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THE WORLD BANK

World Bank-financed HIV Projects in the Caribbean: *Lessons for working with Small States*

An "AFTER ACTION REVIEW" of HIV Projects financed by the World Bank in the Caribbean

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19. Swaziland HIV Modes of Transmission and Prevention Response Analysis. March 2009
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LESSONS FOR WORKING WITH SMALL STATES

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Latin America and Caribbean Region
and Global HIV/AIDS Program
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World Bank-Financed HIV Projects in the Caribbean: *Lessons for working with Small States*

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The Knowledge-Sharing Forum held in St. Kitts & Nevis from November 18-20, 2009 as well as technical assistance for monitoring and evaluation of the projects and to review outcomes and lessons from several of the projects, were part of the work done by the World Bank within the UNAIDS Unified Budget and Workplan.

Abstract: This paper summarizes the key findings of an "After Action Review" (AAR) that reflects a decade of experience in designing and implementing ten HIV/AIDS projects in the Caribbean, financed by the World Bank. The objective is to identify what worked (and what didn't) in the project approach, design and implementation, distilling useful lessons for other projects in small states.

Keywords: HIV, AIDS, Barbados, Dominican Republic, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Trinidad and Tobago, PANCAP, World Bank, Caribbean, After Action Review, Knowledge Sharing

Disclaimer: The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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FOREWORD

Dear colleagues,

I would like to share with you this report on the After Action Review of the World Bank-financed HIV Projects in the Caribbean, of which a key event was the Knowledge-Sharing Forum which took place in St. Kitts & Nevis from November 18-20, 2009.

The Forum was a highlight for the Bank's HIV/AIDS work in the region, which effectively featured three days of sub regional knowledge-sharing among the World Bank-financed HIV/AIDS Control Projects. A key factor accounting for the Forum's success was being able to bring together the right people - managers and technical staff responsible for implementing the nine country and one regional HIV/AIDS projects. This shared forum allowed our country clients to learn from one another on what has worked successfully, what has not worked, and how results are being achieved and measured.

Forum participants made their voices heard through their leadership and active participation in the plenary discussions and small break-out group sessions. Through these interactive spaces, country and regional needs areas were surfaced as those that need to be addressed in order to accelerate and strengthen implementation of HIV/AIDS programs.

The World Bank remains committed to providing our Caribbean country clients with leading technical expertise, facilitating knowledge exchange among countries, and promoting innovation in country/regional operations. This commitment has been strengthened thanks to our ongoing collaboration and partnerships with our country clients in the Caribbean and development partner agencies who have played a critical role in surfacing best practices and experiences to carry forward.

As the Bank continues to prioritize its efforts around HIV/AIDS, we hope this paper provides insight into the experience of the Caribbean country clients and can thus serve to strengthen our programs in this critical region and in other small states.

Keith Hansen
Health Sector Manager
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Acronyms and Abbreviations

AAR	After Action Review
ART	Antiretroviral Treatment
ARV	Antiretroviral
CAREC	Caribbean Epidemiology Center
CARICOM	Caribbean Community and Common Market
CBO	Community Based Organization
CCM	Country Coordinating 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 (United Kingdom)
FBO	Faith Based Organization
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 (World Bank)
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
PLHIV	People Living with HIV (includes people with 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

The HIV Epidemic in the Caribbean Today

1. The Caribbean region has been more heavily affected by HIV than any region outside sub-Saharan Africa. UNAIDS' 2009 Global AIDS Epidemic update estimated adult HIV prevalence in the Caribbean at 1.0 percent in 2008, placing it as the region with the second highest adult HIV prevalence (Table 1). An estimated 240,000 people in the Caribbean are living with HIV, out of a total population of 41,000,000. The 2008 figures also estimate 20,000 new HIV infections and 12,000 deaths due to AIDS in the Caribbean that year.

Table 1: HIV/AIDS Statistics by Region (2008)

	Adults and Children Living HIV	Adults and Children newly infected with HIV	Adult Prevalence (15-49)	Adult and Child Deaths due to AIDS
Sub-Saharan Africa	22.4 million [20.8 – 24.1 million]	1.9 million [1.6 – 2.2 million]	5.2 [4.9 – 5.4]	1.4 million [1.1 – 1.7 million]
Middle East and North Africa	310 000 [250 000 – 380 000]	35 000 [24 000 – 46 000]	0.2 [<0.2 – 0.3]	20 000 [15 000 – 25 000]
South and South East Asia	3.8 million [3.4 – 4.3 million]	280 000 [240 000 – 320 000]	0.3 [0.2 – 0.3]	270 000 [220 000 – 310 000]
East Asia	850 000 [700 000 – 1.0 million]	75 000 [58 000 – 88 000]	<0.1 [<0.1]	59 000 [46 000 – 71 000]
Latin America	2.0 million [1.8 – 2.2 million]	170 000 [150 000 – 200 000]	0.6 [0.5 – 0.6]	77 000 [66 000 – 89 000]
Caribbean	**240 000 [220 000 – 260 000]**	**20 000 [16 000 – 24 000]**	**1.0 [0.9 – 1.1]**	**12 000 [9300 – 14 000]**
Eastern Europe and Central Asia	1.5 million [1.4 – 1.7 million]	110 000 [100 000 – 130 000]	0.7 [0.6 – 0.8]	87 000 [72 000 – 110 000]
Western and Central Europe	850 000 [710 000 – 970 000]	30 000 [23 000 – 35 000]	0.3 [0.2 – 0.3]	13 000 [10 000 – 15 000]
North America	1.4 million [1.2 – 1.6 million]	55 000 [36 000 – 61 000]	0.6 [0.5 – 0.7]	23 000 [9100 – 55 000]
Oceania	59 000 [51 000 – 68 000]	3900 [2900 – 5100]	0.3 [<0.3 – 0.4]	2000 [1100 – 3100]
TOTAL	33.4 million [31.1 – 35.8 million]	2.7 million [2.4 – 3.0 million	0.8 [<0.8 – 0.8]	2.0 million [1.7 – 2.4 million]

Source: AIDS Epidemic Update 2009, UNAIDS

2. AIDS-related illnesses were the fourth leading cause of death among Caribbean women in 2004 and the fifth leading cause of death among Caribbean men. Declines in HIV incidence were reported in some Caribbean countries earlier in the decade, but the latest evidence suggests that the regional rate of new HIV infections has stabilized.

3. Nine of the top 15 countries in the world outside Sub-Saharan Africa with the highest adult HIV prevalence are in the Caribbean – including the six countries with highest prevalence (Table 2).

Table 2: HIV Among Adult Population, Ages 15-49, 2007/2008 (% of population)

Africa		
Rank	Country	%
1	Swaziland	26.1
2	Botswana	23.9
3	Lesotho	23.2
4	South Africa	18.1
5	Namibia	15.3
6	Zimbabwe	15.3
7	Zambia	14.3
8	Mozambique	12.5
9	Malawi	11.9
10	Kenya	7.4
11	Central African Republic	6.3
12	Gabon	5.9
13	Tanzania	5.7
14	Uganda	5.4
15	Cameroon	5.1

Outside Africa		
Rank	Country	%
1	Bahamas	3.0
2	Guyana	2.5
3	Suriname	2.4
4	Haiti	2.2
5	Belize	2.1
6	Jamaica	1.6
7	Ukraine	1.6
8	Papua New Guinea	1.5
9	Trinidad and Tobago	1.5
10	Thailand	1.4
11	Estonia	1.3
12	Barbados	1.2
13	Dominican Republic	1.1
14	Russia	1.1
15	Panama	1.0

Source: PRB 2009 World Population Data Sheet
http://www.prb.org/Datafinder/Topic/Bar.aspx?sort=v&order=d&variable=80

4. Caribbean countries fall into two groups: HIV prevalence rates below one percent, (including Grenada, St Lucia, St Kitts and Nevis, St Vincent and the Grenadines) and rates between 1 and 3 percent (countries listed in Table 2). Despite low general population prevalence, rates are very high in some population groups: for example, as high as 8 percent in drug users in the Dominican Republic (DR), 26.6 percent in commercial sex workers (CSW) in Guyana and 25 to 30 percent among men who have sex with men (MSM) in Jamaica (Table 3). In the lower prevalence countries, the epidemic can be defined as concentrated in most at risk groups such as MSM, CSW, prison inmates, intravenous drug users (IDUs), whereas in the higher prevalence countries, the epidemic is mixed, combining general and concentrated characteristics. The main mode of HIV transmission is heterosexual, with multiple and concurrent partners driving the epidemic.

5. The number of people dying from AIDS and the number of AIDS cases are declining in many countries, largely due to the availability of free ARV drugs. More people are accessing ARV therapy and present themselves earlier, raising the issue of

sustainability in providing and financing more treatment and especially more costly second and third line drugs, which are increasingly being used. Limited change is observed in risky behaviors, emphasizing the need to intensify prevention. Only a slight decline is noted in stigma and discrimination against HIV positive people.

Table 3: HIV Prevalence Rates (%) among Most at-Risk Populations (MARPs)

	Adult HIV Prevalence (%), 2007	Commercial Sex Workers (CSWs)	Men who have sex with Men (MSM)	Prison Population	Intravenous Drug Users (IDUs)
Dominican Republic	1.1	4.8	6.1	2.2	8.0
Guyana	2.5	26.6 *	21.2*	5.24	Not Available
Jamaica	1.6	9.0	25-30	3.3	5.0

** Data from the capital city only.*

Source: UNGASS 2008 Country Progress Reports

The World Bank's Lending Program to Address HIV/AIDS in the Caribbean

6. In 2001, an estimated 360,000 people were living with HIV in the Caribbean, but the figures may have been underreported. Under-reporting meant that the actual figure could have been more than half a million people, with HIV prevalence in the Caribbean region second only to Sub-Saharan Africa. In this context, several Caribbean Governments decided to initiate and scale up national responses to HIV. World Bank support was influenced by two factors: a sense of urgency that came from data analysis suggesting that a rapid response was needed to avoid a widespread epidemic in the Caribbean; and the potential benefits of a regional approach, which promised economies of scale in surveillance and program evaluation.

7. 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 the Government of Barbados with support from CARICOM, the UNAIDS Secretariat, and PAHO. The Bank's pledge of US$155 million and leadership helped raise awareness of the epidemic and encouraged heads of state to speak out publicly on the issue. In 2001, the Bank's Board of Directors approved the Caribbean Multi-Country HIV/AIDS Prevention and Control Adaptable Program Lending (APL).

8. Under the APL, each country could obtain a separate loan and/or credit to finance its own national HIV/AIDS Prevention and Control Project. Nine country specific projects were launched (Barbados, Dominican Republic, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago) and one regional partnership (PANCAP) that financed four other regional institutions. Barbados and Jamaica are now implementing second generation HIV/AIDS Projects to consolidate their achievements (Table 4).

Table 4: Funding the Caribbean HIV Response from the World Bank, 2001-13[1,2]

	Status	Total	Disbursed	Type	Start Date	End Date
Barbados I	Closed	15,150,000	15,150,000	IBRD	2001	2007
Barbados II	Active	35,000,000	6,247,500	IBRD	2008	2013
Dominican Republic	Closed	25,000,000	24,984,712	IBRD	2001	2008
Grenada	Closed	4,660,000	2,599,192	IDA/IBRD	2002	2009
Guyana	Closed	10,000,000	10,330,385	IDA	2004	2010
Jamaica I	Closed	10,600,000	10,600,000	IBRD	2002	2008
Jamaica II	Active	10,000,000	2,789,868	IBRD	2008	2012
PANCAP	Closed	9,000,000	8,554,694	IDA	2004	2010
St.Lucia	Closed	6,400,000	6,218,334	IDA/IBRD	2004	2010
St.Kitts & Nevis	Closed	4,050,000	3,359,902	IBRD	2003	2009
St.Vincent & the Grenadines	Active	7,000,000	5.457,467	IDA/IBRD	2004	2010
Trinidad & Tobago	Closed	20,000,000	18,450,304	IBRD	2003	2010
Total Commitments		***156,860,000***				

Source: Client Connections, Operations Portal (www.worldbank.org > Projects and Operations

* Disbursement amounts for closed projects are at project completion, for active projects, as of 10/15/10

1. Excludes additional resources from the WB's internal budget and trust funds spent in the Caribbean

2. Recently closed projects in PANCAP, St Lucia, and Trinidad & Tobago have not completed disbursing.

Why an After Action Review (AAR) and Knowledge-Sharing Forum?

9. Ten Caribbean HIV/AIDS projects were developed under the Multi-Country HIV/AIDS Program (MAP) for the Caribbean, beginning in 2001. This paper summarizes key findings in implementing the projects, assessing the approach and outputs and analyzing what worked (and what didn't), distilling what the World Bank learned from implementing these HIV/AIDS projects, and drawing out broader lessons useful to other projects in small states in the Caribbean and elsewhere.

10. An After Action Review (AAR) reviewed the implementation experience of the ten Projects. AARs are a knowledge management technique used to identify and share critical lessons and recommendations from learning exercises and projects. They complement conventional monitoring and evaluation. During an AAR, activities, experiences, and outcomes are analyzed in the light of expectations, to evaluate: What was planned? What happened and why? What worked well? What needs improvement? What are the lessons and recommendations? The technique has several advantages: together, participants review salient facts, make headway in critical interpretation of what occurred, refine hypotheses, enhance their understanding of possible causes of the successes and failures of their projects or activities, and formulate recommendations.

11. As part of the AAR, a Knowledge Forum held in St. Kitts and Nevis on November 18-20, 2009 brought together the ten project teams, national program representatives, and donors to review technical data and discuss critical policy and technical issues faced by many of the projects, and share experiences and lessons learned. The Forum agenda included discussion of some key questions addressed in the AAR. The conclusions reached at the Forum were assessed and synthesized as final input to enrich the AAR report.

12. Project designs were broadly similar in each country, but outcomes and achievements differed. The Forum was an opportunity for joint implementation support for all ten projects, at which the Bank team and counterpart implementing agencies could learn from one another's experiences and identify why some projects were successful in certain areas while others were not. Identifying these lessons and experiences provided invaluable insights that will help finalize implementation and contribute to the sustainability of national responses as most of the projects approach their closing dates.

13. The Knowledge-Sharing Forum also enabled important discussions about possible future strategic engagement in health in the Caribbean after the AIDS projects close. The projects have provided the Bank with opportunities to gain insight into health system constraints and to gauge the interest level and need for governments to tackle health system reforms or to continue disease-specific programs. Countries are faced with the issue of how to ensure that HIV activities financed under the projects are sustained as part of their national response. Sustainability is directly linked to the need to integrate HIV programs into the core health programs of the Ministry of Health. The Knowledge Sharing Forum was a timely venue for reflecting on good practices, sharing challenges, and assessing opportunities for the health sectors to receive support from the Bank within a broader health systems approach with or without HIV components, or to explore new lines of business under a regional approach in areas such as non-communicable diseases (NCDs).

Key Progress Areas

14. Challenges persist in the Caribbean region in responding to the HIV epidemic but steady progress has been made across the Region in the key areas indicated below.

15. *Prevention of Mother to Child Transmission (PMTCT).* The proportion of pregnant women being tested for HIV has increased sharply, exceeding 90% in most countries. Testing more pregnant women as part of antenatal care and treating HIV positive pregnant women has resulted in decreased transmission rates from mother to child. Building strong referral systems, providing free ARVs for PMTCT to all HIV+ pregnant women, hiring a PMTCT Coordinator along with Technical Assistance from the Clinton Foundation were reported as improvements. Capacity building of Health Care Workers (HCWs), continuous monitoring, data availability, and strict adherence to protocols have also contributed to the improvement. This has led to marked reductions in MTCT.

Table 5: HIV-positive pregnant women who received ARV for PMTCT (%)

Country	2007
Barbados	95.2
Dominican Republic	40.4
Grenada	70.0
Guyana*	63.5*
Jamaica	85.0
St. Kitts and Nevis*	100.0*
St. Lucia	78.57
St. Vincent and the Grenadines	100.0
Trinidad and Tobago*	86.0*

* Data are for 2006

Source: UNAIDS 2008 Country Progress Reports

16. *Laboratory Services and Biomedical Waste.* Blood safety practices are in place throughout the Caribbean with a high percentage of the blood screened for HIV antibodies being under quality control measures. Biomedical waste management programs are under implementation in most countries.

17. *Post-Exposure Prophylaxis (PEP).* Universal precautions and post-exposure prophylaxis are standard practices in many countries.

18. *Antiretroviral Therapy (ART).* The Caribbean region has made significant strides in providing its population with access to HIV treatment. In July 2004, only 1 in 10 Caribbean residents in need of treatment were receiving antiretroviral drugs. By December 2008, treatment coverage of 51% had been achieved, higher than the global

average of 41% for low and middle income countries.[1] Data from the Bank-supported projects indicate that 21,276 PLHIV are receiving ART in nine countries (Barbados, Dominican Republic, Grenada, Guyana, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, and Trinidad and Tobago). This suggests reasonable levels of knowledge, competencies and skills in treating HIV and patient adherence to treatment, and consistent supplies of ARVs.

19. *National Strategic Planning (NSP).* All countries have a first National Strategic Plan (NSP) and follow up NSPs have been or are being prepared, usually beginning with a review of the first NSPs. The AIDS Strategy and Action Plan (ASAP) team, a global technical assistance service hosted by the World Bank on behalf of UNAIDS, provided support to many Caribbean countries with their NSP process (Table 6).

Table 6: AIDS Strategic Action Planning (ASAP) Support to Caribbean

	NSP Development	Peer Review	Costed Action Plan
Barbados	2007	2007	-
Dominica	2009/2010	2009/2010	2009/2010
Grenada	2007	2008	Requested
Guyana	-	-	2006
Jamaica	-	-	2007
St. Kitts and Nevis	2007	2007	2009
St. Lucia	Ongoing	Ongoing	Ongoing
St. Vincent and the Grenadines	2009	2009	2009
Trinidad and Tobago	-	2010	-

Source: AIDS Strategy and Action Planning service, World Bank

20. *Condom Distribution.* Most countries have exceeded their set targets for condom distribution and have found partnering with other key partners such as UNFPA and PSI to be key for distribution. The private sector has also been active in distributing condoms.

21. *Monitoring & Evaluation (M&E).* The Caribbean countries with World Bank-financed HIV/AIDS projects have made significant progress in developing and setting-up national monitoring and evaluation systems in comparison to five years ago, when M&E was not a priority, due to the regional culture that does not place emphasis on monitoring and measuring. The World Bank's Global AIDS Monitoring and Evaluation Team (GAMET) has supported M&E in the Caribbean through the following activities: a regional synthesis of all existing data and other relevant information to better understand epidemic dynamics; M&E system development and improvement in St. Lucia, St. Kitts, Trinidad, and Guyana; M&E diagnostic development in Guyana; training on the 12 Components of Functioning M&E Systems in Trinidad and St. Lucia; support to

[1] UNAIDS/WHO 2009 AIDS Epidemic Update

partnership arrangements for achieving the third of the “Three Ones” – one M&E System – with USAID and UNAIDS, and participation in the Regional M&E Steering Group.

22. *Implementing a Multi-sectoral Response.* Civil Society Organizations (CSOs) and non-Health Line Ministry (LM) engagement are a key component in all projects, with projects providing funding and capacity building for CSO and LMs. CSOs have been key throughout the Caribbean in helping to reach the most at-risk populations and LMs have been key in reaching priority target populations such as youth and prisoners.

Challenges in Responding to HIV/AIDS in the Caribbean

23. The Knowledge Sharing Forum provided the Caribbean Government teams and project implementing agencies with the opportunity to share openly and discuss issues and areas that continue to present challenges to effective responses to HIV/AIDS at the national and regional level. This section summarizes the challenges, and presents good practices which might be helpful to countries facing the same issues.

24. ***Sustainability and Integration.*** The World Bank's HIV/AIDS lending portfolio to the Caribbean region has consisted of 12 projects -- 5 have already closed and 5 more will close by December of 2010, which will leave only two active HIV/AIDS projects in the region. This speaks strongly to the need for measures and actions to ensure sustainability. The HIV/AIDS Projects have provided the Bank with an opportunity to gain insight into the constraints facing the overall health systems and to gauge the interest level and need from the governments for scaling up into health reform projects or continued disease-specific programs. From the client perspective, the project closings are being felt in a different manner as countries are faced with the issue of how to ensure that activities that were financed through the Project are sustained as part of their national response. The cost of treatment and care is a particular concern. Sustainability at the country level is directly linked to the need to integrate HIV services into the core health programs of the Ministry of Health. When the National AIDS Councils/Directorates are restructured within the Ministries of Health, it will be critical to retain experienced human resources, to help sustain current service levels in the face of budgetary constraints. The experience of the St. Kitts and Nevis HIV/AIDS Project is an example where one country has already been able to absorb project staff within the structure of the government to ensure sustainability of the project's activities. Efforts still are needed to bring across the message that the HIV epidemic is not only a health issue, but has developmental and financial consequences. There is a need to take proactive steps to integrate HIV into the central government budgets for sustainability.

25. ***Health Systems Strengthening.*** Over the past five years, AIDS has evolved from a terminal illness into a chronic disease. Highly Active Antiretroviral Therapy (HAART) regimens have slowed disease progression, dramatically reduced viral load, and increased quality of life. As people with HIV are living longer lives, providers face a number of new challenges. These challenges include, the increasing number of people living with HIV, enrolling and retaining HIV positive people under care, coordinating HIV services across fragmented payer and delivery systems, simplifying complex treatment regimens to maximize adherence, reducing disparities of HIV care between different subpopulations, integrating ongoing prevention counseling into care, and educating providers about strategies to help patients change behaviors and reduce risk. Amidst these challenges, HIV needs to be integrated into a health systems strategy where payer and delivery systems for HIV services and education for behavior change can be coordinated with other chronic disease services to maximize the use of limited resources to achieve more

effective outcomes overall.[2] The World Bank's Health, Nutrition, and Population Strategy refocused the Bank on health systems strengthening which is especially important where chronic diseases are a priority, such as in the Caribbean. The World Bank will continue to be involved in the prevention and control of HIV and other STIs around the world and in the region, however, the Bank's future support in the Caribbean region will have a broader health system strengthening focus, with the goal of enabling countries to address communicable and non-communicable diseases more effectively.

Organizational and Institutional Arrangements

26. Organizational Arrangements. The funding conditionality for the World Bank Africa Multi-country AIDS Program (MAP) required the establishment of a "*high level multi*-sectoral HIV/AIDS coordinating body" to oversee the implementation of the national strategy and the action plan, which was the major impetus for establishing National AIDS Councils or Committees (NACs). The NAC is usually a supra-ministerial stand-alone agency, independent of a government ministry, and usually comprising a governance body (the Board) and an operational body (the Secretariat). The requirement to establish a national body was inspired by the successful experiences in Uganda, Senegal and Thailand in the 1980s and 1990s. In Uganda President Museveni decided to launch a nation-wide effort to fight HIV/AIDS in 1986, formed a NAC within his office and chaired it himself. Presidential action in Senegal led to the establishment in 1986 of a National Multidisciplinary Committee for the Prevention of HIV/AIDS, and stable leadership by successive Presidents achieved strong cooperation across the government and with non-governmental actors. Thailand's successful program also established a National AIDS Prevention and Control Committee in 1992 under the authority of the Prime Minister, with high political influence and a budget that increased to $44 million by 1993. At the same time a massive public information campaign on AIDS was launched under the leadership of cabinet member Mechai Viravaidya, a well-known Thai AIDS champion and politician.

27. This conditionality of high-level multi-sectoral HIV/AIDS coordinating body was also applied to the Caribbean MAP in 2001. However NACs have experienced significant challenges in effectively leading and coordinating multi-sectoral responses. [3] A key

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[2] Institute for Healthcare Improvement (IHI). Interview with Bruce D. Agins, MD, MPH, Medical Director, New York State Department of Health AIDS Institute.

[3] World Bank (2005) Committing to results: Improving the effectiveness of HIV/AIDS assistance. An OED evaluation of the World Bank's assistance for HIV/AIDS control. http://www.worldbank.org/oed/aids/docs/report/hiv_complete_report.pdf.
Dickinson C (2005) National AIDS coordinating authorities: A synthesis of lessons learned and taking learning forward. DFID Health Resource Centre. http://www.dfidhealthrc.org/shared/publications/Synthesis/NACAs.pdf..
England R (2006) Coordinating HIV control efforts: What to do with the national AIDS commissions. Lancet 367: 1786–1789.
Joint United Nations Programme on HIV/AIDS (2005) Global task team on improving AIDS coordination among multilateral institutions and international donors: Final report. http://www.searo.who.int/LinkFiles/Strategic_Alliance_and_Partnerships_7b_Global_Task_Team_final_report_14_June_2005.pdf.

reason why National Commissions have not worked well in Africa and in the Caribbean is that strong personal political leadership – as evidenced in the cases of Uganda, Senegal and Thailand – has been confused with a prescribed template for a specific form of organization. Setting up a NAC did not elicit a powerful political champion, and was not a substitute. Caribbean HIV/AIDS projects have a supra-ministerial coordinating body at the highest political level chaired by the President or the Prime Minister but this organizational arrangement has not ensured ownership and commitment.

28. The design of the AIDS projects in the Caribbean benefitted from high political commitment and short preparation time. With hindsight, these had both positive and negative effects. High level engagement and commitment enabled quick turnaround time from concept to implementation, but did not translate into ongoing support during project implementation. The short preparation time contributed to a project design that required adjustments and restructuring of all the projects except Barbados.

29. Implementation Arrangements

a) Most non-health ministries remain unclear about their role in, and potential for contributing to, the AIDS response. Even priority line ministries still tend to see AIDS as the sole mandate of the Ministry of Health.

b) Harmonization and Alignment: The need to pool resources and to harmonize work programs is generally a well supported recommendation but harmonization and alignment has not always encompassed all substantial players. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has indicated willingness to pool funding in some countries but still continues to operate as a vertical funding program with multi-year and phased funding commitments but no follow-on funding guarantees. Only Guyana and Haiti have benefitted from the US President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR manages its funding outside of government frameworks through cooperating partners and contractors, and only commits funds annually with future support dependent on US Congress allocation decisions. This makes it difficult to predict the long term financing of the single biggest source of funds for HIV.

c) Smaller countries usually centralize financial accountability and procurement under the purview of the Ministry of Finance. This is cost effective – qualified human resources are in short supply and training fiduciary staff for each donor-supported project would be expensive. Experience shows that it takes time and consistent effort to have the fiduciary and technical teams cooperate harmoniously with teams located in separate ministries with their own hierarchical reporting relationships. Fiduciary staff in HIV/AIDS projects in the larger countries (Jamaica, Trinidad &Tobago, Dominican Republic, Guyana) are part of the NAS.

Putzel J (2004) The global fight against AIDS: How adequate are the national commissions? J Int Dev 16: 1129–1140.

30. ***Human Resource Capacity.*** The Caribbean region lacks skilled manpower and has limited resources to attract and retain skilled staff. This is particularly felt in the inability to staff a full program of HIV prevention, care and treatment services. The issue is shortage of people more than absence of skills. Inadequate budget to recruit skilled people is also often an issue. In-country staff are generally qualified and motivated, however, there simply are not enough staff to fully implement all activities of the program. Fueling this is the Caribbean region's high attrition rate of health workforce personnel which is reflected in the nursing shortage in the region – there are roughly three times as many English-speaking CARICOM-trained nurses working abroad as working in the English-speaking CARICOM. This ratio of migrants to locally remaining health workers is without parallel in the world.[4] Figures from 2005 indicate that in eight of the Caribbean countries with a Bank-financed project, Jamaica being excluded, less than 200 people were working full-time on HIV/AIDS.[5] Some donor funded programs (and some Project Coordination Units) are paying premiums to attract individuals, further depleting capacity in the public services responsible for responding to the epidemic. Training programs often make it easier for students to emigrate. The shortage of skilled staff, next to the effects of stigma and discrimination, is the single greatest obstacle to an effective response.

31. ***Financing for HIV/AIDS.*** AIDS has imposed huge economic and social costs in the Caribbean region. According to Aids2031, a consortium assessment of what we could do now to change the face of the pandemic by 2031, if there is no significant change in the actions being taken in the global response to HIV, future resource requirements to control AIDS will be between US$19 billion and US$35 billion annually by 2031. The challenge for the Caribbean region is to mobilize the financial resources needed, and use them efficiently. Even though the Caribbean region has many sources of funding available for HIV (GFATM, PEPFAR, Gates Foundation, bilateral agencies, others), with the Bank regarding itself as the lender of last resort, predictability of resources for supporting the National AIDS Programs is a major issue. The approval process for donor funding is long and often unpredictable, which makes planning at the country level difficult. The recent global financial crisis has reduced many governments' ability to finance national AIDS programs. For example, the budget allocation for the National AIDS Program in Jamaica was significantly cut in 2009, which has significant impact on the implementation of the program.

32. ***Donor Coordination and Harmonization.*** The challenges that emerged centered on duplication of efforts, scheduling of donor meetings, and reforms/projects being driven by multiple donors with differing agendas, priorities, timelines, indicators, reporting requirements and procurement requirements. There is a need for better communication of roles and responsibilities within institutional arrangements, e.g., PCU, NACC, NAP, Regional Cooordinating Mechanism (RCM)/Country Coordinating Mechanism (CCM), PANCAP, Organization of Eastern Caribbean States HIV/AIDS Program Unit (OECS/

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[4] World Bank". "The Nurse Labor & Education Markets in the English-Speaking CARICOM: Issues and Options for Reform, May 2009.

[5] World Bank. "HIV/AIDS in the Caribbean Region: A Multi-Organization Review", November 2005

HAPU), etc., and better briefing of NGOs and CSOs so they can come to the negotiating table more informed. Stronger support is needed for joint annual reviews to coordinate financing mechanisms and multiple funding sources. Projects need to be more country driven, rather than donor driven, harmonized within a nationally owned response and the country's systems. One example is St Lucia's development of a single quarterly reporting format to serve the government, the GFATM and the World Bank. Another example is the Dominican Republic and Guyana outsourcing auditing to a local company which serves the needs of all donors.

33. ***Addressing Stigma and Discrimination***. Stigma and discrimination disproportionately affect groups such as CSWs, MSM, and injecting drug users, whose behaviors put them at higher risk of HIV infection. Resources devoted to HIV prevention, treatment and care for these groups are inadequate. Only 5 percent of injecting drug users[6], 11 percent of MSM and 16 percent of CSWs[7] have access to HIV prevention services. An essential policy action for HIV Prevention in the Caribbean is to review and reform "legal frameworks to remove barriers to effective, evidence based HIV prevention, combat stigma and discrimination and protect the rights of people living with HIV or vulnerable or at risk to HIV."[8] Anti-stigma campaigns need a supportive legal framework to be effective. There is a need for stronger national-level efforts in each country to revise legislation to protect the rights of people with HIV and vulnerable populations, and to enact human rights initiatives and work-place policies.

34. ***Strategic Planning at the National Level***. NSPs in the Caribbean have helped to increase access to HIV services and to involve various ministries and civil society. However, setting priorities informed by epidemic dynamics and contexts of vulnerability remain a challenge. Limited evidence on HIV transmission dynamics among those most at risk and on determinants of vulnerability hamper informed prioritization and target setting based on evidence. This is compounded by the existence of coercive legal and policy environments and stigma, and by social tension around setting priorities. Approaches need to be adapted to specific country contexts, including building alliances with selected individual and influential policy makers as well as broadening partnerships.

35. ***Stakeholder Involvement***. The HIV/AIDS Projects in the Caribbean all aim to scale up their national responses by engaging non-Health Line Ministries (LMs) and Civil Society Organizations (CSOs) in implementing activities and educational outreach to vulnerable populations. Guyana has been recognized as a model in its multi-sectoral approach to HIV/AIDS Control through the engagement of LMs and CSOs and the project has commissioned assessments of their experiences.[9] All countries agreed on the need to balance participation of a greater number of LMs and CSOs against ensuring that

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[6] Report on the global AIDS epidemic 2006, UNAIDS

[7] Coverage of selected services for HIV/AIDS prevention, care and support in low and middle income countries in 2003, USAID, UNAIDS, WHO, UNICEF, and the POLICY Project, June 2004

[8] Pan Caribbean Partnership Against HIV/AIDS. HIV Prevention. Extracted on 07/08/2009 from http://pancap.org.

[9] World Bank. ISR 12. Guyana HIV/AIDS Prevention and Control Project (P076722). 06/23/2009.

those that are part of the process add value and specialization that helps reach out to at-risk and vulnerable populations. The challenge is that not all civil society activities are strategic from the perspective of the needs of the national program. In general there are no processes for prioritizing which interventions Non Governmental Organizations (NGOs) and Community Based Organizations (CBOs) undertake to ensure efficiency and that prevention targets the main sources of new infections. In many if not most instances, any proposal that passes muster is being funded. CSOs tend to be focused on specific issues within specific sectors with a specific implementation focus and should be steered in the direction of dealing with high priority issues or working with difficult to reach populations at risk.

36. ***Scaling up Prevention Services***. Scaling up prevention services for high-risk and vulnerable groups and for the general population has had variable results across the projects. Condom distribution, Prevention of Mother-to-Child Transmission (PMTCT), Voluntary Counseling and Testing (VCT), and Information and Education Campaigns/ Behavior Change Campaigns (IEC/BCC) are key activities being carried out across the projects. Recent experience in Grenada raises the question of how effective these prevention services are. In Grenada despite a six-fold increase in the number of condoms distributed in each of the last four years, the project did not reach vulnerable groups such as female sex workers and MSM. Furthermore, the project reported more people being counseled and tested, but only 0.23 percent testing positive, suggesting that few people in the most at-risk groups are being reached.[10] Better targeting of prevention services was discussed with the country client teams.

37. ***Expanding and Strengthening Treatment, Care, and Support.*** There have also been variable results in expanding treatment, care, and support for people living with HIV (PLHIV). In Trinidad and Tobago (T&T), antiretroviral medications are available for PLHIV at seven treatment centers. As of March 31, 2009, T&T's Ministry of Health (MOH) reported that 6,099 HIV/AIDS patients were receiving care, of which 3,270 are on ART, and a pilot home-based care model and training curriculum had been developed. Thirty individuals were being selected for training to form an integrated health care team under the pilot. In Barbados, Bank support for antiretroviral treatment (ART) began before funding from the Global Fund or PEPFAR, and is recognized for its success and as paving the way for treatment programs around the world.[11] The experience of Barbados can be looked to as good practice where the Government has put in place a free, comprehensive treatment and care program for PLHIV. Of the approximately 2,100 PLHIV who are currently alive and know their status, about 1,102 are registered with the government clinic for treatment, and 615 are receiving anti-retroviral treatment (*AR*T). In direct contrast to the T&T and Barbados experiences, in Grenada, the supply of ARV drugs is adequate, but HIV positive patients present themselves late for treatment, drug adherence is an issue for lack of patient monitoring, and home-based care is minimal.

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[10] World Bank. Grenada HIV/AIDS Prevention and Control Project Implementation Support and Completion Mission, June 22-26, 2009. Aide-Memoire
[11] idem

38. ***Monitoring and Evaluation (M&E).*** The Caribbean region is known to have incomplete, unreliable, fragmented, and inconsistent epidemiological data for HIV. Each of the World Bank-financed HIV/AIDS projects in the Caribbean has an M&E framework against which it reports, but each presents its own set of challenges. One common challenge faced by many projects is that reporting demands on each project by the many development partners for the same, different, or more indicators can be daunting and burdensome for the project coordinator if there is no dedicated M&E person. Project teams report against the UNGASS indicators and a useful discussion during the Forum was how to harmonize reporting requests and demands and how the countries can strengthen their capacity for routine M&E. The Dominican Republic HIV/AIDS Project's participatory, three-phase approach to implementing an M&E system offered insight in this area. The approach involved (i) a comprehensive survey of all existing M&E activities dispersed around many institutions in the public sector and the bulk of those conducted by NGOs and civil society; (ii) building consensus on a single M&E system to consolidate data from multiple sources including existing sub-systems in the public sector and NGOs and other civil society activities; and (iii) agreed-upon steps for gradually implementing the M&E system starting with the construction of a baseline.[12] Without baselines and monitoring data, performance cannot be tracked and supported, and progress cannot be measured.

39. ***Fiduciary Issues***. The areas of financial management, procurement, and disbursements have presented challenges at some point in every HIV/AIDS Project in the Caribbean. One reason for this is the capacity gaps in every country whether personnel, skills and/or experience. The regional PANCAP Project faced significant delays with implementation due in part to its inability to comply with fiduciary rules and policies; Guyana and St. Lucia, soon after reallocating the project budget as part of their restructuring already needed to overdraw some categories; and the CSO component in some projects such as St. Kitts and Nevis was stalled for some time due to the projects requiring flexibility from the Bank in order to disburse small amounts to CSOs in a simplified manner. These are some of the difficulties faced at the country level which need to be evaluated against the operating practices and support provided by the Bank.

[12] World Bank. Dominican Republic HIV/AIDS Prevention and Control Project. Implementation Completion and Results Report. March 31, 2009, Report No. 00001011

Lessons Learned from Implementing HIV Projects in the Caribbean

40. The World Bank's engagement in HIV/AIDS in the Caribbean began in 2001 with the first loans to Barbados and the Dominican Republic. Nine years of experience have provided the Bank and its counterpart agencies with the opportunity to learn from the challenges and good practices that have emerged in implementing ten HIV/AIDS lending projects in the Caribbean. A summary of the key lessons learned is provided below.

Ideas for structuring smooth partnership relationships with non-health line ministries and CSOs

41. HIV/AIDS programs in small countries face human resource constraints. The limited staff is already overwhelmed with managing main program functions, with little time to participate directly in activities targeting hard to reach and most at-risk populations. This is where CSOs and Line Ministries have a critical role to play in taking on important activities that project staff are unable to carry out.

42. In the initial stages of project implementation, it was difficult to engage CSOs in HIV– there was limited CSO capacity and CSOs found the project reporting requirements difficult. CSO activities were delayed as projects needed to focus first on mentoring and building CSO capacity. In the smaller Caribbean countries, CSO engagement continues to face the challenges of low capacity and continuity of activities as most of the work is done on a voluntary basis. In the larger Caribbean countries, resource-constrained CSOs see their engagement in HIV as an opportunity to access funding and were all committed to the HIV response work. There is also a perception that the CSO component in the projects was donor driven, using a one-size fits all approach taken from the Africa model which does not apply to the Caribbean where a vibrant CSO base does not exist.

43. As for the engagement of non-Health line ministries (LMs), rather than one focal point in each Ministry, some countries suggest having one focal point to coordinate several ministries, because given the limited human capacity and smaller populations, top management in small countries may not see the duties of a focal point as sufficient to justify a full time staff position. Taking this idea further, another option to consider would be to have focal points only in key ministries where there is buy-in and that would be critical in reaching the most at-risk groups (MARPs). In some of the larger Caribbean countries, public servants may be reluctant to take on focal point roles and may resist cooperating with HIV project staff since there is a general perception that project staff get better salaries than public servants. The smaller and larger countries share the challenge of needing to provide monetary and non-monetary incentives to focal points in a resource-constrained environment in order to be able to assign them focal point duties in addition to their already assigned responsibilities.

44. The Bank recognizes the importance of CSO and LM involvement in the national response; however, this involvement needs to be given the necessary support in order for it to be effective. To strengthen the CSO component, training was offered to CSOs under the Bank project in the areas of procurement, financial management, monitoring and

evaluation (M&E), and understanding the HIV epidemic. The Bank has learned that many CSOs want to be actively involved in the national response, but that there are few technical organizations with expertise in HIV. Future CSO participation could benefit from what some Caribbean countries are already doing -- implementing a partnership approach through which they pair CSOs with different strengths and different capacity levels, providing the opportunity to build partnerships among the CSO themselves who mentor one another on the technical and fiduciary aspects.

45. To support CSO engagement, flexible processes and arrangements need to be put in place as the CSOs themselves are small organizations with limited, but focused capacity. Successful strategies in working with CSOs include providing training and capacity building opportunities for implementation and reporting, calling for expressions of interest before the call for proposals so the project team can work with the interested CSOs to develop proposals. Other good practices include multiple funding cycles to allow successful activities to continue, and more CSO to become involved, and developing a database to track the progress of activities and disbursements.

46. LM engagement could benefit from identifying existing positions with similar responsibilities before assigning a new person to take on focal point duties, and from making the role not just HIV, but a wellness focal point, to achieve synergies across health. To support the engagement of LMs, there is a need for simple and standardized reporting tools and buy-in of the focal points. Monthly reporting can be especially challenging when HIV is not their main task, and the Caribbean countries recommend shifting to quarterly reporting.

Effectively Reaching the Most-at-Risk Populations (MARPs)

47. Experience with the nine national programs shows large variation in the percent of the adult population being tested and in who is being tested. First, some countries test a smaller percent of the adult population and need to scale up their prevention programs; in addition what is recorded is the number of tests administered therefore double counting people who are tested more than once. Second, the differences in the percent of people testing positive raise the question as to who is being tested: the general population including the worried well and/or the MARP groups. Third, differences show up among countries in the time elapsed between the diagnosis of an AIDS case and the time of dying from AIDS. A short elapsed time indicates late presentation with already a low CD4 count or of lack of adherence to the treatment regimen that may result in drug resistance and require switching to second line ARVs that are much more expensive than first line drugs. Targeting and reaching MARPs early remains a major challenge in the Caribbean partly because of a culture of stigma and discrimination and partly because of outdated punitive laws that criminalize the behaviors of the MARPs.

48. To ensure that projects are indeed reaching the MARPs, it is important to systematize the activities that are currently conducted on an ad hoc basis, e.g. surveying MSM, mapping CSWs, targeting uniformed services personnel etc. Countries also reported insufficient support to orphans and vulnerable children, which further enhances the need for regular monitoring and

surveys to identify and better target the most vulnerable groups. Understanding the composition, location and number of MARPs will provide a clearer picture on ARV needs and resource requirements to sustain the cost of treatment programs. Well designed and better targeted IEC/BCC campaigns need to be further scaled up.

Continuing to Strengthen Monitoring & Evaluation (M&E)

49. Throughout the forum, a strong emphasis was placed on 'knowing your epidemic and knowing your response' – once countries understand their epidemic, its dynamics, and strengths and gaps in the national response, they are better able to strengthen the response; hence the urgency to operationalize and strengthen M&E systems. Caribbean countries are at different stages of operationalizing their M&E systems. Many project staff have had M&E training, but M&E capacities vary across countries. What the Bank has learned from this is that M&E cannot be measured in the number of people trained; what is important is the extent to which M&E data are collected, available, and used. Training must be accompanied by incentives for consistent data use over the longer-term.

50. The Bank has learned that in many countries, routine data collection and verification systems, harmonization of result framework indicators, definitions and existing M&E tools were a challenge due to competing priorities and varied demands from donor agencies. To respond to this, it was important for the Bank and other donors to agree to use indicators from the country's National Strategic Plan. Overall, the lesson learned is that there is a still a strong need for the Bank and other donors to support actions to strengthen the M&E system, especially the data collection process, to make it possible to evaluate the impact of HIV/AIDS programs and to provide programmatic guidance. At present, programmatic decisions and resource allocations are inadequately supported by a systematic review of evidence. This results in ineffective targeting of prevention interventions, misapplication of available resources and loss of early opportunities to address factors driving infections in the populations most at risk.

51. The area of M&E is particularly challenging when considering the needs and benefits of compiling and centralizing information. In going forward it is important to try and integrate HIV M&E functions into a centralized Health Management Information System (HMIS), however, the HMIS needs to consider multi-sectoral participation when designing the data recording templates for HIV. Overall, the main issue in the Caribbean around M&E is the need to strengthen M&E capacity to monitor and collect data that can support evidence-based policy-making. A reliable understanding of the dynamics of the epidemic – especially where and how most new infections are occurring – is essential for targeting prevention effectively.

Persistence in Seeking an Enabling Environment

52. The Caribbean country teams characterize the region as suffering from a persistent environment of stigma and discrimination. Complex cultural and social factors, coupled with outdated and punitive laws and policies often drive vulnerable populations, such MSM, CSWs, and drug users underground due to fear of being stigmatized, discriminated against and prosecuted. This prevents HIV programs from adequately addressing sensitive

social issues, and results in an environment that is not conducive for disclosing HIV status. The Bank recognizes that establishing a supportive, enabling environment is imperative for achieving universal access to prevention, treatment, care and support services, which is one of the greatest challenges in the Caribbean region.

53. The Caribbean region is a culturally conservative society with outdated laws that criminalize and punish CSWs and MSM behaviors. In Jamaica, the "Offenses against the Person Act" and the "Towns and Communities Act" are often applied to MSM and the country's vague statutes are used to limit the distribution of condoms and educational information.[13] The repeal of the Buggery Law continues to be a challenge in Jamaica due to political sensitivity and cultural underpinnings, so a softer and more feasible approach is being undertaken than fighting the Buggery Law head on, separating the legal issues from the sensitivity issues. As part of its efforts to find feasible ways to deal with stigma and discrimination, Jamaica is looking to India's experience where these issues are dealt with case-by-case in legal courts rather than through legislative reform which can be lengthy, cumbersome, and politically sensitive. Jamaica's experience can serve as a pragmatic experience for small, conservative states that face similar policy and legislative environments in responding to HIV.

54. Adding to the mostly conservative Caribbean culture is the lack of political will to address human rights and anti-discriminatory practices in policy and legislation, limited understanding and appreciation of issues related to political directorates, reluctance of PLHIVs and vulnerable communities to advocate law and policy reform related to stigma and discrimination, and no legal response to offences related to stigma, discrimination and hate crimes directed at MARPs. In response to this environment, advocacy strategies and social mobilization campaigns targeting policy makers can be considered, anti-discriminatory policy and anti-hate crime legislation that covers HIV and other broader issues can be developed, existing national laws can be reviewed and amended, and Faith Based Organizations (FBOs) and the general population can be engaged in the dialogue.

55. Anti-stigma campaigns need a supportive legal framework to be effective. Few Caribbean countries have legislation that addresses HIV/AIDS, and turn to regional bodies such as PANCAP to develop model policies, guidelines and legislation that can be adapted to individual country needs. PANCAP has offered support to the countries in the region to carry out national assessments of laws and regulations, ethics and human rights, to determine legal changes needed to protect against stigma and discrimination. Small countries may not have the expertise to embark on a thorough review of legal frameworks and even if carried out, one person's assessment may not carry enough weight to convince traditional bodies to support legislative change. Support from a regional body offers economies of scale, and also brings to the table the convincing power of a regional body.

Overcoming Organizational and Institutional Challenges

[13] Gable, L., Gamharter, K., Gostin, L., Hodge, J., Van Puymbroeck, R.. The World Bank: 2007. Legal Aspects of HIV/AIDS. Section 6.3 Vague or Overboard Criminal Statutes and Police Harrassment.

56. There are at least five reasons for why the National HIV/AIDS Commissions/ Councils (NACs) and National HIV/AIDS Steering Committees tended to not have worked well.

(a) NACs tend to be quite large ranging from 15 to 30 members with an extreme example of 45 in Trinidad & Tobago. Large boards tend to have large transaction costs and limited effectiveness. Members are usually appointed by government decree or resolution and identified either by name of the person or organization. Some members are selected for their skills or experience but other selection decisions are made to be representative and try to bring all stakeholders including civil society on board. Good governance and full representation are often not compatible. Meetings are irregular and the usual twice a year norm is rarely respected.

(b) Creating commissions by an Act of Parliament or Presidential Decree imposes a rigidity that makes it difficult to make changes in functions or membership.

(c) Many functions for which the Commissions are responsible are delegated to or assumed by or taken over by the National AIDS Secretariat (NAS) or Directorate (NAD) with the latter becoming a de facto Board.

(d) There is a danger in transferring institutional models into different contexts and assuming they will work the same way. The successful Barbados institutional model (see Box 1) was transferred to Trinidad & Tobago and Grenada, but without making the Secretariat a statutory body with its own budget. As a result project implementation has been moderately unsatisfactory and development objectives will be achieved only partially.

Box 1. Mainstreaming a Multi-Sector Program: the case of Barbados

An important factor in the Barbados HIV/AIDS program was the Government's strong commitment. In 2000 the Barbadian Parliament approved increased funding for HIV activities, and launched the high-level National HIV/AIDS Commission (NHAC) reporting to the Prime Minister. NHAC's main role was to institutionalize all program activities within line ministries and civil society organizations. NHAC's Secretariat performed the functions of Project Coordination Unit. Making the NHAC secretariat a statutory body managed by a Director-level civil servant and with a line item budget was a key factor in the success of the program. The NHAC Secretariat and the MOH provided technical assistance to 18 line ministries. The MOH and MOE were the main implementers of the project, and both have mainstreamed the interventions into their regular program activities. GOB solidified its high priority by including HIV funding in the national budget, providing an incentive for all line ministries to plan activities to support the national strategy.

(e) The NAS or NAD in five of the nine national projects is located in the Ministry of Health or reports to the Health Minister or Permanent Secretary. In three countries the NAS is located in the Office of the Prime Minister resulting in a disengagement of the MOH, the lead technical agency for HIV treatment and testing. This is consistent with the view of the World Bank's Independent Evaluation Group (IEG) in its 2005 review of World Bank HIV/AIDS projects, that: "Evidence to support

the effectiveness of institutions to manage the AIDS response outside of the Ministry of Health from the Bank's experience is scant".[14]

57. Putting prescribed policy and institutional structures in place does not necessarily mean that there will be long term political and multi-sector commitment to tackling AIDS. Structures are not a proof of real commitment, and even if they do indicate commitment, they are not necessarily effective organizations.

Knowing and Understanding your Country Counterpart

58. The fiduciary aspects of implementing Bank-financed projects have been a consistent challenge across the Caribbean countries. All countries noted challenges in financial management, disbursements, and procurement, but were unaware that neighboring countries shared these challenges. It is important for the Bank to recognize these potential problem areas and support networking among PCUs. The Bank can play a role in fostering systematic sharing of information to help resolve common problems. A regional review and approach can be of benefit in small countries with few fiduciary staff. Increased training in the fiduciary areas should be considered for Caribbean counterparts and could include LMs and CSOs. A better use of IT systems for fiduciary transactions and reporting should also be explored.

59. The Bank needs to recognize that it is working with counterpart agencies that operate within highly regulated public sector organizational structures. This delays decision-making and slows implementation decisions. Furthermore, the economic recession can directly affect the project in terms of counterpart funding availability. The Bank needs to be aware of these risks and be prepared to seek flexible solutions. The Bank also needs to play a role in ensuring that National AIDS Councils/Directorates are working within the health sector and are part of the coordinated response and are not replicating essential health functions already carried out by the MOH. When the National AIDS Councils/Directorates are restructured within the MOH it will be critical to retain experienced human resources, to help sustain current service levels in the face of budgetary constraints. The Bank can help work with Caribbean Government counterparts to ensure there is a fiscal space for HIV/AIDS expenditures and seize opportunities to address the sustainability of HIV programs.

A Commitment to Knowledge Generation

60. The Bank has a role to play as the "Knowledge Bank" in supporting counterpart agencies to commission studies that will elicit new knowledge on HIV/AIDS and help guide future interventions and better targeting activities (Table 7). These special studies can include areas such as drug resistance, treatment adherence and surveillance, and can help countries prepare for or carry out KAPB or BSS surveys. Countries acknowledge that knowledge, attitudes, behaviors and beliefs have improved somewhat, and that generating new knowledge can help this to continue.

[14] World Bank (2005) ibid

Table 7: Studies Commissioned by PANCAP and financed through the HIV/AIDS Projects

Name of Study	Organization or Consultant Conducting study	Date of completion	Dissemination approaches
1. HIV and Tourism Study: Slow-onset Disasters and Sustainable Tourism Development: Exploring the Economic Impact of HIV/AIDS on the Tourism Industry in Selected Caribbean Destinations	University of the West Indies- Health Economics Unit	June 2009	Study has been placed on the PANCAP website
2. Costing of Health Programmes in small Island States: Issues and Challenges	University of the West Indies- Health Economics Unit	April 2009	Study is on the PANCAP website
3. Poverty and HIV/AIDS in the Caribbean	University of the West Indies- Health Economics Unit	May 2009	Study is on the PANCAP website
4. Evaluation of the Bahamas HIV/AIDS Programme	University of the West Indies- Health Economics Unit	March 2007	Study is on the PANCAP website
5. Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome: A Reference Text of Major Milestones, Key Events and Developments in the Caribbean	University of the West Indies- Health Economics Unit	April 2009	Study will be printed and disseminated to relevant stakeholders by June 2010, then placed on the PANCAP website.
6. Prostitution, sex work and Transactional sex in the English, Dutch and French speaking Caribbean	Dr Kamala Kempadoo	September 2009	Study is on the PANCAP website. Study will be printed and disseminated to relevant stakeholders
7. Regional Assessment of Drug Registration and Regulatory Systems in CARICOM Member States and the Dominican Republic	Health Research for Action (HERA)	July 2009	Electronic copies will be sent to CARICOM Member States and the Dominican Republic
8. Regional Assessment of Patent and Related Issues and Access to Medicines	Health Research for Action (HERA)	October 2009 (draft final report)	Electronic copies will be sent to CARICOM Member States and the Dominican Republic

Strategic Flexibility in National Strategic Planning

61. A special effort should be made to link evidence on drivers of the HIV epidemic to identification of results to be achieved over the strategic plan period. The Operational Plans in some countries are not integrated in the NSPs and there are disconnects between strategies delineated in the NSP and the Operational Plans implemented. Articulation of results and resource allocation in the Operational Plans should be based on the NSP and on epidemic dynamics that inform program priorities. Clearly set priorities that are strongly aligned with the dynamics of the epidemic should guide donor assistance, which will avoid misdirected or duplicated efforts.

62. Many countries are currently embarking on reviews of their strategies. This provides an opportunity for support from the Bank and to ensure that new evidence and the best possible understanding of the epidemic dynamics drives program prioritization and resource allocation. Joint country-led reviews, conducted at two year intervals, are a useful approach to ensuring that the strategy is appropriate to changing circumstances, and need to be built into the plan.

63. ***Know your Target Populations***. Small countries may have limits on the range of activities they are able to carry out, making it essential to understand the nature of the epidemic. This will enable stakeholders, e.g., CSOs, LMs, donors, etc., to target their treatment and prevention activities to the right populations. CSOs should be steered in the direction of dealing with high priority issues or working with difficult to reach populations most at risk of HIV. This is critical to ensure that all actors involved in the national response are working towards the goal of having an impact on the epidemic.

64. ***Look to Pragmatic Approaches.*** Any initiative must recognize the realities of the setting and culture to be able to move forward and have an impact. Small countries with a conservative culture are unlikely to be supportive of efforts to enact policy and legislative reform in support of anti-stigma and discrimination. However, it may be possible to address individual cases of discrimination in a legal court, and create practical precedent that enables progress to be made.

65. ***Leverage Partnerships to coordinate (not implement) your National Response***. Small countries face particular limitations, especially in human resources. It is not the role of the National AIDS Secretariat to implement every program activity, but it can guide interventions and promote the participation of other stakeholders in support of the national response. Partnering with stakeholders with specific abilities to effectively reach most at risk populations will be important for implementing an effective National Program.

66. ***There are ways around the "dis-economies" of small scale***. International donor projects in small, medium and large countries vary in design, but all require the same skills for fiduciary oversight and project management. Although small countries usually receive smaller loans or credits, this may not imply a simpler project design. The small country will need to cope with the same project complexities with less human capacity. Small countries often face common challenges with program management and project implementation and can benefit from the experience and input from a neighboring small state and sharing ideas. A regional approach to training fiduciary and management staff and for pooling procurement of ARVs and other pharmaceuticals and supplies in the region has economies of scale and has proven to be effective and should be further explored. Small countries usually centralize financial accountability and procurement under the Ministry of Finance. This is a cost effective arrangement where qualified human resources are in short supply and training fiduciary staff for each donor supported project would be expensive.

67. ***Understand the Costs and Financing of your Program.*** Small countries are often highly vulnerable to macroeconomic shocks from downturns in their national economy, putting at risk counterpart funding and limiting fiscal space. It is important for small states to have costed National AIDS Strategic Plans to be able to allocate funds appropriately and to flexibly adapt and reallocate resources if faced with economic and

financial challenges. In addition, a costed strategic plan will put the country in the driver seat in guiding donor participation.

68. ***Integrate with Nationally Recognized Responsible Sector Body.*** The experiences of the HIV/AIDS programs in the Caribbean underscore the importance of working within the established sector environment, in this case health, rather than creating new organizational structures and parallel reporting mechanisms. In the initial stages of project implementation, independent AIDS Directorates/Councils were established reporting directly to the highest levels. This resulted in poor coordination and duplication of efforts, and isolated HIV/AIDS from the main Ministry of Health budget and activities.

69. ***Nurturing Political Commitment.*** Bank assistance has induced Caribbean governments to act earlier or in a more focused and cost-effective way. It helped raise political commitment, create or strengthen AIDS institutions, enlist nongovernmental organizations, and prioritize activities. Political commitment and capacity, however, were overestimated during the design phase and need to be continuously addressed in the country context. The experience in the Caribbean small states underscores the importance of not only securing political commitment, but continuing to nurture it as priorities can change, especially in small countries with many active donors.

Conclusion

70. Since 2001 the World Bank has been actively engaged in the Caribbean through its HIV/AIDS lending portfolio. From these years of experience in project design, project adjustments, and implementation, lessons are surfacing from which we can learn for future Caribbean engagement, but also lessons that can be applied to our engagement strategies in other small states. A critical lesson that emerges from this opportunity to reflect on the good practices and challenges experienced across the years is the need for countries know their epidemic and have a thorough understanding of what behaviors and other factors are driving it. This reflects back on the need for the region to strengthen its M&E capacity and culture which would allow a true picture to emerge on where the epidemic is growing and who the most at-risk groups are. There is still much unknown about how the epidemic is affecting those most at-risk, but initial quantitative and anecdotal evidence points to this being where the focus of prevention and treatment efforts should be directed.

71. While it can be helpful to look to other countries for insight and input in the design and implementation of programs, a region with the rich experience of the Caribbean can reap the benefits of south-to-south knowledge-sharing with other small states and intra-regionally among Caribbean neighbors. Exchanging knowledge and experiences with countries that work within similar environments can stimulate joint problem solving and lead to pragmatic and effective interventions and approaches.

The Way Forward

72. By December 2010, the World Bank's HIV/AIDS lending portfolio to the Caribbean region will consist of only two active HIV/AIDS projects, Barbados and Jamaica. This speaks strongly to the need for measures and actions to ensure sustainability. The HIV/AIDS Projects have provided the World Bank with an opportunity to gain insight into the constraints facing the overall health systems and to gauge the interest level and need from the governments for scaling up into health system strengthening projects. From the client perspective, with the project closings, countries are faced with the issue of how to ensure that activities that were financed by the World Bank are sustained as part of their national response. Sustainability at the country level is directly linked to the need to integrate HIV services into the core health programs of the Ministry of Health. Efforts still are needed to bring across the message that the HIV epidemic is not only a health issue, but has developmental, financial and economic consequences. There is a need to take proactive steps to integrate HIV into the central government budgets for sustainability.

73. Over the past five years, AIDS has evolved from a terminal illness into a chronic disease. As people with HIV are living longer lives, providers face a number of new challenges. These challenges include the increasing number of people living with HIV, enrolling and retaining HIV positive people under care, coordinating HIV services across fragmented payer and delivery systems, simplifying complex treatment regimens to maximize adherence, reducing disparities of HIV care between different subpopulations,

integrating ongoing prevention counseling into care, and educating providers about strategies to help patients change behaviors and reduce risk. Amidst these challenges, HIV needs to be integrated into a health systems strategy where payer and delivery systems for HIV services and health promotion and disease prevention can be coordinated with other chronic disease services to maximize the use of limited resources to achieve more effective outcomes overall. The World Bank's Health, Nutrition, and Population Strategy refocused the World Bank on health systems strengthening, which is especially important where chronic diseases are a priority, such as in the Caribbean. The World Bank will continue to be involved in the prevention and control of HIV and other STIs around the world and in the region. However, the World Bank's future support in the Caribbean region will have a broader health system strengthening focus, with the goal of enabling countries to address communicable and non-communicable diseases more effectively.

Annex 1. Agenda

The Agenda at Glance

Nov 18	Nov 19	Nov 20
08:30-09:00 - Registration 09:00-10:00 - Opening Session: HIV/AIDS in the Caribbean and its position within the overall Health Sector 10:00-10:15 - COFFEE BREAK 10:15-12:00 - Progress in the Fight Against HIV/AIDS in the Caribbean: A Country Perspective 12:00-13:30 - LUNCH 13:30-17:00 - Parallel sessions: Session I-A: Reaching the at-risk through a Multi-Sector Response Session I-B: Monitoring and Evaluation 13:30-14:30 - Plenary 14:30-15:20 - Break-out Group Discussions 15:20-15:35 - COFFEE BREAK 15:35-16:35 - Group Presentations 16:35-17:00 - Plenary Discussions and Conclusions	09:00-09:15 - Recap of the Previous Day 09:15-12:30 - Parallel sessions: Session II-A: The Health Sector Response to HIV/AIDS: Prevention, Treatment, and Care Session II-B: Parallel Fiduciary Workshop: Financial Management, Procurement, and Disbursements 09:15-10:15 - Plenary 10:15-10:30 - COFFEE BREAK 10:30-11:20 - Break-out Group Discussions 11:20-12:00 - Group Presentations 12:00-12:30 - Plenary Discussions and Conclusions 12:30-14:00 - LUNCH 14:00-17:00 - Parallel sessions: Session III-A: National Strategic Planning Session III-B: Advocacy, Legal Reform, and Human Rights Session III-C: Parallel Fiduciary Workshop: Financial Management, Procurement, and Disbursements 14:00-14:40 - Plenary 14:40-15:30 - Break-out Group Discussions 15:30-15:45 - COFFEE BREAK 15:45-16:35 - Group Presentations 16:35-17:00 - Plenary Discussions and Conclusions	09:00-09:15 - Recap of the Previous 9:15-10:30 - Session IV: Implementation Completion Reports (ICRs) – Surfacing Lessons Learned and Challenges Faced 10:30-10:45 - COFFEE BREAK 10:45-12:30 - Cont. session IV 12:30-14:00 - LUNCH BREAK 14:00-15:00 - Session V: Ensuring a Continued Fight against HIV/AIDS in the Caribbean 15:00-16:00 - Session VI: Ensuring a Continued Fight against HIV/AIDS in the Caribbean 16:00-17:00 - Plenary Discussions and Conclusions 17:00-17:20 - Closing Words: The World Bank

Knowledge Forum of World Bank- financed HIV Projects in the Caribbean - Nov 2009

Annex 2. List of PowerPoint Presentations presented at Knowledge Forum

Setting the Stage

Greene, E. "HIV/AIDS in the Caribbean and its position in the overall health sector: pointing to a wider problem and a broader response." Opening speech at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

World Bank, Latin America and the Caribbean Region (LCR). "Knowledge Forum: HIV Projects in the Caribbean." Opening statement and presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Country Overviews Presentations

Best, A. Ministry of Health. "Barbados: country overview presentation." Country overview presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

COPRESIDA, HIV/AIDS Presidential Council. "Progress in the Fight Against HIV/AIDS in the Dominican Republic." Country overview presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Emmanuel, E. "Scaling up the Caribbean Response to HIV/AIDS." Pan-Caribbean Partnership Against AIDS Presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

"Grenada's Response to HIV / AIDS Prevention and Control." Country overview presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Guyana HSDU, National AIDS Programme Secretariat. Country overview presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Jamaica country overview presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Minott, K. Trinidad and Tobago country overview presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

"St. Lucia's Perspective: Progress in the Fight Against HIV/AIDS in the Caribbean." Country overview presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

St. Kitts and Nevis country overview presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

St. Vincent and Grenadines country presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Technical Presentations

Health Sector Response

Alexander, S. "Saint Lucia Health Sector Response." Country health sector response presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Best, A. Ministry of Health. "Health Sector Response to HIV/AIDS in Barbados." Country health sector response presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

"Health Sector Response to HIV/AIDS in Jamaica." Country health sector response presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Majszyk, A. UNAIDS-Caribbean Regional Support Team. "Health Sector Response to HIV in the Caribbean: Successes and Future Actions." Regional health sector response presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Monitoring and Evaluation

Camara, B. UNAIDS-Caribbean Regional Support Team. "Monitoring and Evaluation: Making Information Work to Achieve MDGs 3- 4-5-6-7." M&E system presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

COPRESIDA, HIV/AIDS Presidential Council. " M&E National Response to STD/HIV/AIDS: Progress Level." Country M&E system presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Drakes, N. NHAC. "Presentation on Achievements: Status of M&E Operational Plan." Country M&E system presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Lynch, H. Jamaica Ministry of Health. "Evolution of the M&E System: Understanding Roles and Responsibilities." Country M&E system presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

"Saint Lucia: Health Management Information System (HMIS)." Country M&E system presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Multisectoral Response

"Guyana Ministry of Health and the World Bank HIV AIDS Prevention & Control Project: Multisectoral Engagement." Country multisectoral response presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

"St. Kitts and Nevis Country Perspective: Role of Non-Health Ministries in National Response." Country multisectoral response presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Fiduciary Parallel Workshop:

Karunaratne, S. World Bank, Loan Department. "Disbursement Overview." World Bank presentation on disbursement issues at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Njomo, E. World Bank, Financial Management Department. "Financial Management Overview." World Bank presentation on financial management issues at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Advocacy, Legal Reforms, Human Rights

Grenada country presentation on advocacy, legal reforms and human rights at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Saint Kitts and Nevis country presentation on advocacy, legal reforms and human rights at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

National Strategic Planning

Alexander, S., Lloyd-Felix, N. "Saint Lucia National Strategic Plan." Country National Strategic Plan presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Semini, I. ASAP, Global AIDS Program, World Bank. "AIDS Strategy and Action Plan (ASAP) Business Model." ASAP presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

"St. Vincent and the Grenadines National Strategic planning." Country National Strategic Plan presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Implementation Completion Reports

Nobakht, H. World Bank, Development Effectiveness Department. "Evaluation of the World Bank Operations." World Bank presentation on implementation completion evaluation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

"Trinidad & Tobago: The Global Economic Crisis and the Impact on HIV & AIDS Services." Country presentation at the Knowledge-Sharing Forum of the Bank-financed HIV Projects in the Caribbean, St. Kitts and Nevis, 18-21 November, 2009.

Annex 3. List of Participants

BARBADOS

NAME	Title	Organization
CLAUDIA ROSE CLARKE	Finance Officer	Ministry of Youth, Family & Sports National HIV/AIDS Commission
JACQUELINE WILTSHIRE GAY	Director, National HIV/AIDS Commission	Ministry of Youth, Family & Sports National HIV/AIDS Commission
WINIFRED HAREWOOD	Financial Controller	Ministry of Health National HIV/AIDS Commission
ESTHER WILLIAMS	Procurement Officer	Ministry of Health HIV/AIDS Prevention and Control Project Unit
NICOLE DRAKES	Assistant Director	Ministry of Youth, Family and Sports National HIV/AIDS Commission
RHONDA GREENIDGE	Administrative Officer II/Project Officer	Ministry of Youth, Family and Sports National HIV/AIDS Commission
ANTON BEST	Sr. Medical Officer of Health	Ministry of Health HIV/AIDS Programme Unit

DOMINICAN REPUBLIC

Name	Title	Organization
GUSTAVO ROJAS LARA	Executive Director	COPRESIDA (Consejo Presidencial del Sida)
NELSON BELISARIO BATISTA	Assistant Executive Director COPRESIDA	COPRESIDA
LUIS ALBERTO RODRIGUEZ REYES	M&E/Research	COPRESIDA M&E/Research Unit
HENRY ARTURO MERCEDES VALES	Strategic Planning Coordinator	COPRESIDA
JESUS ENNAR DORADO	Financial Coordinator	COPRESIDA Finance Unit

GUYANA

Name	Title	Organization
SONIA ROBERTS	Finance Director	Ministry of Health Health Sector Development Unit
PATRICK EWART MENTORE	Coordinator, Line Ministries	Ministry of Health Health Sector Development Unit
NICHOLAS PERSAUD	National HIV Treatment of Care Coordinator	Minster of Health National AIDS Program Secretariat

ASMITA CHAND	Civil Society Coordinator	Ministry of Health Health Sector Development Unit
PRAKASH SOOKDEO	Procurement Officer	MOH Health Sector Development Unit

GRENADA

Name	Title	Organization
CLIFTON NEDD	Former M&E Officer	HIV/AIDS Program
JESSIE J. HENRY	Director	Ministry of Health National Infectious Disease Control Unit
ARTHUR PIERRE	HIV/AIDS Response Coordinator	Ministry of Health HIV/AID Program Unit
CLAUDINE V. HENRY	Operations Analyst	Ministry of Finance Project Management Unit
JENNY ALEXANDER	Procurement Officer	Ministry of Finance Project Management Unit

JAMAICA

Name	Title	Organization
KEVIN HARVEY	Director	Ministry of Health National HIV/STT Programme
TERRY ANN SMITH FRITH	Senior Procurement Officer	Ministry of Health National HIV/STT Programme
HEATHER BURROWES	Finance Officer	Ministry of Health National HIV/STT Programme
NICKOLETTE GORDON	Program Administrator / Administration Officer	Western Regional Health Authority Epidemiology & research Unit / Regional STI/HIV Program
HOWARD LYNCH	Director, Policy, Planning, and Development	Ministry of Health Policy, Planning, and Development

PANCAP

Name	Title	Organization
EDWARD LEONARD EMMANUEL	Program Manager	CARICOM / PANCAP PANCAP Coordinating Unit
GLADSTONE SKEETE	Project Officer	CARICOM Secretariat Donor Resources - Finance Unit
JOHN PRIMO	Procurement Specialist	CARICOM PANCAP Unit

EDWARD GREENE	Assistant Secretary General	CARICOM PANCAP Unit

ST KITTS AND NEVIS

Name	Title	Organization
ELVIS NEWTON	Minister of Health (PS)	Ministry of Health
LONDYA LENNON	Data Entry Clerk / M&E Officer	Ministry of Health Health Information Unit
JULETTA FYFIELD	Health Educator	Ministry of Health National AIDS Secretariat
RENA WARNER	Procurement Officer	Ministry of Sustainable Development Project Coordination Unit
KAREN DOUGLAS	Project Accountant	Ministry of Sustainable Development Project Coordination Unit

ST LUCIA

Name	Title	Organization
NAHUM JN BAPTISTE	Director	Ministry of Health National AIDS Program Secretariat
CALUS MONCHERY	Financial Management Assistant	Ministry of Economic Affairs Project Coordination Unit
NATASHA LLOYD	Line Ministry Civil Society Coordinator	National AIDS Program Secretariat
SONIA ALEXANDER	Director	Ministry of Health National AIDS Program Unit
CHERYL MATHURIN	Project Coordinator	Ministry of Finance, Econ, Planning, and National Development Project Coordination Unit
ERMA JULES	M&E Coordinator	National AIDS Programme Secretariat, M&E Department

ST VINCENT AND THE GRENADINES

Name	Title	Organization
DEL HAMILTON	Director, National AIDS Secretariat	Ministry of Health & the Environment
CELOY NICHOLS	Health educator	Ministry of Health & the Environment Health Promotion Unit
MAURICE JOHN	Procurement Specialist	Ministry of Finance and Planning Project Coordination Unit

TRINIDAD & TOBAGO

Name	Title	Organization
CAROL ANN-SENAH	Technical Director	National AIDS Coordinating Committee
ANTHONY SMITH	Financial Management Officer	National AIDS Coordinating Committee
KIMLAN MINOTT	Project Coordinator	Office of the Prime Minister Project Coordinating Unit
PATRICIA LEE BROWNE	Director of Projects	Ministry of Finance
BRIAN AMOUR	Assistant Programme Director	Ministry of Health HIV/AIDS Coordinating Unit
ROANNA MORTON-WILLIAMS BYNOE	Coordinator Monitoring, Evaluation & Research	Ministry of Health HIV/AIDS Coordinating Unit

INTERNATIONAL DONORS

Name	Title	Organization
Arkadius Majszyk	Director a.i. Caribbean Regional Support Team	UNAIDS
Bilali Camara	Senior Regional M&E Advisor	UNAIDS
Carmen Carpio	Public Health Specialist	World Bank
Joana Godinho	Sr. Health Specialist	World Bank
Willy de Geyndt	Consultant - Health Management Advisor	World Bank
Hoveida Nobakht	Sr. Operations Officer	World Bank
Iris Semini	Sr. HIV/AIDS Specialist	World Bank
Brian Pascual	Operations Analyst	World Bank
Ndella Njie	Operations Analyst	World Bank
Emmanuel Njomo	Consultant – Financial Management	World Bank
Judith Morroy	Consultant - Procurement	World Bank
Saman Karunaratne	Disbursement Analyst	World Bank
Jorge Gamarra	Consultant – Knowledge Management	World Bank
Zukhra Shaabdullaeva	Consultant – Research and Operations	World Bank
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