</tr>
<tr>
<td>Trinidad &amp; Tobago</td>
<td>FY03</td>
<td>20.0</td>
<td>1.4</td>
<td>7</td>
</tr>
<tr>
<td>PANCAP</td>
<td>FY04</td>
<td>9.0</td>
<td>0.9</td>
<td>10</td>
</tr>
<tr>
<td>Guyana</td>
<td>FY04</td>
<td>10.0</td>
<td>0.4</td>
<td>4</td>
</tr>
<tr>
<td>St. Vincent &amp; the Grenadines</td>
<td>FY05</td>
<td>7.0</td>
<td>0.3</td>
<td>4</td>
</tr>
<tr>
<td>St. Lucia</td>
<td>FY05</td>
<td>6.4</td>
<td>0.3</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>117.65</strong></td>
<td><strong>25.40</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>

73. Early cost estimates showed that treatment would be expensive and not sustainable at the then prevailing prices of drugs and Bank policy therefore at the outset focused only on prevention, judging treatment not to be cost-effective.

74. The World Bank was the first major funder to recognize the threat posed by the HIV/AIDS epidemic to the people and to the economies of the Caribbean region and the first multi-lateral organization to finance projects. Its early action as a financier and as a strong advocate helped to jump-start the fight against the HIV/AIDS epidemic, raised awareness and secured political commitment at the highest level in support of a comprehensive response including prevention and treatment. The technical assistance accompanying the financing helped build organizational structures and supportive implementing arrangements that included the public and private sectors.
The World Bank insisted on good governance, appropriate organizational and fiduciary arrangements and efficient and effective implementation mechanisms.

75. At the same time, implementation results so far are mixed and are partly due to Bank actions and partly to regional and country situations. As of October 2005, about 22 percent of approved funds have been disbursed. The average rate of disbursement as of the same date for the first three projects that were approved in 2001 and 2002 was only 39 percent which is a slow rate by any standard. The review team reviewed nine of the ten projects in the field on a half-dozen major aspects and rated half of the projects unsatisfactory or marginally unsatisfactory overall.

76. The team felt that several projects were prepared too quickly without the benefit of baseline data and without fully matching the development objectives and programmatic activities with the countries’ needs and capacity. High level political pronouncements did not translate into changes in government operations or budget allocations. Recipient countries often had limited or no experience with the World Bank and its requirements.

77. The countries’ own bureaucratic procurement procedures were often compounded by the World Bank procurement procedures. World Bank fiduciary requirements often required countries to create parallel systems and have served as disincentives to using loan proceeds. Not enough attention was paid to capacity constraints and to capacity building. With more donors becoming active as of 2004 with grant financing, the Bank did not adjust its strategy taking into consideration the additional funding and absorptive capacity, and failed to harmonize its efforts with the new partners.

78. In short, the Bank did the right thing in becoming involved early and in providing financial resources. It did not always do things right during implementation – even when taking into account the heterogeneous and idiosyncratic nature of the Caribbean countries

79. The Global Fund signed its first contract in the Region in December 2002 with Haiti followed by Cuba in June 2003. To date, it has committed about $225 million to seven countries and three Regional organizations—PANCAP, the OECS Secretariat and CRN+. The approach and procedures of the Global Fund differ considerably from those of the World Bank, including the use of a Country Coordinating Mechanism (CCM) to review and approve proposals rather than the National HIV/AIDS Councils (NAC) established under many Bank-funded projects. Project execution is the responsibility of a Principal Recipient that may, or may not, be implementing World Bank-funded projects. The Global Fund does not supervise projects in the field and relies on a Local Fund Agent (LFA) to oversee fiduciary compliance. The Global Fund also provided grants at a time when the World Bank made only IBRD loans or IDA credits (it has since begun providing some grant funding). Disbursements from the Global Fund are performance based and the first phase of the grant must be disbursed within two years to be eligible for additional resources.

80. These differences between the two largest multi-lateral donors have often complicated implementation, with national programs trying to respond simultaneously to very different requirements for procurement, disbursements, monitoring and reporting. The Global Fund has also faced initial implementation difficulties similar to the World Bank program. As of August 2005, the average Global Fund program was 4.6 months behind schedule in the Caribbean, ranging from 5 months ahead of schedule in Cuba to 9 months behind schedule in Haiti. With a time limitation of 24 months, these delays can have significant consequences for additional funding.
81. The other major financier of HIV/AIDS Programs in the Caribbean is the US Government - through USAID and President Bush’s Emergency Plan for AIDS Relief (PEPFAR). The US Government has committed about $120 million for work in four countries—the Dominican Republic, Guyana, Haiti and Jamaica—plus a regional program. Guyana and Haiti are PEPFAR focus countries. Unlike the World Bank and the Global Fund, the US funded programs do not rely on “national execution” by the local government or local agencies. Implementation responsibility is vested in US government agencies like the Center for Disease Control, US-based consulting firms and international and national non-governmental organizations to carry out the program. PEPFAR did not participate formally in this review, but Review team members met with PEPFAR staff in the field. It appears that there is a good deal of informal collaboration at the local level but there is no formal mechanism for harmonizing the activities of PEPFAR with other major donors.

82. In essence, the arrival of significant new funding has been a welcome development in supporting the national and regional response, but has created significant problems and inefficiencies in coping with the proliferation of demands from funders. It suggests the importance and value of concentrated donor attention to harmonizing business practices and “walking the talk” about the “Three Ones”.

VI. THE OVERALL SENSE OF PROGRESS

83. On the basis of its analysis, interviews and site visits, the Review team assessed the progress in the Caribbean Region response to the HIV/AIDS epidemic to be positive in several respects but generally much less forceful and coherent than needed. In some respects, it found most countries in the Caribbean at the level of response comparable to that of the Africa Region a decade ago. Fortunately, the Caribbean is well-positioned to sidestep many of the difficulties of the past decade elsewhere, and has the financial resources at the moment to make significant progress. But there will need to be far higher levels of political commitment, human resources, domestic funding, commitment to combating stigma and discrimination and the collaborative approach of major donors to ensure an effective long-term response to the epidemic.

84. On the positive side, the review team found that every country had made progress in organization, staffing, strategic planning, administrative procedures and initiating and publicizing the response. Although needing to become more functional and efficient, the administrative foundations are in place. Political awareness is high. Treatment is intensifying. New infections appear to be declining in some places for some groups, although consistent evidence is still hard to come by. Countries like Barbados are allocating significant budget resources (US $50 million). Other countries like Guyana are encouraging donors like the World Bank, The Global Fund and PEPFAR to collaborate more systematically. There are examples emerging of an effective regional response such as the common pharmaceutical purchasing program by the OECS countries. And at the international level, donors have committed over US$460 million to fight HIV/AIDS in the Caribbean.

85. At the same time, the overall response is still lagging. Evidence on the nature and course of the disease is still limited and no operational M&E systems are in place. Staff resources are still very scarce and likely to remain so. Country strategies tend to be generic and generally not used for developing annual work programs. The response in several countries is still health sector-oriented, and line ministries and the civil society are not playing the roles they could in combating the illness. The current focus on treatment has not been complemented by an adequate effort on prevention, including the need to combat stigma and discrimination. The Regional response is still nascent. International donors have complicated the response at the national level and are responsible in no small part for the slow implementation of their projects.

86. In essence, the Review team believes the foundations are in place for an accelerated and more effective response. What is needed now is better focus, simplicity and collaboration—intensifying prevention and combating stigma and discrimination and greater simplicity in implementation arrangements. In addition an explicit collaboration at the national level (with government, civil society and private sector), at the regional level (with PANCAP, CAREC and others with regional programs) and at the donor level, particularly harmonization efforts by the World Bank and Global Fund. The theme of focus, simplicity and collaboration is the basis for the recommendations that follow.
VII. RECOMMENDATIONS

87. The Review team has grouped its recommendations into three clusters: enhancing the national response, the regional response and the international response. The principal recommendations are summarized in the box below.

<table>
<thead>
<tr>
<th>Principal Recommendations</th>
</tr>
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<tbody>
<tr>
<td><strong>Enhance the national response:</strong> (i) Refocus attention on prevention, especially stigma and discrimination, (ii) simplify implementation; and (iii) build local capacity, particularly on monitoring and evaluation.</td>
</tr>
<tr>
<td><strong>Enhance the regional response:</strong> Invigorate PANCAP and other regional agencies such as CAREC, CHRC, CRN+ and the OECS Secretariat to serve national programs more effectively.</td>
</tr>
<tr>
<td><strong>Enhance the international response:</strong> (i) Develop a strategy for sustainable financial support for HIV/AIDS; and (ii) harmonize the donor response around the “Three Ones.”</td>
</tr>
</tbody>
</table>

A. ENHANCING THE NATIONAL RESPONSE

The Review team felt that two aspects of the national response warranted priority attention: (i) the restoration of a strategic balance among prevention, care and treatment and (ii) more effective implementation, based on evidence. Recommendations (a) and (b) relate to the strategic balance. Recommendations (c), (d) and (e) focus on ways to enhance implementation capacity.

(a) **Restore strategic balance**

**Recommendation:** A new generation of useful, practical strategic plans should be prepared in each country with priorities, costs and annual work plans reflecting unique local conditions. Renewed emphasis is needed on prevention and especially on vulnerable populations, the multi-sectoral dimension and the full engagement of civil society and the private sector. These strategic plans could be the foundation of a more programmatic approach.

88. Though prevalence levels are currently relatively low, it is not possible with certainty to predict the eventual course of the epidemic in the region. A more strategic design of interventions presents an opportunity to take into account the lessons learned elsewhere, to curtail the possibilities of a much more serious epidemic. The current emphasis on treatment needs to be balanced with a renewed focus on prevention.
89. Several countries in the region are either coming to the mid-term of their World Bank projects, to the second phase of GF financing, or need to review and revise their NSPs. The review team recommends that in these countries, a full review of national priorities and strategies (including attention to balance between program components, implementation arrangements, and operational modalities) be undertaken in light of existing evidence, and that national programs, World Bank projects, and initiatives financed by the Global Fund and other donors be revised in light of these reviews. International bodies should jointly provide the technical and financial support necessary to undertake these strategic processes as necessary.

90. National programs should review in particular the multi-sectoral approach, civil society and private sector engagement during the proposed strategic planning processes, with a view to enhance financial and technical support for capacity development. Countries should consider prioritizing a reduced number of line ministries for short-term support.

(b) Address stigma and discrimination head-on

Recommendation: As a first priority in restoring the strategic balance, each country should initiate a concentrated attack on stigma and discrimination. The effort should focus on analysis of the nature of discrimination, a public communications program, legislative action especially on discrimination in the workplace, and possibly monitoring and reporting incidents. Regional organizations should recommend interventions that have been introduced, measured and proven to be successful in similar environments.

91. Many forms of stigma and discrimination were identified in this review that require different types of sensitization/communication strategies and interventions, policy and legal reform approaches, and other strategies directed to the particular bias, prejudice or intolerance within a human rights context. A first step should be to analyze the nature and extent of discrimination in a particular country context paying special attention to vulnerable populations that are among the most stigmatized.

92. A second step is to develop a communications strategy. The general public needs to understand the epidemic and receive appropriate information to protect their health, and obtain testing, care and treatment services, and to understand that the persistence of stigma will retard efforts to expand services and bring the epidemic under control. The strategy should include campaigns to reduce discrimination, such as that against MSMs and commercial sex workers and to safeguard the human rights of all citizens.

93. A third step is to build on and expand the Champions for Change initiative bringing together and engaging the support of leaders from other sectors.

94. National programs should consider assessing incidents of discrimination against PLWHAs by type of incident whether committed by an individual, community, company, health care worker, school, and developing different approaches to dealing with such incidents ranging from communication campaigns to penalizing offenders.

95. Special attention should be directed towards discriminatory practices by health professionals who engage in unethical practices, such as refusing to respond to PLWHAs crises or illnesses, or disseminating information about HIV positive persons among their peers, and in the community. Approaches may vary from sensitization of health professionals to reprimands for unethical conduct.
(c) Develop a more-evidence-based approach: implement practical M&E processes and expand epidemiological surveillance.

**Recommendation:** National programs should adopt as a first priority a simple, low-tech and practical monitoring and evaluation system. Basic indicators and expected results should be harmonized by donors and national programs in each country. Epidemiological surveillance should be intensified.

96. National programs need to finalize national M&E frameworks and the systems required to support these frameworks, to allow, among other things, prioritizing interventions for vulnerable populations based on evidence collected at the national level.

97. M&E systems should be simple and low-tech and focus on development of national capacity, both within AIDS programs and within the health sector. The focus of such systems should primarily be on enhancing the current information data collection procedures from local entities (health facilities, schools, etc). In addition, simple systems should also be used to gather population-based data to assess behavior changes and measure outcomes.

98. Regional and international expertise should be provided since local experience and staff are limited, and several countries have no individuals skilled in M&E. CHRC needs to build its own capacity to provide support to national programs.

99. Ministries of Health already have the capability of collecting epidemiological data and have a legal obligation to report certain communicable diseases. MOH epidemiology departments require support to be able to carry out sero-prevalence studies and behavior surveillance surveys that include biological indicators (incidence and prevalence data) and behavioral indicators combined with socio-demographic indicators.

(d) Simplify implementation arrangements and procedures

**Recommendation:** To speed implementation, a joint review in each country with donors should be carried out on basic implementation procedures related to procurement, financial reporting, disbursements and decision-making for grants to line ministries and civil society organizations. The review should aim to harmonize donor procedures with national procedures, wherever possible. The World Bank should consider special arrangements for meeting the fiduciary requirements of small states.

100. Ways need to be found to simplify processes and procedures. Bureaucratic requirements of both countries and donors overly complicate program implementation. One approach to dealing with this over-complexity would be through a participatory review of basic procedures, involving key stakeholders and international partners and keeping with the principals of the Three Ones. A review could be organized as follows:

- Constitute a task-team with qualified technical professionals, consultants, and partners to review the program, management practices and setup, and propose a practical and a harmonized arrangement suitable for small states;
• Review World Bank disbursement and procurement procedures, CSO and line ministry proposal approval processes, operational manuals, and coordination mechanisms and propose revised processes for key implementation partners;

• Clarify roles and responsibilities of the key institutions and the individuals responsible to coordinate or implement various interventions;

• Avoid a competitive process to finance CSO proposals and approve them on the basis of clearly spelled out selection criteria. Consider contracting national or international umbrella NGOs to jump-start the civil society response.

(e) Build local management and capacity

Recommendation: To reflect the reality of a permanent shortage of skilled staff in many countries, mechanisms need to be put in place that facilitate cross-country sharing of staff, greater use of volunteers, selected donor-managed activities and other innovations to enhance efficiency without increasing numbers of people.

101. Implementing agencies are likely not to be able to add new staff and new skills on a permanent basis. There is too much labor mobility and too few people in some parts of the Region. Alternative ways are needed to attract and retain skilled staff.

102. The Review team recommends exploring a range of technical assistance mechanisms for countries focused on results over the short to medium term with special attention to OECS countries. Options to explore:

• A resource directory or registry of regional consultants/ experts by area of expertise to be made available to countries online.

• Setting up opportunities for sharing management experiences between countries through horizontal cooperation, de-emphasizing the large regional workshop approach.

• Explore developing cooperation agreements with volunteer organizations (VSO/Great Britain, Peace Corps and others) to provide day to day “hands-on” assistance.

• Examine the possibility of developing partnerships with the private sector to provide management training for program managers.

• Establish new or reinforce existing inter-university technical cooperation agreements between The University of the West Indies (UWI) at country level and universities within the region, in the UK and US through which

  - Faculty members can collaborate on a series of projects (not studies) in areas such as communication, civil society response, tourism, public administration,

  - Students from a variety of disciplines can participate in an internship program in countries to assist with basic day to day management functions.

• Conduct a joint donor-country assessment of civil society capacity needs and assist the development of CSO partnerships so that more experienced organizations can partner with less experienced NGOs/CBOs/FBOs.
103. In addition, over the short to mid term, it would be useful to organize a joint donor–
country sponsored assessment of government needs/demands for technical managerial support of
day-to-day program management focusing on practical areas. In particular:

- national strategic plan development, emphasizing understanding the strategic balance
  necessary in developing national responses and costing exercise,
- program management including day to day management, prioritizing, assigning task,
  monitoring and reporting,
- basic approaches to manage M&E systems,
- contracting services in cases where the public sector or country size are limiting factors.

B. ENHANCING THE REGIONAL RESPONSE

The Review team felt that an effective regional response has to be the centerpiece of the attack on HIV/AIDS epidemic
in the Caribbean Region. Individual countries are typically too small to mount a full-scale response, and the mobility of
the Region argues strongly for a coordinated multi-country response. The team feels that a priority of both the donor community and individual country programs should be to help regional organizations build their own capacity to serve the Caribbean community more effectively.

(a) Invigorate the Regional Response

Recommendation: Build the capacity of PANCAP and other regional agencies such as CAREC, CHRC, CRN+ and the OECS Secretariat to coordinate critical aspects of the response and serve national programs more effectively.

104. The Caribbean Region has a relative abundance of regional organizations, including those focused on health. These organizations will inevitably have to play a more prominent role in dealing with the HIV/AIDS crisis.

105. At the moment, most of the regional bodies are not yet able to fulfill their responsibilities due to staffing shortages, lack of clarity over certain roles, uncertain relationships among each other and other factors. Multiple donor demands also complicate their situations.

106. PANCAP is the single-most critical regional body on HIV/AIDS. To play its role fully, it needs to develop its strategic direction, a results-based work program, staffing plan and standards of performance in full collaboration with its partner countries and organizations.

107. As a first priority, PANCAP needs to increase the number of staff and its technical, managerial and language skills, possibly by seconding staff from other organizations on a temporary basis.

108. PANCAP also needs to build its relationships with national programs, carrying out client surveys and possibly rotating staff through implementing agencies and national programs to understand better their needs and enhance the provision of value-added services.

109. The regional strategic framework should also be updated, with a comprehensive action plan, cost estimates, annual work programs, benchmarks and a harmonized M&E framework supported by
all donors. PANCAP’s capacity to foster technical collaboration can be improved through the development of a web-based portal to improve information sharing on experiences, good practice, technical support availability, training opportunities and other regional support activities.

110. Over time, PANCAP may wish to consider structural changes that could enhance the regional HIV/AIDS response, including (i) creating a more “virtual organization” with key staff stationed in countries more centrally located, closer to its clients, and with a good communication and transportation network to support implementing agencies and national programs; and (ii) converting PANCAP into a self-supporting, service-oriented organization with decision-making authority on the acquisition and use of its technical and human resources and functioning as an autonomous unit within CARICOM with a full-time manager.

111. To develop a specific program of action, donor organizations, national programs and the regional bodies should meet to consider how best to support these regional bodies—PANCAP, CAREC, CHRC, CRN+ and the OECS Secretariat—to fulfill their mandates and take greater responsibility for results.

C. ENHANCING THE INTERNATIONAL RESPONSE

The Review team felt that international organizations, including their own, should be playing a more collaborative and supportive role in the Region, and “walking the talk” on harmonization in support of the “Three Ones.” The team believes that the harmonization effort should focus on financial sustainability, formal efforts to collaborate at the national level among major donors and a more prominent role for UNAIDS within the Region.

(a) Develop a Strategy for Sustainable Financial Support in the Medium Term

Recommendation: To ensure greater predictability and avoid the moral hazard of countries adopting a policy of free universal access to treatment and prevention services without the capacity to sustain treatment, UNAIDS should carry out an analysis of future funding requirements at the country level. UNAIDS, the World Bank, the Global Fund and bilateral donors should subsequently meet to indicate their likely funding for HIV/AIDS activities over the medium term. The Bank and UWI and others should also analyze potential funding from national budgets and possible “cost-sharing” arrangements.

112. The medium-term financial stability of the HIV/AIDS Program in the Region depends on two factors: (i) a realistic estimate of the likely cost over the next five years and (ii) more predictable funding. UNAIDS has recently estimated the “resource needs for an expanded response to AIDS in low-and middle-income countries” (August 2005). It estimated global funding needs of $15 billion in 2006 rising to $22 billion in 2008 for prevention, care, treatment support to orphans and vulnerable children as well as program and human resource costs. The same approach could be used to estimate the three year cost for each national program and the regional program in the Region. We suggest that UNAIDS, the World Bank and PANCAP collaborate on developing a medium-term funding framework for the Caribbean.
(b) The World Bank, Global Fund and other major donors should articulate their future intentions to support the HIV/AIDS response in the Caribbean.

Recommendation: The World Bank, the Global Fund, bilateral programs (including PEPFAR) and other donors including foundations should articulate strategies to support the HIV/AIDS response over the medium term.

113. The development of the medium-term financing strategy recommended above will depend in large measure on the articulation of a medium term program of support by the major funding agencies. As the principal provider of long-term development finance, the World Bank program in particular needs to be articulated to give a measure of predictability to national and regional efforts.

114. The current World Bank program focusing on nine countries and PANCAP needs to be reviewed and revised in light of current implementation difficulties. It may include “re-dimensioning” several projects, intensified supervision of the portfolio and development of a strategy for future engagement, focused on its comparative advantages in relation to other funders.

115. Similarly, the future involvement of the Global Fund in the Region, reflecting its current policies on eligibility and performance, should be reviewed. It may wish to revisit the use of IDA-eligibility criteria in a Region with relative higher income levels but serious constraints on funding and human capacity.

116. While outside the scope of this Review, PEPFAR represents an important instrument for addressing critical issues in the national response and scaling-up treatment. Ways should be found to encourage more formal collaboration at the national level and greater harmonization of approaches.

(c) Initiate Donor Harmonization at the Operational Level

Recommendation: The World Bank and Global Fund, in collaboration with bi-lateral partners, should implement an explicit harmonization program in two countries—the Dominican Republic and Guyana—to test out the practical implications for using single mechanisms for procurement, financial management, reporting, disbursements and program oversight. For a fee, the World Bank might agree to serve as implementation agent for the Global Fund which does not supervise projects in the field.

117. Donors should work together to identify approaches to improving alignment of their financing with country cycles and systems. In particular, joint assessments of financial management procedures can be carried out in pilot countries, and adjustments made to increase alignment.

118. Wherever feasible, donors—particularly the World Bank and Global Fund—should carry out joint assessments before execution starts (procurement, financial, M&E, etc) and work with the same executive agencies.

119. In terms of national coordination, we recommend that countries, the Global Fund and UNAIDS revisit the possible duplication and conflict between the CCM and National AIDS Committee mandates, and move toward a single national authority in line with “The Three Ones.” This would be a prerequisite for moving to the preparation of annual action plans and budgets that might form the basis of a programmatic approach by multiple donors.
120. We recommend that the WB and the GF should carry out joint program reviews in two countries of the region on a pilot basis to share information, align procedures, and methodologies, to pave the way for performing evidence-based assessments or evaluations of results in the future. Guyana and the Dominican Republic might make good pilot countries given the current efforts toward a more programmatic approach generally. The World Bank and Global Fund might consider having the World Bank carry out supervision of implementation of both organizations’ programs on a fee basis, as the World Bank currently does for the Global Environmental Facility and the International Fund for Agricultural Development.

(d) Encourage greater collaboration among UN agencies and UNAIDS leadership in the Region

Recommendation: The UNAIDS Secretariat should increase its presence in the Region, especially in smaller countries like the OECS, and exercise the leadership expected on facilitation among UN agencies and harmonization among major donors.

121. With the advent of the Global Task Team (GTT) focus on clarifying the UN system division of labor in response to the epidemic in light of implementation bottlenecks and the comparative advantages of UN system organizations, the UN in the Caribbean has an important opportunity to change the course of the region’s epidemic. The UNAIDS Secretariat, in particular, will play a key role in facilitating more effective UN system support, in addition to providing leadership to the general harmonization processes of multi- and bi-lateral development partners.

122. To play this leadership role effectively, the review team believes that the UNAIDS Secretariat should urgently review its operations in the region, including the number, location and skills mix of staff. While several countries already benefit from the support provided by UNAIDS Country Offices (Guyana, Jamaica, Dominican Republic, Haiti), the review team urges UNAIDS to intensify its presence in the region and to consider adding additional staff. Of particular concern in this regard is the sub-region comprised of OECS countries, where there is currently a vacuum in coordinating support.
VIII. CONCLUSION

123. While the Caribbean may have the second largest HIV prevalence after Africa, in absolute terms the number of people living with HIV/AIDS is still modest, an estimated 440,000. This is half the number in Malawi alone, and a third of the numbers in Kenya or Tanzania. External funding for the moment is also generous.

124. Why, then, does the Review team recommend intensified action and greater international presence in the Region?

125. There are several reasons.

- First, HIV/AIDS is still hidden from view and there is still too little knowledge about the epidemic and its possible future course. Hence our emphasis on gaining evidence through M&E and attacking stigma and discrimination that perpetuates the darkness around the disease.

- Second, if there is a single-most important lesson from experiences elsewhere it is the importance of addressing the disease early and quickly before it becomes generalized (as it has already in Haiti and elsewhere). Hence our stress on prevention, communications and good program management.

- Third, the health costs of the epidemic are about to explode if countries adhere to the G8 call for “universal access” to prevention and treatment, when 90% of infected persons are still not being treated. Hence our call for an analysis of medium term funding needs and development of a sustainable financing strategy.

- Fourth, the countries of the Region are particularly vulnerable due to their small size and fragile economies. Economic and human losses through HIV/AIDS could have a particularly devastating impact.

- Finally, the Region is the ideal place to test out and realize the concepts of donor and country harmonization on the ground. Efforts are already underway in some countries. The Region is also blessed with regional organizations with a history of collaboration that can demonstrate the value-added of regional cooperation in this area.

126. The principal message of this Review is about focus, simplification, harmonization and improved effectiveness in working together in the fight against HIV/AIDS. Taken together, we believe these recommendations can help make the response in the Caribbean a model for the world.
ANNEXES

1. Terms of reference

2. Review teams and countries

3. Acknowledgments

4. Suggested Responsibility for Follow-Up to Recommendations
Annex 1 - Terms of Reference

Caribbean Region HIV/AIDS Review

Introduction

1. Faced with a growing HIV/AIDS threat in the Caribbean Region and the lack of an effective response in most countries, the World Bank initiated a significant program of support to the Region in 2001. HIV/AIDS projects were approved for Barbados and the Dominican Republic in FY01 and Jamaica and Grenada in FY02. Five other projects followed in FY03 and FY04 for three small island countries (St. Kitts, St. Lucia and St. Vincent), Trinidad and Tobago, Guyana and the Pan Caribbean HIV/AIDS Partnership of the Caribbean Community. World Bank support for these ten operations totals $117.65 million.

2. The projects were prepared quickly to stimulate a rapid response to the epidemic—developing strategic plans, a structure of governance, building implementation capacity, raising awareness and initiating a major effort for prevention and care.

3. The quick response by the Bank has not been accompanied by a quick response on the ground. Less than 20% of the funds had been spent as of June 30, 2005. The five oldest projects are all officially classified as problem projects or “projects at risk,” and the five newer projects have disbursed only $2.6 million of $52.4 million, or 5%. Several of them are problem-projects-in-waiting.

4. Moreover, since the appraisal of these projects, a number of important new players have become actively involved in the battle against HIV/AIDS in the Region, including the Global Fund to Fight HIV/AIDS, Malaria and TB (Jamaica, The DR and elsewhere), the US PEPFAR program (in Guyana), UNAIDS, the Clinton Foundation and others. These are grant programs in contrast to the majority of the Bank-financed projects which are loans.

5. Given these changing circumstances, the World Bank Latin America and Caribbean Region wishes to undertake a review of its HIV/AIDS Program in the Caribbean, to assess its progress, challenges, viability, relationship to other activities and future direction.

Objectives

6. The Caribbean HIV/AIDS Program Review will review progress of the individual projects and the program as a whole against their original objectives and in conjunction with the programs available from major bilateral and multi-lateral partners, especially the Global Fund for AIDS, TB and Malaria. Its principal objectives are the following:

- To identify obstacles and challenges that limit progress and threaten the viability of the Bank and other major donor programs in realizing their objectives
- To identify opportunities for strengthening the role of the Secretariat of the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP/CARICOM) and partner agencies supported by PANCAP (in particular the UNAIDS Regional M&E office) in addressing capacity-building needs and bottlenecks faced by national and regional agencies supporting project implementation
• To identify the principal value-added of the Bank program and presence and suggest ways to harmonize the Bank-funded effort with the other bilateral and multilateral partners

• To recommend the future strategic direction for the Bank program and specific measures to rationalize the Bank-financed portfolio in light of the above, and

• To estimate the possible cost and timing to the Bank of any reconfiguration effort.

7. In reviewing progress on the implementation of the Bank projects, particular attention will be paid to (i) initial project designs, (ii) institutional arrangements and procedures, (iii) operational support by the Bank, (iv) progress in such areas as M&E, treatment and IEC, and (v) partnership arrangements with other international and regional programs such as the Global Fund, UNAIDS, US Government (PEPFAR, USAID) and PANCAP/CARICOM, the Caribbean Epidemiological Center (CAREC) and the University of the West Indies.

Approach

8. The review will be carried out by a multi-donor team from the World Bank, UNAIDS, the Global Fund, DfID and potentially others. The team will assess the overall international and national response to the HIV/AIDS epidemic in the Region with a view to rationalizing and focusing the future efforts of the World Bank program.

9. The team will carry out its review as follows:

• **Review relevant information** on (i) the strategic HIV/AIDS plans for the countries of the Region and national response programs, (ii) the most recent epidemiological information that depicts the type of epidemic on each island and in the Region, (iii) the strategic plans of the donor agencies for the Region, including the World Bank, Global Fund, UNAIDS, the USPEPFAR, (iv) project documents for the ten World Bank-financed projects (concept notes, Project Appraisal Documents (PADs) and project implementation reports), and (v) other relevant material on the response to the epidemic in other parts of the world, including Bank economic and sector work, OED reports and assessments by UNAIDS and others

• **Participate in portfolio reviews** of these projects, such as the review of procurement and financial management arrangements for the Region scheduled for September 2005

• **Interview stakeholders** both in the World Bank and in the field, including task team leaders and staff, Bank managers in LAC and in the Health and HIV/AIDS sectors, project implementation unit (PIU) managers and staff and other officials in selected countries of the Region, NGO and private sector representatives and specialists in the academic communities

• **Carry out site visits** to selected countries, including Barbados (or Dominican Republic), Jamaica, St. Lucia, Grenada, St. Kitts and Guyana, including visits to VCT clinics, organizations of people living with AIDS and other activities at the grass roots level

• **Organize a day-long brainstorming session** with PIU and other staff on operational issues, and
• Invite the representatives of the partner organizations to provide their individual perspectives on the appropriate role of the World Bank-supported program. In addition, they will each be asked to draft a specific portion of the Final Report and to do one brief country report on the site visits.

Staffing

10. The review will be carried out by a collaborative team representing the principal agencies involved in the HIV/AIDS effort in the Caribbean, including the following:
   • World Bank
   • UNAIDS Secretariat
   • Global Fund
   • DfID

11. The team will consult with other major donors in the Region including the Inter-American Development Bank, USAID/PEPFAR, the Caribbean Development Bank, Canadian CIDA, GTZ, France and UN agencies.

12. The review will seek to include staff with the following skills:
   • Epidemiological understanding of the HIV/AIDS epidemic and approaches to treatment, care and prevention
   • Experience in project analysis, design and management
   • Fiduciary management (financial management and procurement, if possible)
   • Knowledge of the Caribbean Region
   • Strategic understanding of the global effort to combat the HIV/AIDS epidemic,
   • Capacity in governance/institutional diagnosis (DfID), and
   • Specialist in M&E.

Output

13. The review team will produce a focused report of no more than 25 pages on their findings and recommendations. It will include (i) suggestions for the future strategic direction of the Bank-supported effort, (ii) recommendations for changes to individual operations to support the strategic direction, including cancellations if appropriate, (iii) proposed mechanisms to further strengthen collaboration with partner agencies, and (iv) suggested modifications, if any, to Bank support to the program, including staffing, budgeting, management oversight, and procedural improvements.

Timing

14. The review will be carried out from mid-September 2005 to the end of October 2005. The tentative schedule:
• September 19-23: Washington. Document review, interviews with Bank staff, refinement of work plan, discussions with Washington-based partners like USAID

• September 26-October 7: Field visits. Initial joint meeting with selected PIU managers and staff in convenient location such as St. Lucia, team visits (in two groups) to Jamaica, Barbados (or the Dominican Republic), St. Lucia, St. Kitts, Grenada and Guyana (including PANCAP)


• October 28: Submission of Final Report to Bank Management.

• Mid-November: Release of Final Report to participating partner agencies.

Cost

The estimated cost of the Review is $130,000. It is expected that the partner agencies will cover the salary costs of their representatives. The World Bank will cover travel and expenses of these representatives where necessary. Travel costs of PIU and other staff that participate in the brainstorming session will be met from project proceeds. The out-of-pocket costs for the World Bank will consist primarily of the costs of two consultants for five weeks, travel and subsistence costs of the team and other logistical requirements. A detailed budget is being prepared separately.
Annex 2 - Review Teams and Countries

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- Daniel Ritchie (World Bank – Team leader)
- Miriam Maluwa (UNAIDS Secretariat)
- Elizabeth Mziray (World Bank)
- Wolfgang Munar (Global Fund)

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- Heather Royes (DFID)

_Dominican Republic, Trinidad & Tobago, PANCAP_

Team 3
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- Jessie Schutt-Aine (Global Fund)
- Ahmadou M. Ndiaye (World Bank)

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Annex 3 - Acknowledgments

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4. Guyana

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Frank Anthony  Director, HSDU [met in St. Lucia]
Mario Telles  Manager, GUM Clinic
Julio Cesar Norori  Social Development Specialist, IDB
Asmita Chand  Civil Society Coordinator, HSDU
Daniel Wallace  Country manager, World Bank
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Sharlene Johnson  Focal Point, Education
Paula Sampson  Focal Point, Culture, Youth and Sports
Diane Hinds  Focal Point, Labor, Human Services, Social Security
Raoul Khan  Focal Point, Agriculture
Bernadette Theodore-Gandi  PAHO Representative
Michel de Groulard  UNAIDS Representative
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James Tiwary  HSDU Finance
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Ernst Messiah  Advisor (seconded from IDB)
Desmond Alfred  Finance Director, CARICOM
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Yolanda Simon  CRN+
Nicola Taylor  Consultant, CRN+
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Karl Theodore  University of West Indies
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Sheila Samiel  NGO/Community Mobilisation, CAREC
### 7. St. Kitts & Nevis,

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Robert Herbert</td>
<td>Minister of Health</td>
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<tr>
<td>Elvis Newton</td>
<td>Permanent Secretary, MOH</td>
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<tr>
<td>Andrew Skerritt</td>
<td>Health Planner, MOH</td>
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<td>Kathleen Allen-Ferdinand</td>
<td>Director-designate, NAC</td>
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<tr>
<td>William Turner</td>
<td>Epidemiologist</td>
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<td>Marleen Libud</td>
<td>National AIDS Program Coordinator</td>
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<tr>
<td>Clifford Griffin</td>
<td>Administrative Officer, NAC</td>
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<td>Hazel Williams-Roberts</td>
<td>Director, Community Based Health Services</td>
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<tr>
<td>Patricia Daniel-Salter</td>
<td>VCT Health Center nurse</td>
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### 8. St. Lucia

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Fidelis Williams</td>
<td>Permanent Secretary, MOH</td>
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<tr>
<td>Stephen King</td>
<td>Chief Medical Officer, MOH</td>
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<tr>
<td>Xyxta Edmund</td>
<td>Chief Health Planner, MOH</td>
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<tr>
<td>Elizabeth Alexander</td>
<td>Financial Analyst, MOH</td>
</tr>
<tr>
<td>Marie Granderson Didier</td>
<td>Clinical Care Coordinator, MOH</td>
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<tr>
<td>Jaime</td>
<td>Surveillance Officer, MOH</td>
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<tr>
<td>Nahum Jean Baptiste</td>
<td>Director, NAPs</td>
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<tr>
<td>Natasha Lloyd</td>
<td>Line Ministry/Civil Society Coordinator, NAPs</td>
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<tr>
<td>Virnet St. Omer</td>
<td>IEC/BCC Coordinator, NAPs</td>
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<tr>
<td>Isaac Anthony</td>
<td>Director of Finance, MOF</td>
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<tr>
<td>Hildreth Laurencin</td>
<td>Deputy Director, MOF</td>
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<tr>
<td>Tracy Poline</td>
<td>Deputy Director, MOF</td>
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<td>Dale Bernard</td>
<td>Economist, MOF</td>
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<tr>
<td>Hyacinth Hughes</td>
<td>Procurement, MOF</td>
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<tr>
<td>Cointha Thomas</td>
<td>Project Coordinator, PCU</td>
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<tr>
<td>Cheryl Mathurin</td>
<td>Deputy Project Coordinator, PCU</td>
</tr>
<tr>
<td>Mattle Drysdale</td>
<td>Project Officer, Contracts, PCU</td>
</tr>
<tr>
<td>Sophia Edwards</td>
<td>MOE</td>
</tr>
<tr>
<td>Cindy Emmanuel-McLean</td>
<td>MOE</td>
</tr>
<tr>
<td>Catherine Albert</td>
<td>Human Resource Development, Youth and Sports</td>
</tr>
<tr>
<td>Claudia Roache</td>
<td>Human Resource Development, Youth and Sports</td>
</tr>
<tr>
<td>Tessa Thomas</td>
<td>Ministry of Tourism</td>
</tr>
<tr>
<td>Joan Didier</td>
<td>AIDS Action Foundation (AAF)</td>
</tr>
<tr>
<td>Veronica Cenak</td>
<td>AAF</td>
</tr>
<tr>
<td>Two representatives of MSM</td>
<td>Tender Loving Care (TLC):</td>
</tr>
<tr>
<td>group</td>
<td></td>
</tr>
<tr>
<td>Two representatives</td>
<td></td>
</tr>
</tbody>
</table>
9. St. Vincent & the Grenadines

Douglas Slater  Minister, MOH:
Permanent Secretary  MOH
Del Hamilton  Director, HIV/AIDS Unit, MOH
Marjorie Brown  M&E Consultant, HIV/AIDS Unit, MOH
Lisa Quammie  Line Ministry and CSO Coordinator, HIV/AIDS Unit, MOH
Samuel Joyles  Counsellor HIV/AIDS Unit, MOH
Abner Richards  MOE
Marina Lampkin,  Ministry of Tourism
Hudson Nedd  Project Coordinator, PCU
Decima Corea  Senior Economist/Planner, PCU
Janelle Quon  Assistant Procurement and Contract Management Specialist, PCU
John Hall  Assistant Financial Management Specialist, PCU
Sr. Zita  Bread of Life
Kingsley Duncan  Executive Director Planned Parenthood Association
Two representatives  PLWHA support group

10. Trinidad & Tobago

Sandra Marchack  Permanent Secretary, OPM
Amery Browne  Technical Director, NACC
Kimlan Minott  Coordinator, PCU
Sandra Barratt  Procurement, PCU
Andy Fearon  Finance, PCU
Courtenay Bartholomew  Medical Research Foundation
Chris Mahabir  Permanent Secretary, MOH
Balkaran Shivnauth  Ag CMO, MOH
Violet Forsythe Duke  Consultant HIV/AIDS, MOH
Nasif Ali  Director of Finance, MOH
Aldington Spencer  Secretary of Health, Tobago
Victor Wheeler  OB/GYN, Tobago
Mowell DeGannes  Coordinator, Tobago
Harry Bruce  Advisor, Tobago
Carolyn Williams  Executive Director, CARE
## Annex 4 - Suggested Responsibility for Follow-Up to Recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Focal Point</th>
<th>Chief Implementation Partners</th>
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</thead>
<tbody>
<tr>
<td>1. Restore strategic balance</td>
<td>National Programs</td>
<td>PAHO, PANCAP, WB, GF, UNAIDS Secretariat, bilateral agencies</td>
</tr>
<tr>
<td>2. Address stigma aggressively</td>
<td>National Programs</td>
<td>PANCAP, WB, ILO, UNAIDS Secretariat, bilateral agencies</td>
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<tr>
<td>3. Adopt M&amp;E Processes and expand biological surveillance</td>
<td>National Programs</td>
<td>CHRC, PANCAP, WB</td>
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<tr>
<td>4. Simplify implementation</td>
<td>National Programs, WB, GF</td>
<td>UNAIDS Secretariat, bilateral agencies, OECS Secretariat</td>
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<tr>
<td>5. Build local management &amp; capacity</td>
<td>National programs, PANCAP</td>
<td>WB, bilateral agencies,</td>
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<tr>
<td>6. Invigorate the Regional Response</td>
<td>PANCAP</td>
<td>CAREC, CHRC, CRN+, WB, GF, UNAIDS Secretariat, bilateral agencies</td>
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<td>7. Develop sustainable funding framework</td>
<td>UNAIDS, WB, GF, PEPFAR</td>
<td>National Programs, bilateral agencies</td>
</tr>
<tr>
<td>8. Articulate strategies to support the response</td>
<td>WB, GF, PEPFAR, bilateral agencies</td>
<td>National programs</td>
</tr>
<tr>
<td>9. Apply harmonization in practice</td>
<td>WB, GF, national programs</td>
<td>UNAIDS Secretariat</td>
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<tr>
<td>10. Encourage collaboration among UN agencies</td>
<td>UNAIDS</td>
<td>Other UN agencies, national programs</td>
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