ORGANISATION OF EASTERN CARIBBEAN STATES (OECS):

Developing an HIV and TB Sustainability Strategy

9 November 2020
Final Report

Pharos Global Health Advisors
for the OECS Regional Coordination Mechanism (RCM)
and the Global Fund

Pharos Global Health Advisors

Authors and Acknowledgements
This report was prepared for the Global Fund to Fight AIDS, TB, and Malaria by Nathan Isaacs, Devyn Rigsby, Sandra McLeish, Catalina Gutierrez, and Robert Hecht of Pharos Global Health Advisors. The authors thank Joan Didier, Tricia Leo, Morris Edwards, Lynette Hardy, Letitia Nicholas, Lisa James, Kimbely Mills, Christy S. N. Butcher, Malgorzata Matysek, Cristina Riboni, and Alwin De Greeff for their valuable support and feedback provided throughout the preparation of this report. Special thanks also to all interviewees who shared their time and insights for this report. All errors and omissions are our own.

Table of Contents

List of Figures

Abbreviations

AAF	AIDS Action Foundation (St. Lucia CSO)
AIDS	Acquired immunodeficiency syndrome
AMFAR	Foundation for AIDS Research
ART	Anti-retroviral therapy
ARV	Anti-retroviral
CARICOM	Caribbean Community
CARPHA	Caribbean Public Health Agency
CBI	Citizenship by investment
CCM	Country Coordinating Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CHAA	Caribbean HIV/AIDS Alliance
CMLF	Caribbean Med Labs Foundation
CMO	Chief Medical Officer
CRN+	Caribbean Regional Network for People Living with HIV
CSO	Civil society organization
CSW	Commercial sex worker
CT	Computed tomography
CVC	Caribbean Vulnerable Communities Coalition
DAH	Development assistance for health
DFID	Department for International Development (U.K.)
DOTS	Directly observed therapy, short-course
DR	Dominican Republic
ECADE	Eastern Caribbean Alliance for Diversity and Equality (Regional CSO)
eCBS	Electronic case-based surveillance
EMTCT	Elimination of mother-to-child transmission
EU	European Union
FSW	Female sex worker
FY	Fiscal year
GDP	Gross domestic product
GHE	Government health expenditure
GNI	Gross national income
HIV	Human immunodeficiency virus
HMIS	Health management information system
HR	Human resources
HSS	Health systems strengthening
HTEP	HIV and TB Elimination Project (OECS Commission)
IEC	Information, education, and communication
IMF	International Monetary Fund
IPPA	International Planned Parenthood Association
KfW	Kreditanstalt für Wiederaufbau (German Development Bank)
KP	Key population
LAC	Latin America & Caribbean
LFU	Lost to follow-up
LGBTQ+	Lesbian, gay, bisexual, transgender, queer +
LQMS-SIP	Laboratory Quality Management System—Stepwise Improvement Process

M&E	Monitoring & evaluation
MBS	Medical Benefits Scheme (Antigua & Barbuda)
MDR-TB	Multi-drug resistant tuberculosis
MoH	Ministry of Health
MoHWE	Ministry of Health, Wellness, and Environment
MSJMC	Mount St. John's Medical Center (Antigua & Barbuda)
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NACU	Nevis AIDS Coordinating Unit
NAPC	National AIDS Program Coordinator
NASA	National AIDS Spending Assessment
NCD	Non-communicable disease
NGO	Non-governmental organization
NHA	National Health Accounts (WHO)
NHARP	National HIV/AIDS Response Program (Dominica)
NHI	National health insurance
NIDCU	National Infectious Disease Control Unit (Grenada)
NSP	National strategic plan
ODA	Official development assistance
OECS	Organization of Eastern Caribbean States
OOP	Out-of-pocket
PAHO	Pan-American Health Organization
PANCAP	Pan-Caribbean Partnership Against HIV/AIDS
PDL	People deprived of liberty
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief (U.S.)
PHC	Primary health care
PHDP	Positive health, dignity, and prevention
PLHIV	People living with HIV
PPS	Pharmaceutical Procurement Service (OECS Commission)
PR	Principal Recipient
PrEP	Pre-exposure prophylaxis
PS	Permanent Secretary
PSE	Population size estimate
PSI	Population Services International
PSM	Procurement and Supply Chain Management
RCM	Regional Coordinating Mechanism
RR-TB	Rifampicin-resistant tuberculosis
RSSH	Resilient & sustainable systems for health
SC	Social contracting
SIDS	Small island developing states
SR	Sub-recipient
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SW	Sex worker
TA	Technical assistance
TB	Tuberculosis
TG	Transgender

THE	Total Health Expenditure
TLC	Tender Loving Care (St. Lucia CSO)
TS	Transactional sex
UHC	Universal health coverage
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
US	United States
USAID	U.S. Agency for International Development
USD	U.S. dollars
VCT	Voluntary counseling and testing
VL	Viral load
WAD	World AIDS Day (December 1)
WAR	Women Against Rape (Antigua & Barbuda CSO)
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization
3H	Health, Hope, and HIV (Antigua & Barbuda CSO)

Executive Summary

The Challenge of HIV and TB Sustainability in the OECS

With overall rising national incomes and relatively low HIV and TB burdens, the six countries of the Organisation of Eastern Caribbean States (OECS) – Antigua & Barbuda, Dominica, Grenada, St. Kitts & Nevis, St. Lucia, and St. Vincent & the Grenadines – have been expected to transition from Global Fund assistance. The Global Fund is the last major international health donor operating within the region, and upon its departure, the six OECS countries must manage their national HIV and TB programs solely with local resources and personnel. This upcoming transition is expected to increase certain key risks to the disease control programs in these six countries, including limited fiscal space for health made tighter by the Covid-19 pandemic, suboptimal progress towards 90-90-90 HIV treatment goals, fractured outreach programs to key vulnerable groups, inadequate monitoring and evaluation of programmatic outcomes, and a resurgence of TB in certain locations.

It is crucial that the OECS develop a comprehensive sustainability plan to assume increasing domestic responsibility for their HIV and TB programs, preparing to transition efficiently while extending and sustaining the disease control gains that they have achieved.

In early 2020, Pharos Global Health Advisors was asked to facilitate the development of the OECS HIV/TB Sustainability Strategy, working closely with public sector and civil society leaders in the six countries and with the regional coordination mechanism and the Global Fund-backed HIV and TB Elimination Project (HTEP) team located in St. Lucia. This report is the final output by Pharos.

Methodology

At the start of the project, Pharos conducted literature reviews and preliminary interviews with 15 national, regional, and global stakeholders to understand the regional and national contexts (a list of all interviewees attached in Annex 2). At this stage, Pharos drafted a set of hypothesized sustainability risks and proposed solutions using the following analytical categories employed successfully in other engagements across the LAC region and world: Financing, Health Systems, Governance, and Key Populations/Civil Society Organizations.

The Pharos team conducted in-country missions in March 2020 to Antigua & Barbuda, Dominica, St. Kitts & Nevis, and St. Lucia, but were unable to travel to Grenada and St. Vincent & the Grenadines due restrictions imposed by the Covid-19 pandemic. In each country, the team conducted interviews with government and civil society representatives and collected important documents and data, maintaining the engagement digitally with the two remaining countries. With the input from all six countries, Pharos adapted its analysis and refined the list of sustainability risks and recommendations. Remote workshops were held in autumn 2020 with each individual country for roughly three hours with each over ten participants from health ministries, finance departments, civil society organizations, and other key stakeholders. A list of the results and attendees of the workshops can be found in Annex 3.

Context of the HIV and TB Response in the OECS

Epidemiology and Program

The HIV burden in the OECS is low, with average prevalence in the general population of 0.8%.[1] However, progress towards 90-90-90 HIV goals is variable and low across the region. The HIV epidemic in the OECS is concentrated heavily in key populations (KPs): men who have sex with men (MSM), sex workers (SWs), transgender (TG) populations, people deprived of liberty (PDL), migrants, and youth. New infections and prevalence are substantially higher in these KPs.

[1] OECS HTEP, 2019.

Figure 2.1: General Characteristics of the HIV Epidemic in the OECS (Sources: UNAIDS, 2018, and OECS HTEP, 2019)

Country	Antigua & Barbuda	Dominica	Grenada	St. Kitts & Nevis	St. Lucia	St. Vincent & the Grenadines	OECS Total
HIV prevalence, general population, 2018	1.1%	0.6%	0.5%	0.5%	0.6%	1.5%	0.8%
Estimated total PLHIV, 2019	707	412	437	332	792	820	3500
Number of patients under HIV care, 2019	324	84	158	89	346	401	1402
New patients under HIV care, 2019	25	8	10	11	37	17	108

Overall, the OECS region has an HIV treatment cascade of 82-40-20, well below the UNAIDS goal of 90-90-90. The first goal – the percent of PLHIV who know their status – is within reach for the OECS region, but the second and third goals – percent of PLHIV who know their status on ART and the percent of PLHIV on ART who are virally suppressed – are far from achievement. This significant underperformance presents a key challenge for the OECS region.

Like HIV, the TB burden in the OECS is low. The six OECS countries are within the WHO's range for TB elimination (incidence of <10 per 100,000).[2] Regional TB incidence in 2017 stood at 4.21 per 100,000, and national incidences in 2018 and 2019 ranged from 0.0 to 6.4 per 100,000. In 2019, most countries faced very low rates of TB cases, except Dominica where 9 cases of TB were identified and incident rate for TB of 11.5 per 100,000 persons. Encouragingly, however, Dominica has prioritized TB detection and treatment, as confirmed through interviews and workshops.

Health Systems

Overall, health systems in the OECS struggle with a set of key challenges that create risks to HIV and TB program sustainability. Human resources, especially in the public sector, remain a key challenge, as most governments lack the necessary funding, and there is often a lack of qualified individuals. Often this is due to brain drain and the low salaries and unique challenges facing the public heath sectors in the region. This has left certain NAPC positions vacant and clinics understaffed. Even though HIV and TB treatment is free in the public sector, many PLHIV seek private care despite the out of pocket payments due to concerns of privacy and discrimination.

The Global Fund has assisted in the development of an electronic case-based surveillance (eCBS) system to conduct HIV surveillance and reporting of diagnostic testing and treatment. However, several countries are not yet fully utilizing this system due to technical and program-specific difficulties. The region has medical laboratory capacity (e.g. Antigua & Barbuda with a Tier 1 public laboratory), but the five other countries are still working to reach Tier 1. The OECS uses a pooled pharmaceutical procurement service (PPS), overseen by the OECS Commission, to purchase HIV and TB products along with other health and pharmaceutical goods at low prices. However, the countries still rely on the Global Fund financing for a large share of their HIV and TB commodities annually, potentially up to one quarter the cost of ARVs.

Financing

The OECS region has benefited from a variety of grants over the last few decades for their HIV and TB responses. In the last decade, other funders have left the Global Fund as the final remaining large external financier. The current Global Fund grant, the OECS Multi-country Strategic Response Towards HIV and TB Elimination, is expected to disburse US$8.6 million from 2016 to 2022. The first phase of $5 million (2016-19) had a poor performance rating due to a lack of progress demonstrated towards agreed upon programmatic outcomes and suboptimal management of grant funds. The second grant (April 2019

[2] D'Auvergne, 2018.

– March 2022) is for an additional US$3.5 million, after which the OECS may be eligible for one additional grant before it transitions from Global Fund support.

On the domestic side, the national governments of the OECS provide the large majority of financing for their HIV programs. This is encouraging, but there are still financing sustainability risks associated with program activities which are heavily funded by the Global Fund, especially KP outreach, PLHIV support, and health systems strengthening. Due to a lack of fiscal space, stigmatization and a host of other challenges, some interviewees expressed concerns that these program areas may not receive the necessary funds from national governments post-Global Fund. Moreover, the Covid-19 pandemic is likely to exacerbate the difficulties of the six governments in paying for HIV and TB programs.

KPs and CSOs

The HIV epidemic in the OECS is largely concentrated within KPs, including commercial sex workers (SWs), men who have sex with men (MSM), transgender (TG) persons, people living with HIV (PLHIV), youth, people affected by TB or TB and HIV coinfection, and missing TB cases. Due to societal and legal discrimination, many of these groups remain difficult to reach. Members of the KP communities and their allies have formed legal entities with a mandate to serve their own communities. In most of the OECS countries, these civil society organizations (CSOs) lead the HIV response among KPs. Despite their importance, national governments have not yet used forms of social contracting to support these non-government entities to carry out agreed-upon outreach, prevention, and treatment services. Based on interviews and workshops, several of the OECS countries expressed their interest in social contracting.

Covid-19

The Covid-19 pandemic poses significant social, economic and health threats to the OECS region despite a low case burden thus far. The almost total halting of tourism and lockdowns instated to control the epidemic will likely result in significant contractions of GDP, deterioration of the terms of trade, and increased government deficits. The financing needs to cover the deficits will inevitably require incurring additional debt and/or budgetary reallocations, which could result in diminished resources for the HIV and TB responses. IMF estimates from August 2020 indicate that national GDP in the OECS region may decrease between about 5% and 10% across the six countries. The workshops conducted in the fall of 2020 indicate that all of the nations are already seeing negative impacts from Covid-19 on their overall health, HIV, and TB programs. Many countries have also reported budget cuts and revisions to their national strategic plans (NSPs). This creates additional challenges and may make it more difficult for countries to implement measures that were seen before Covid-19 as possible ways of achieving financial sustainability (e.g. National Health Insurance funds).

Risks and Recommendations

As a result of extensive research, interviews, and consultations, a set of thirteen major risks to HIV/TB program sustainability emerged. They are presented below under the four headings: Health Systems, Financing, Governance, and Key Populations/Civil Society Organizations.

Main Sustainability Risks for the HIV and TB Response in the OECS

Risk Area	Risk
A. Health Systems	A.1: At least five of the six countries may not be able to **train and retain adequate public-sector health staff** to maintain and expand testing, treatment, and other essential HIV/TB activities, especially as such training is currently Global Fund-funded and the OECS countries continue to experience heavy staff turnover and brain drain. **Nursing vacancy rates** average to 40% across the Caribbean[3], and four of the six OECS nations have ratios of doctors per capita far below global and regional averages.
	A.2. Countries may not adequately **improve their HIV and TB strategic information systems** to record and track new infections, monitor disease burden, and identify gaps in prevention, testing, and treatment, especially among KPs.
	A.3. The six countries may face challenges in overcoming the barriers to an improved **HIV treatment cascade** from its low current levels to reach 90-90-90 targets, without which the countries will not be able to achieve HIV elimination.
	A.4. The **TB program responses** in the six countries are not **adapting rapidly enough** to respond to a potential surge in TB, especially cases imported through labor migration. **Political awareness and support and national funding for TB** are not increasing quickly enough to meet this new reality.
B. Financing	B.1. Domestic funding may not be allocated in a timely way to sustain HIV and TB **laboratory maintenance and purchase of ARVs, VL reagents, test kits and condoms/lubricant,** especially because due to the fiscal strains of Covid-19, shifts of national budgets to other diseases, the expected phasing down of Global Fund grants in this area, and the occasional natural disaster.
	B.2. **UHC/national health insurance schemes** may not be implemented before Global Fund financing ends. Guaranteed benefits may not cover 100% of the population, such as low-income households and non-nationals. Covid-19 likely to exacerbate this situation.
	B.3. The six countries may not appropriate adequate funds to pay for **KP programming**, directly or through public-private partnerships and social contracting mechanisms, resulting in incomplete HIV and TB services for KPs.
	B.4. Governments may not develop **adequate financial monitoring systems for HIV and TB programs**, especially as Global Fund support for M&E declines, resulting in insufficient accountability and reduced capacity to identify and plan for transition and NSPs.
C. Governance	C.1. The **RCM and HTEP**, which play an important coordination and technical assistance role in the OECS, may not continue to function with the departure of the Global Fund, with potential negative impacts on country responses. The lack of a plan to integrate the HTEP in the OECS Commission's health unit exacerbates this risk.
	C.2. **National leadership and political support for HIV and TB responses** may weaken or fluctuate in certain countries, especially with the competing demands of Covid-19, making it hard to sustain the HIV/TB responses during political cycles and changing governments.
D. Key Populations & CSOs	D.1. The six countries may not have the **legal/administrative frameworks and procedures** for conducting social contracting.
	D.2. **CSOs working on HIV and TB are fragile and may not be able to sustainably provide services to KPs**. Without increased capacity and the necessary skills and systems, social contracting may struggle even with the appropriate government laws, administrative procedures, and funding.
	D.3. The six governments may not be willing or able to **allocate budget funds for social contracting,** leading to a decline in CSO effectiveness in the OECS as the Global Fund winds down as a source of funding.

When presented with these risks during the fall 2020 workshops, country stakeholders generally endorsed these risks and proposed a wide range of solutions. Each country had its own priority risks and solutions, as shown in Figure 3.3 below. Nearly every country felt that *shortfalls in domestic financing* posed a major risk, especially to pay for HIV and TB drugs, diagnostics and other supplies, and to ensure

[3] Rolle Sands, S., Ingraham, K. & Salami, "B.O. Caribbean nurse migration—a scoping review." *Human Resources for Health* **18,** 19 (2020).

adequate funding for programs targeting key populations. Many suggested increased Ministry of Health budget outlays and national health insurance as possible sources of increased domestic financing.

Countries also expressed concerns about *funding gaps to cover laboratory services* and the need to *integrate HIV information* from public, private, and NGO service providers, especially as Global Fund support for the newly introduced eCBS information system is unlikely to continue for many more years.

The six islands acknowledged weaknesses in the *90-90-90 treatment cascade* and proposed ways to increase coverage through variety of means, including stronger partnerships between public clinics and CSOs and expanded efforts by civil society to reach KPs safely and confidentially.

The countries also recognized the importance of OECS governments developing policies and initiatives to *contract with CSOs* to deliver HIV and TB services to KP. At least three of the six countries – Antigua & Barbuda, Grenada, and St. Lucia – stated their desire to create such systems of social contracting with the idea that governments and Global Fund might initially co-finance such social contracts with governments progressively taking over full responsibility for these contracts after a few years.

Additionally, nearly every country in the workshops called for *advocacy campaigns* to build high level political support for HIV and TB, admitting that earlier interest in the two diseases had waned and needed to be renewed.

Finally, countries indicated that they valued the coordination and technical assistance offered by the Global Fund's HIV and TB Elimination Project and from the HTEP unit located in St. Lucia. Many countries and members of HTEP expressed concern in the sustaining this *regional mechanism* post-Global Fund. Some suggested potentially integrating the HTEP unit into the OECS regional commission's health office.

Figure 3.3: Key risks as selected by country

	Health Systems	Financing	Governance	KPs and CSOs
Antigua & Barbuda		B1, B3		D1, D3
Dominica	A1, A4	B1, B3, B4		
Grenada	A2, A3	B3		D2, D3
St. Kitts & Nevis	A1	B1, B4	C2	
St. Lucia	A2	B1, B2, B4		D1, D3
St. Vincent & the Grenadines	A1, A3		C1	

In addition to the above listed risks and potential solutions, Pharos workshops and further analysis triggered by Covid-19 suggest that the countries and the OECS region as a whole consider the risks associated with *natural disasters and future pandemics*, including future hurricanes and future pandemics. Countries might consider developing more explicit contingency plans to mitigate the deleterious effects of such exogenous "shocks" on their HIV and TB programs.

Pharos concurs with each country's assessment of sustainability risks and the search for solutions. Based on its work in the OECS and in other countries, Pharos sees four risks as being most acute and requiring rapid responses from the OECS: (a) the absence of a tradition of social contracting and of government budget allocations to enter into service agreements with CSOs; (b) serious gaps in the 90-90-90 cascade; (c) fluctuating and uncertain political will to eliminate HIV and TB; and (d) the absence to date

of a long-term plan to transform the HTEP team into a permanent regional facility to provide technical assistance and coordination across the OECS countries. Pharos recommends that the OECS countries, with support from the Global Fund, develop a detailed plan of action to address these risks.

Implementing Actions to Sustain HIV and TB Responses

With one more year remaining in the current Global Fund grant and a new 3-year grant on the horizon, the countries of the OECS must keep building their HIV and TB programs while preparing for the eventual decrease in Global Fund funding. Covid-19 could delay the timeline, but transition is inevitable given low disease burdens and middle-income economic status.

Country Action Plans. It is suggested that each of the six countries should develop, through a rapid stakeholder consultation process led by the national HIV/TB manager, a concise action plan of perhaps 2-3 pages in length that spells out the 3-5 key sustainability and transition actions the country intends to pursue during 2021-24, with special focus on the first 24 months. We would urge the six countries to develop these action plans during November-December 2020 and to have them finalized by March 1, 2021 to include in the upcoming grant.

To compile these action plans, each country can use a standard matrix such as the one included in this report (Annex 14). The plan should include: (1) the proposed actions, (2) the lead and supporting agents, (3) the steps that need to be taken for implementation, (4) the timeline, and (5) the estimated costs if known. Once completed, the action plan should be endorsed by stakeholders and adopted by the MoH as its commitment to sustainability and transition. The action plan can also assist the NAPCs by feeding into advocacy materials for discussions with senior country leadership.

Throughout this process, the RCM and HTEP can provide critical support to countries, in the form of technical assistance, coordination, and sharing of lessons across countries.

Global Fund Grants. The Global Fund can enhance the implementation of HIV and TB sustainability strategies and national action plans in several ways. First, it can engage in policy dialogue with the regional bodies (OECS Commission and RCM) to encourage the design and implementation of the country action plans. Second, while the purpose of the plans is ultimately to reduce dependence on outside funding and facilitate a smooth transition to 100% domestic financing, the Global Fund grants can also be catalytic in the short-run adoption of sustainability activities by the countries. Re-programmed money from the final year of the current grant (April 2019 – March 2022) could be used for example to design social contracting pilots, accelerate adoption of the electronic case-based reporting system, and develop HIV and TB advocacy plans. The new 3-year grant (April 2022 – March 2025) can also can also incorporate activities to promote sustainability, for example by co-financing the Social Contracting pilots and by backing the full integration of HTEP within the OECS Commission's health office.

Conclusions

The nations of the OECS have made substantial progress over the past decades in the fight against HIV and TB, making strides toward achieving the 90-90-90 targets and the elimination of TB. These efforts must be sustained and further strengthened.

This Sustainability Strategy report provides a framework to understand the complex contexts of the countries, especially during the unprecedented challenges posed by the Covid-19 pandemic. It identifies the strengths and weaknesses of the national HIV and TB programs and highlights the 13 key risks that could prevent the six OECS countries from putting in place an effective and sustainable response to the two infectious disease, especially as the Global Fund and other donor financing is waning and will end in the near future. It also proposes specific priority actions that the six countries can take to improve

their chances of overcoming HIV and tuberculosis and keeping a lid on the two diseases using predominantly national funding.

Ultimately, to eliminate HIV and TB, the OECS countries must expand their budgetary support for the national disease programs; intensify focus on overcoming stigma, discrimination, and other barriers; use public, private, and CSO resources in a seamless partnership that draws on the strengths of each set of national institutions; and most importantly, build and maintain political backing from top officials from all political parties. If the OECS implements the mitigating actions highlighted in this report, the six countries can successfully forge a smooth transition from Global Fund financing to sustainable self-financed HIV and TB responses.

Chapter 1: Introduction

Context of this Analysis

The 2016 Global Fund policy states that all upper middle-income countries regardless of disease burden and all lower middle-income countries with low to moderate disease burden need to prepare early and systematically for the phase-out of Global Fund support, especially those countries with growing economies and declining HIV, TB, and malaria disease burdens.[4] As part of this process, the Global Fund recommends that countries develop sustainability strategies and use these to define a clear workplan and roadmap to enable effective country assumption of responsibility for Global Fund-financed activities over time and strengthen key areas of the national response to the these diseases.

The Global Fund requested Pharos Global Health Advisors to develop a comprehensive Sustainability Strategy for the HIV and TB responses in the Organization of Eastern Caribbean States (OECS). This report represents the final deliverable of this consultancy: a full set of prioritized, actionable sustainability strategies developed with the input and buy-in from local and international stakeholders that can be used to guide the OECS's HIV and TB responses in the coming years and inform the development of future grant proposals to the Global Fund. This process has been guided by the HIV and TB Elimination Project (HTEP) under the auspices of the OECS Commission.

Problem Statement

Because of their rising national incomes and relatively low HIV and TB burdens, the six countries of the OECS – Antigua & Barbuda, Dominica, Grenada, St. Kitts & Nevis, St. Lucia, and St. Vincent & the Grenadines – are approaching transition from Global Fund assistance. The Global Fund is the last major international health donor operating within the region, and upon its departure, the six OECS countries must manage their national HIV and TB programs solely with local resources and personnel. This upcoming transition is expected to increase certain key risks to the disease control programs in these six countries. Ongoing threats include limited fiscal space for health made tighter by the Covid-19 pandemic, suboptimal progress towards 90-90-90 HIV treatment goals, fractured outreach programs to key vulnerable groups, inadequate monitoring and evaluation of programmatic outcomes, and a resurgence of TB in certain locations. It is crucial that the OECS region develops a comprehensive sustainability plan to assume increasing domestic responsibility for their HIV and TB programs, preparing to transition efficiently while extending and sustaining the disease control gains that they have achieved.

Methodology

In brief, the Pharos methodology for conducting this study is as follows:

- The team reviewed the HIV and TB literature for the OECS and the Caribbean region. For a selected list of documents reviewed, see Annex 1:
- We conducted preliminary interviews with 15 national, regional, and global stakeholders to discuss the OECS HIV and TB contexts and to identify key sustainability challenges facing the regional response. A list of all interviewees for this report can be found in Chapter 5:Annex 2:
- Following the literature review and interviews, the Pharos team drafted a set of hypothesized sustainability risks to be assessed during the in-country mission. The risks were classified into one of the following analytical categories: Financing, Health Systems, Governance, and Key Populations/Civil Society Organizations.
- In early March 2020, the Pharos team, accompanied by staff of HTEP and the RCM, conducted field visits to Antigua & Barbuda, Dominica, St. Kitts & Nevis, and St. Lucia. In each country, the team

[4] https://www.theglobalfund.org/media/4221/bm35_04-sustainabilitytransitionandcofinancing_policy_en.pdf

conducted interviews with key interviewees from government and civil society and collected important documents and data. The Pharos team was scheduled to return to the OECS region to visit Grenada and St. Vincent & the Grenadines in late March 2020; however, the emergence of Covid-19 precluded international travel. Interviews from these two countries were conducted remotely.

- With input from the OECS RCM, HTEP, and Global Fund, the Pharos team synthesized in-country findings into a matrix of HIV and TB sustainability risks and recommendations and prepared a Sustainability Strategy report.
- In the final phase of this project, national, regional, and global stakeholders reviewed the draft report through validation workshops held with each individual country. We conducted workshops with key stakeholders in all six of the countries. Each workshop ran for roughly three hours over Zoom and with over ten participants from health ministries, finance departments, civil society organizations, and other key stakeholders. The meetings discussed our approach and methodology, the epidemiological contexts of the country, the strengths and weaknesses of their HIV and TB programs, and the impacts of Covid-19 on the financial and health systems of the country. We followed this analysis with an in-depth discussion of key risks and recommendations. Overall, the countries agreed with our findings and pointed to what they viewed as the priority risks and recommended actions in their country. For further detail on the specifics of each discussion, please refer to Annex 3.
- Based on the input and prioritization of proposed risks and solutions from the diverse set of country stakeholders, the Pharos team finalized the report to incorporate the most recent feedback and the evolving demands and limitations imposed by the Covid-19 pandemic. The final report contains suggested next steps for implementing sustainability and transition actions in each country and for regional coordination and technical support.

Report Organization

This report has 15 chapters with five overarching themes. The Introduction presents the problem statement and project methodology. Chapters 2 through 7 provide background information about the OECS HIV and TB response. This information is sourced from key documents and data as well as interviews conducted in-person and remotely in winter to spring 2020. Chapters 8 through 13 synthesize the data presented in prior sections into a set of key HIV and TB sustainability risks and recommendations in the categories of Financing, Health Systems, Governance, and Key Populations/Civil Society Organizations. Chapter 14 offers actionable steps to implement the project's recommendations, and Chapter 15 contains concluding remarks. The Annexes contain additional useful context and data.

This report represents the most up-to-date findings and professional evaluations of the Pharos Global Health team and includes the input and validation of country and regional stakeholders. Importantly, this report has been updated to include the impacts of the Covid-19 pandemic upon the region's public health system and HIV and TB program sustainability. The Covid-19 pandemic will continue to evolve and change circumstances in the OECS countries, yet our findings and recommendations are designed to apply to all the OECS nations irrespective of the exact course of the novel coronavirus.

Chapter 2: National and Regional Contexts

2.1. Epidemiology

HIV

The HIV burden is low among the general population in the OECS. In 2018, the regional HIV prevalence in the general population was 0.8%, according to UNAIDS Spectrum models.[5] However, progress towards global 90-90-90 HIV goals is unsteady and variable across the region.

Salient characteristics of the HIV epidemic in each of the six OECS countries and the region as a whole are presented in Figure 2.1. HIV prevalence is sourced from UNAIDS Spectrum models (2018), and other data comes from OECS HTEP reports (December 2019). As indicated in the table, Antigua & Barbuda, St. Lucia, and St. Vincent & the Grenadines have the largest populations of HIV patients under care and new HIV patients. D'Auvergne (2018) reports that the age group of 30-44 years is most affected by HIV, followed by the 45-59 age group, and males are disproportionately affected.

Figure 2.1: General Characteristics of the HIV Epidemic in the OECS (Sources: UNAIDS, 2018, and OECS HTEP, 2019)

Country	Antigua & Barbuda	Dominica	Grenada	St. Kitts & Nevis	St. Lucia	St. Vincent & the Grenadines	OECS Total
HIV prevalence, general population, 2018	1.1%	0.6%	0.5%	0.5%	0.6%	1.5%	0.8%
Estimated total PLHIV, 2019	707	412	437	332	792	820	3500
Number of patients under HIV care, 2019	324	84	158	89	346	401	1402
New patients under HIV care, 2019	25	8	10	11	37	17	108

Vertical transmission of HIV is low in the region. In 2015, the WHO certified Antigua & Barbuda and St. Kitts & Nevis as having achieved elimination of mother-to-child transmission of HIV and syphilis.[6] The other OECS countries report promising EMTCT indicators but must improve data quality and availability to secure WHO validation.[7] A single case of MTCT was recorded in Grenada in 2018.[8]

The HIV epidemic in the OECS is concentrated among vulnerable populations, particularly men who have sex with men (MSM). The Global Fund grant focuses on two key populations (KPs): MSM and sex workers (SWs). Other vulnerable groups also include transgender (TG) persons, people deprived of liberty (PDL), migrants, and youth. HIV prevalence data for these vulnerable groups are poor and rely on small numbers of self-identified KP members presenting for HIV tests each year. Available 2018 KP data from the OECS HTEP is presented in Figure 2.2, along with population size estimates from Waters et al., 2018. MSM are disproportionately affected by HIV, with a prevalence rate of 4.4%, or 5.5 times that of the general population. In contrast, SWs appear to have a lower prevalence of HIV (0.6%) than that of the general population (0.8%).

[5] OECS HTEP, 2019.
[6] https://www.who.int/reproductivehealth/congenital-syphilis/WHO-validation-EMTCT/en/
[7] Strategic Framework for the Holistic Response to HIV/STI and TB in the OECS, 2015-2020.
[8] Valles, X. M&E Review for the OECS, 2019.

Figure 2.2: Characteristics of the HIV Epidemic among Key Populations in the OECS (Sources: OECS HTEP, 2019, and Waters et al., 2018)

Country	Mean Estimated MSM Population, 2018	Number of MSM tested, 2018	Number of MSM testing positive, 2018	Estimated HIV prevalence among MSM, 2018	Mean Estimated Female SW Population, 2018	Estimated HIV prevalence among SW, 2018
Antigua & Barbuda	1539	57	4	7.0%	N/A	0.8%
Dominica	N/A	24	4	16.7%	600	0.6%
Grenada	1923	134	0	-	1056	N/A
St. Kitts & Nevis	893	0	0	N/A	517	N/A
St. Lucia	2998	47	5	10.6%	1676	0.5%
St. Vincent & the Grenadines	1533	36	0	-	1047	0.9%
OECS Region	7347	298	13	4.4%	4896	0.6%

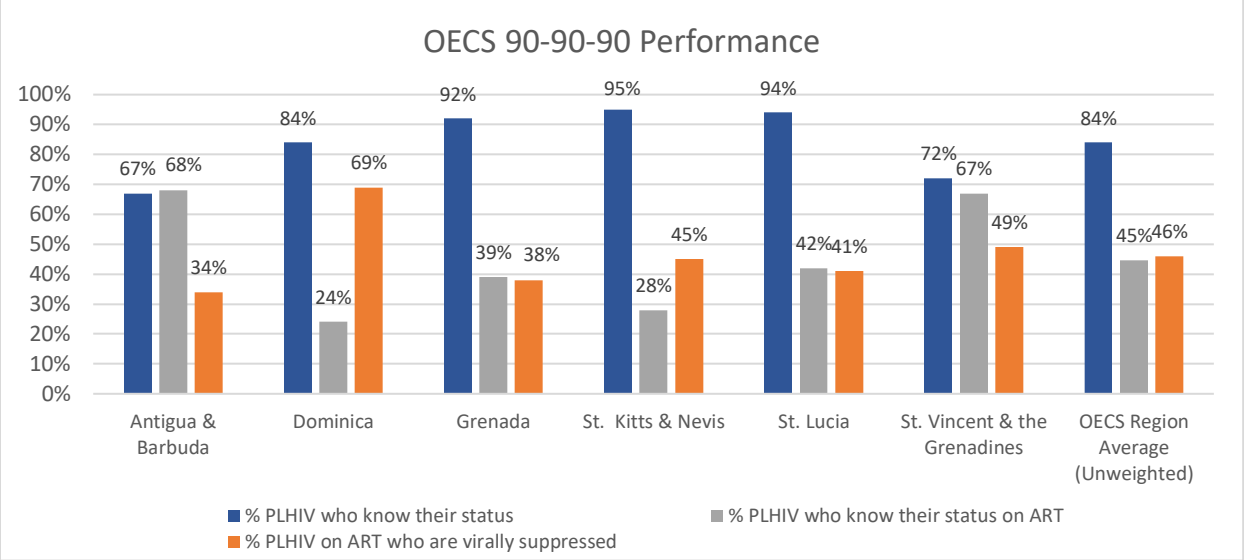
There are multiple concerns on the quality of data in Figure 2.2. According to the OECS HTEP, the 0% prevalence among MSM observed in some countries is the result of poor targeting of tests to vulnerable individuals. In 2018, St. Kitts & Nevis did not report any testing of MSM or SWs, and Grenada also reported no testing of SWs. Moreover, since few self-identified members of KPs were tested, these results may not be representative of the true HIV prevalence for MSM and SWs in the country. These data gaps limit understanding of the full characteristics of the regional HIV epidemic and inhibit evidence-based planning of HIV interventions for KPs.

HIV treatment cascade data is presented in Figure 2.3 and progress towards 90-90-90 goals for the OECS in 2019 is shown in Figure 2.4. The data are sourced from the OECS HTEP.

Figure 2.3: OECS HIV Treatment Cascade Data, December 2019 (Source: OECS HTEP, 2019)

Country	Estimated PLHIV	Estimated PLHIV who know their status	PLHIV on ART	PLHIV on ART who are virally suppressed
Antigua & Barbuda	707	473 (67%)	324 (46%)	111 (16%)
Dominica	412	346 (84%)	84 (20%)	58 (14%)
Grenada	437	402 (92%)	158 (36%)	60 (14%)
St. Kitts & Nevis	332	315 (95%)	89 (27%)	40 (12%)
St. Lucia	792	744 (94%)	346 (44%)	236 (30%)
St. Vincent & the Grenadines	820	590 (72%)	401 (49%)	198 (24%)
OECS Region	3500	2870 (82%)	1402 (40%)	703 (20%)

Figure 2.4: OECS 90-90-90 Performance, December 2019 (Source: OECS HTEP, 2019)



As demonstrated by these data, the OECS countries have made the most progress towards the first 90: the percent of PLHIV who know their status. However, most countries fall well short of reaching the second and third 90 targets (the percent of PLHIV who know their status on ART and the percent of PLHIV on ART who are virally suppressed). Progress towards one 90 does not appear to correlate to progress in other treatment goals. For example, Dominica reports the poorest performance on the second 90 but the strongest results on the third 90. National AIDS Program Coordinators from across the six countries cited a variety of factors contributing to the low rates of ART uptake and VL suppression. As discussed in the Health Systems section below, many national programs report a lack of sufficient staff members to follow up with new and non-adherent patients and offer individualized counseling and support. Furthermore, they indicate that current budgets, bound to become increasingly restricted due to Covid-19, are inadequate to offer special incentives for PLHIV to start and adhere to treatment. Other important factors include perceived stigma and discrimination from PLHIV's healthcare providers, Caribbean cultural norms against adherence to medical care, difficulties in traveling to distant treatment facilities and pharmacies, and patients' fear of a loss of confidentiality when obtaining HIV care and medications. Suboptimal progress thus far towards 90-90-90 goals constitutes a major challenge to the success and sustainability of the regional HIV response, and this topic will be explored further throughout this report.

Tuberculosis

Like HIV, the TB burden in the OECS is low. The six OECS countries are within the WHO's range for TB elimination (incidence of <10 per 100,000).[9] Regional TB incidence in 2017 stood at 4.21 per 100,000.

Key TB data for the OECS are presented in Figure 2.5. Incidence is generally low, though Antigua & Barbuda, Dominica, and St. Vincent & the Grenadines had higher estimated TB incidence in 2018. Incidence of MDR/RR-TB is extremely rare. Because of the small number of HIV-positive and TB-affected individuals, the number of HIV-positive TB cases is very small; in 2017, Grenada was the only country to report one HIV and TB case. The OECS countries have been successful in detecting and treating nearly all TB cases. Most individuals who have developed TB are aware of their HIV status.

[9] D'Auvergne, 2018.

Figure 2.5: Characteristics of the TB Epidemic in the OECS (Sources: StopTB Partnership and WHO, 2018-19)

Country	Antigua & Barbuda	Dominica	Grenada	St. Kitts & Nevis	St. Lucia	St. Vincent & the Grenadines
Estimated total TB cases, 2018	6	5	2	0	6	7
Estimated total TB incidence (rate per 100,000), 2018	6	6.4	2.1	0	3.2	6.3
Estimated MDR/RR-TB incidence (rate per 100,000), 2018	0.19	0.04	0.13	0	0.02	0.10
Case detection rate (number on treatment/estimated cases), 2018	83% (5/6)	80% (4/5)	100% (2/2)	N/A (0/0)	83% (5/6)	86% (6/7)
Treatment success rate (number successfully treated/number on treatment), 2017	100% (1/1)	100% (1/1)	67% (2/3)	N/A (0/0)	91% (10/11)	67% (2/3)
HIV-positive TB cases registered, 2017	0	0	1	0	0	0
Percent of registered TB patients who know their HIV status, 2018	100%	50%	50%	N/A	100%	100%

Preliminary data for the OECS's TB cases in 2019 is presented in Figure 2.6. These data reveal an increase in TB cases in Dominica, consistent with reports from in-country interviews. As of March 2020, the country had registered 19 TB cases in the year, more than double the 2019 total.

Figure 2.6: TB Cases by OECS Country (Source: OECS HTEP, 2019)

Country	Antigua & Barbuda	Dominica	Grenada	St. Kitts & Nevis	St. Lucia	St. Vincent & the Grenadines
Total reported TB cases, 2019	1	9	3	1	6	5

The Dominican TB program reported that TB was previously a "back burner" issue in the national health sector but containing the growing epidemic had now become a top priority for the country. Moreover, the Dominican TB case total represented only the Dominican nationals who developed TB; however, there were likely many more foreign nationals affected by TB living in the country. In interviews, members of the Dominican Ministry of Health speculated that the current epidemic is fueled by immigrants, especially from the Dominican Republic (DR) and Haiti, who arrive in Dominica having already developed TB and who then spread the infection to others. While it is not possible to verify this theory at present, Haiti and the DR are known to be major "sending" countries of migrants within the Caribbean region and especially to Dominica.[10] Furthermore, according to national interviews, there is currently no mandatory TB screening for immigrants from higher-TB burden countries prior to entering Dominica, even though the Ministry of Health has recommended such a policy. The Ministry of Health has limited reach and influence in migrant communities, and TB officials state that it is nearly impossible to follow up with a patient who has tested positive for TB, in part because many migrants are undocumented and fear deportation if they are found to be TB-positive or if they seek health services.

Because the OECS permits free movement of people and capital within the region, intra-OECS migration is common, including seasonal and transient migration.[11] Therefore, an outbreak of TB in Dominica is a threat to health sustainability in all OECS states.

[10] Aragon, E., and El-Assar, A. 2018. Migration Governance in the Caribbean. International Organization for Migration. https://caribbeanmigration.org/sites/default/files/reporte_regional_web_2.pdf

[11] https://www.oecs.org/en/who-we-are/about-us

Epidemiological Data Collection

Currently, health data (including for HIV and TB) in the OECS is either recorded on paper or entered into a national health management information system (HMIS). Paper records are common in testing and treatment facilities lacking computers or Internet access, but some facilities with sufficient technology still utilize paper records. The Global Fund has provided laptops to countries to enhance technological capacity at HIV testing sites and improve online data collection.[12] Data recorded on paper is at risk of loss, damage, and/or never being reported to national surveillance mechanisms, while HMIS data is more readily accessible and permits more robust data visualization across the population and over time.

With the financial and technical backing of the Global Fund, the OECS has introduced a new electronic case-based surveillance (eCBS) system to conduct HIV and TB surveillance and monitor the epidemics across the region. However, an interviewee from the OECS HTEP explained that this system is not fully functional yet due to considerable technical difficulties with Internet access, data storage, and connectivity to individual countries' online health information systems. Some national programs also claimed that they did not have sufficient staff, financial and technological resources, and training to utilize the eCBS fully. It was predicted that the US$200,000 currently allocated to resolve these difficulties will not be sufficient to get the eCBS running smoothly, and future investments and technical assistance will be needed. The eCBS is discussed further in the Health Systems section below.

Epidemiological Data Uncertainty

Some individuals interviewed for this study, including national program and HTEP staff members, reported a lack of confidence in the HIV prevalence, TB burden, and KP population size estimates provided through the UNAIDS Spectrum software and other modeling studies. Interviewees suggested that the global modeling programs did not adequately account for the small population sizes of the OECS islands. Pharos has consulted with an expert HIV modeler at Avenir Health, who did not know of any limitations to the Spectrum model for small populations. Additionally, regional experts claimed that HIV and TB burden estimates were inflated due to frequent migration and/or double-counting of patients. Double-counting of HIV patients is possible if an individual is tested multiple times and assigned a new unique identifier at each test. Improved use of online data collection systems, which assign a unique patient ID based on one's birthday, family initials, and other characteristics, will reduce the incidence of double-counting.

HTEP staff and National AIDS Program Coordinators also disputed recent population size estimates for KPs in the OECS, conducted by Waters et al. (2018) and funded by the Global Fund. They claimed that the estimated sizes for MSM, SWs, and TG people are much higher than what they have observed and suggest that the data may be biased because of the financial compensation used to encourage KP members' participation in the study. For their part, Waters et al. describe multiple precautions taken to identify and remove fake participants.

The current uncertainty of HIV and TB burden estimates poses an ongoing challenge to the OECS countries because it inhibits evidence-based decision making and planning. As the OECS countries approach the Global Fund transition period, strategic planning and budgeting of limited domestic resources will become even more important. Current and former HTEP staff indicated that a population-based survey to determine the HIV and TB epidemiological situation in the OECS would be the ideal solution to the perceived data quality problem, though it would be very expensive, and the Global Fund funded a population size estimate only two years ago (see Waters et al., 2018).

[12] HTEP interviewee.

2.2: Health Systems

Health and HIV and TB Service Delivery

The public-sector health systems in the OECS consist of several community or district health facilities and a main reference hospital. Local health clinics provide general care for a variety of conditions, while the main hospital provides specialized care. Some health services are not available on-island, and patients must travel to Barbados, Trinidad, the U.S., or elsewhere. In some cases, the government will cover the cost of this treatment abroad.

Historically, centralized HIV programs have been most common in the OECS. In this vertical model, HIV care is offered at one main site on the island, usually at the reference hospital. Many PLHIV prefer to see the same set of trusted providers at the central clinic to minimize the number of people aware of their status. However, centralized clinics may limit access for PLHIV who live far from the main clinic (including on sister islands) and who cannot afford the transportation costs. St. Kitts & Nevis utilize a decentralized HIV care model in which PLHIV can access care and treatment at any local public-sector health facility. While this approach reduces the cost and time for the patient to attend appointments, it also increases PLHIV's fear of confidentiality breaches because multiple providers rotate through community health facilities and local health clinic staff may be personal acquaintances. As more OECS countries—including St. Lucia, Dominica, and St. Vincent & the Grenadines—move towards a decentralized model of HIV care to eliminate parallel vertical systems, PLHIV's privacy concerns remain paramount to ensure continued treatment.

There are few cases of TB in the OECS. These cases are typically detected at community health centers, and patients are then referred to the main hospital for inpatient treatment (DOTS). Follow-up and contact tracing usually occur at the community level. Once again, St. Kitts & Nevis utilize a fully decentralized model in which all aspects of TB treatment and follow-up occur at the local health centers.

In the OECS, HIV and TB treatment is free in the public sector. All aspects of direct HIV and TB care, including medications, laboratory work, and clinic visits, are covered, even for foreign nationals. In some countries, treatment for associated conditions, such as opportunistic infections, may cost a small sum.

Many PLHIV in the OECS seek treatment and care from private physicians despite the out-of-pocket (OOP) cost. Respondents suggest that these individuals worry about potential confidentiality breaches in the public sector through public laboratory and pharmacy databases. Private physicians and laboratories are not required to share data with the national HIV program, and most PLHIV seeking private-sector care do not want to share their information. Some PLHIV even seek HIV testing and care abroad (e.g., in the U.S.) or order ARVs through foreign pharmacies at full cost to maintain confidentiality.

However, the public-sector health systems do not reach all people. It is reported that the reach of the national health systems is limited among migrant communities, especially among undocumented immigrants and migrant SWs who may fear interactions with public-sector officials. Other members of KPs, such as MSM and TG people, may also consider fear the ongoing stigma and discrimination of some healthcare providers and other employees at the clinic. Specific characteristics of the health and HIV and TB service delivery systems in each of the OECS countries are presented in Annex 4.

Human Resources

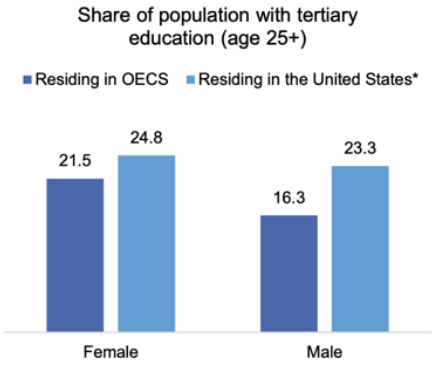
Developing a robust workforce to staff the public-sector HIV and TB response is a challenge in the OECS. First, most governments do not have the funds to support large staffs, and HIV and TB programs may not be prioritized with limited staffing resources. For example, salaries for government officials in one island were recently paid by a private individual because there was not enough revenue to cover

payroll.[13] There are very few staff devoted full-time to HIV care; most providers also work in district medical centers or in other specialty clinics. For this reason, personnel expenditures for the HIV program are not possible to obtain, as salaries paid to HIV staff also include payments for services delivered across a variety of health programs. With limited staff who have numerous responsibilities, most national HIV and TB programs lack the manpower to consistently follow up with lost patients, document cases in an online database, and conduct contact tracing, contributing to the suboptimal progress towards 90-90-90 targets observed in the OECS. The St. Kitts AIDS program stated the need for six or seven more employees to achieve a fully staffed HIV office capable of a robust response.

Moreover, the Covid-19 pandemic has exacerbated the human resources and limited fiscal space challenges. Currently, due to Covid-19, the staffing shortage in national AIDS programs has become even more severe, as employees are reassigned to pandemic-related duties. For example, Antigua & Barbuda have reallocated many HIV workers in the afternoons to the airport to test visitors for Covid-19. However, Antigua & Barbuda is the only country without a severe human resource challenge pre-Covid-19, where the National AIDS Secretariat has 20 staff members.

Second, national AIDS programs have difficulty in recruiting qualified workers to fill open positions and in retaining skilled staff. As of the on-the-ground mission, the NAPC position in St. Kitts had been vacant for over a year because a qualified individual had not been identified. Moreover, HIV program employees often leave their positions within a few years to pursue other (often more lucrative) opportunities either domestically or abroad. St. Lucia, for example, has had three NAPCs in the past five years. So-called "brain drain" of highly educated citizens, especially health professionals, is a common phenomenon in developing countries worldwide. However, the OECS countries are particularly affected by the flight of educated individuals to the U.S. According to the World Bank, a larger share of the OECS population with a tertiary education resides in the U.S. than in the OECS region (see Figure 2.7).[14]

Figure 2.7: Brain Drain of College Educated OECS Citizens to the U.S. (Source: World Bank, 2018)



Source: American Community Survey (ACS) 2015.
Note: *Migrants who migrated to the United States after the age of 21.

The high rate of staff turnover and the lack of qualified health personnel—both consequences of heavy emigration from the region—inhibit the OECS HIV and TB responses and dilute the institutional knowledge necessary to enhance programmatic sustainability in the absence of external financing and technical assistance.

Staff trainings are an important component of HIV and TB human resource development. Thus far, OECS countries have relied on external funding for HIV and TB training for their government health workers and CSO members. For the period April 2019 to March 2022, the Global Fund allocated over US$500,000 of the total US$3.5M OECS grant for training-related expenses.[15] Interviewees have commented that the Global Fund—the largest HIV and TB training funder in the region—also pays for staff training through wider Caribbean grants such as QRA-H-CARICOM. Prior to Global Fund involvement in the OECS, PEPFAR, the WB, and other large donors funded HIV and TB trainings. Interviewees reported that their governments have grown accustomed to external funding of trainings and may be unwilling to absorb this expense. Some national program coordinators reported that they plan seek funding from

[13] In-country interview.
[14] World Bank, 2018. OECS Systematic Regional Diagnostic.
[15] Detailed Global Fund grant budget, 2019-2022.

PAHO or the CVC to continue trainings in the Global Fund's absence because they do not expect to receive domestic funding for this purpose.

Training topics for HIV and TB staff include specific treatment regimens and medications for HIV and TB, confidentiality reducing stigma and discrimination in health service provision, and sensitization of KP-related health and social issues. These trainings are not standard in regional health professional schools, [16] and multiple interviewees report that some providers, including physicians in national HIV clinics, have engaged in discrimination against PLHIV or KP members or have breached patient confidentiality. Workshops with countries have clarified that often these breaches may occur informally, and trainings should cover both formal and informal breaches of confidentiality. Trainings should begin in health professional schools, and patients should be educated about their legal rights to report behavior. Stigma and discrimination experienced in the public sector also contribute to many PLHIV's decisions to seek care from specific private providers who are known to be KP/PLHIV-friendly and whom the patients trust to maintain their privacy. However, some PLHIV cannot afford to pay for healthcare OOP. Overall, poor training of public-sector providers can lead to distrust and avoidance of the health system, contributing to high rates of LFU patients and suboptimal progress towards 90-90-90 goals. Thus, OECS governments' current reliance on foreign funding for trainings and their perceived unwillingness to take on these expenses constitutes a significant risk to the sustainability of the regional HIV and TB response.

CSO members frequently take part in trainings with MoH staff, and many are fully certified in HIV-related activities such as VCT, adherence counseling, and peer navigation. These individuals could help to ease the burden on understaffed national programs by providing basic services to PLHIV in public-sector clinics and developing relationships that keep patients in care. CSO volunteers already provide support to the government-run HIV clinics in St. Vincent and St. Lucia. To ensure the sustainability of civil society participation in the clinics, however, governments should offer CSO members some compensation.

Health Information Systems

With the financial and technical backing of the Global Fund, the OECS has introduced a new electronic case-based surveillance (eCBS) system to conduct HIV and TB surveillance and monitor the epidemics across the region. However, this system is not fully functional yet due to considerable technical and program-specific difficulties.

All six OECS states have formally agreed to utilize the eCBS to conduct HIV M&E activities in all relevant settings, including clinics, pharmacies, VCT sites, and laboratories. The eCBS is designed to capture data from public, private, and CSO facilities and to record each patient's medical history longitudinally. In January 2019, all national governments and affiliated CSOs were trained in eCBS use. A Global Fund-funded study of M&E gaps and eCBS implementation was completed in October 2019. The researcher concluded that eCBS implementation was "heterogeneous," and specific challenges—like fear of confidentiality breaches—limit accurate data collection.[17]

During the March 2020 mission, it was apparent that eCBS use in the OECS was still in a nascent stage. The national programs in St. Kitts & Nevis, Dominica, and St. Lucia rarely use the system, and St. Vincent & the Grenadines had previously entered HIV test data into the eCBS but this use declined following the departure of a recent NAPC. Grenada has overcome initial challenges—including a failure to pay for cloud-based data storage—and the national program is now using the eCBS to record some HIV test results. The Antigua & Barbuda program has used the system most consistently to record testing data. Among CSOs, only United & Strong (St. Lucia), GrenCHAP (Grenada), and SKN CARE (St. Kitts & Nevis) enter testing data into the eCBS at the time of interviews. Data from tests conducted by the Antiguan CSOs 3H

[16] In-country interview.
[17] Valles, X. 2019.

and WAR are uploaded by the national program. Interviewees did not know of any private providers who shared data with the eCBS.

Interviewees offered numerous reasons for the lack of OECS participation in the eCBS. While the Global Fund paid for trainings and laptops at testing sites to facilitate eCBS use, one interviewee from Dominica stated that many staff members needed additional training. Interviewees from Dominica and St. Vincent & the Grenadines also cited Internet access as a limiting factor. One interviewee in Dominica stated that only three district clinics had consistent Internet, and the HIV/STI clinic in St. Vincent does not currently have Internet access. In these situations, data must be recorded on paper, transferred to the national program office, and uploaded by staff members there—a process that does not consistently occur. St. Lucian government representatives expressed frustration over the interoperability of the eCBS with their national HMIS. To upload data to the eCBS would require staff to duplicate their efforts, which they explained that they did not have the time to do. Such staffing shortages were a commonly cited barrier to eCBS use; the St. Kitts program, for example, is understaffed and reported a lack of capacity for eCBS use. Among CSOs, with a few notable exceptions (e.g., United & Strong, WAR, GrenCHAP), a culture of limited impact reporting was observed. Most CSOs had only a few employees, some or all of whom were volunteers, and they were not accustomed to recording their activities or results. This habit likely translates to the observed low utilization of the eCBS. Private physicians are not required to share data with the national program/eCBS, and most of their patients do not wish for them to do so due to privacy concerns.

OECS providers do not consistently upload HIV test results for the many reasons listed above. Moreover, according to a regional M&E officer, none of the six countries are using the system to track individual cases over time—that is, uploading not only the result of one HIV test but recording a patient's VL and CD4 over time, inputting medications prescribed and picked up at the pharmacy, noting any coinfections or other health conditions, etc. This more advanced use of the system will likely not materialize in the near term.

The eCBS was designed as a remedy for the lack of high-quality data about the HIV epidemic in the OECS region. In its current form, the eCBS does not fulfill this objective. As described in the Epidemiology chapter, limited and/or poor-quality epidemiological data inhibits an effective HIV and TB response because national programs are not armed with the proper information to make decisions. For example, sparse use of the eCBS can hide important trends of HIV infection in the population that could otherwise inform targeted interventions. For these reasons, limited eCBS use in the OECS region is a sustainability risk. The Global Fund has allocated US$200,000 over the current grant period to resolve technical difficulties associated with eCBS use, such as interoperability with national HMIS.[18] Regional interviewees stated that Global Fund funds could also be allocated for additional trainings and equipment—such as laptops—if needed. However, the Global Fund will not pay for Internet services, cloud storage, or staff salaries, necessary inputs into eCBS reporting and recurrent expenditures that will persist after the Global Fund departure. Governments and CSOs must invest themselves in these areas to promote sustainability in epidemiological surveillance.

Medical Laboratory Capacity

A major objective of the current Global Fund grant in the OECS is to increase public-sector medical laboratory capacity. Previously, OECS states relied on specialized laboratories outside the region (e.g. the Ladymeade facility in Barbados) to conduct VL, CD4, MDR-TB, and other testing essential to the HIV and TB response. In addition to the time and expense associated with shipping biological samples to foreign labs, the OECS's reliance on an external organization for these crucial tests inhibits regional sustainability of the HIV and TB response. As part of domestic capacity building to achieve HIV and TB elimination in the

[18] Detailed Global Fund grant budget, 2019-2022.

region, PAHO and other stakeholders encouraged each country to purchase GeneXpert machines using Global Fund funds. All six countries fulfilled this goal by 2019. CMLF, a Global Fund sub-recipient, supports each country to utilize and maintain laboratory equipment and achieve international accreditation.

Accreditation of all laboratories (public and private) in the OECS is governed by the Caribbean Laboratory Quality Management System—Stepwise Improvement Process (LQMS-SIP). Laboratories in the region are classified in a tiered system. Tier 1 represents a facility meeting mandatory minimum requirements, and Tier 3 facilities have reached the highest standards for the region and may seek international accreditation.

Antigua & Barbuda is the only country in the OECS with a Tier 1 public laboratory, located at MSJMC. The other OECS countries are working towards meeting the mandatory minimum requirements needed for this classification. The only internationally accredited laboratory in the OECS is at Tapion Hospital, a private facility in St. Lucia.[19]

Despite the receipt of new equipment from the Global Fund, general laboratory capacity remains a major challenge in the OECS region. Interviewees in St. Lucia, for example, described turnaround times of a month or more for confirmatory HIV testing. The challenge is not limited to HIV; nearly all public-sector test results in the country are reported to be very slow. The cost of running and maintaining expensive laboratory machines also poses a problem. Interviewees from Dominica, for example, estimated that they would run VL tests only 1-2 times per year because they could not afford to purchase more reagents. Currently, the Global Fund is funding maintenance contracts for the countries' GeneXpert and CD4 machines, but these agreements expire in 2022, and the OECS countries have committed in writing to take on the costs of laboratory equipment upkeep. However, interviewees were concerned that governments may not devote proper resources to machine maintenance and that the machines could fall into disrepair. Finally, CMLF is receiving Global Fund funding to conduct GeneXpert trainings in the OECS countries, but government interviewees from multiple countries reported uncertainty in this machine's use.

Enhancing laboratory capacity is a critical component of achieving sustainability in the OECS HIV and TB response. Fortunately, it is also a popular political action item; high-ranking MoH officials in every country expressed strong interest in reaching Tier 1 accreditation (and Tier 2 in Antigua & Barbuda) in the next 1-2 years. Health officials uniformly recognized the value of cutting-edge national laboratory services not just to aid the HIV and TB response but also to conduct testing for hepatitis B and C, STIs like chlamydia and gonorrhea, SARS-CoV-2, and other conditions. When running efficiently and at full capacity, laboratories can also be a source of revenue for the Ministry of Health, but the OECS country governments have yet to devote the requisite resources to develop and maintain strong laboratory equipment and skilled laboratory personnel. This deficiency will become even greater with the decline in Global Fund assistance for machine maintenance and cartridges, scheduled to begin across the OECS in 2022. Moreover, there is increased concern that some of the medical laboratory equipment may be repurposed for the testing and management of SARS-CoV-2.

OECS Pooled Pharmaceutical Procurement Service

The six OECS states utilize a pooled pharmaceutical procurement service (PPS), overseen by the OECS Commission, to purchase HIV and TB products along with other health and pharmaceutical goods. The Global Fund provides funding to the OECS states for the procurement of several items through PPS, such as ARVs, condoms, lubricants, rapid testing kits, and laboratory equipment and reagents.[20] The PPS

[19] National interviewees.

[20] CMLF advises the PPS in laboratory equipment procurement.

remains self-sustaining through the imposition of a 7-13% surcharge on goods.[21] According to the OECS, the use of the PPS saves an overall US$4M each year and is recognized as an international best practice.[22]

A summary of purchased items through PPS in 2019 is shown in Figure 2.8. Commodities connected with HIV are generally procured by PPS on behalf of countries. The PPS reports approximately US$420,000 in expenditure in 2019 towards HIV and TB commodities. It appears that a large share of the funding is maintained by the Global Fund, paying for as much as a quarter of ARVs. Significant categories remain heavily funded by the Global Fund, such as GeneXpert supplies, test kits, and CD4 reagents. Moreover, the OECS countries procure many goods listed in Figure 2.8 with domestic funding through PPS as well. For example, member states pay for ARVs for patients diagnosed >1 year ago, and they may choose to purchase additional condoms and lubricants for general population outreach activities. However, domestic expenditures for HIV and TB supply procurement through PPS are not available.

Figure 2.8. Purchases through PPS, 2019 (Thousands USD) (Source: OECS PPS)

PPS Item	Rapid HIV Tests	Rapid Syphilis Tests	CD4 Reagents*	PT Panels	CD4 Software	Anti-TB	Female Condoms	Male Condoms 53mm	Male Condoms 58mm	Lubes	GeneXpert	ARVs*	Total
Global Fund Payment	14.3	14.3	50.6	15.8	0.3	1.2	27.8	20.7	12.3	11.7	111.5	191.5	421.9

*Global Fund pays for one year of CD4 reagents and ARVs for newly diagnosed patients only. Member states are responsible for CD4 and ARV costs associated with patients diagnosed >1 year prior.
**The Global Fund does not cover VL testing costs. In 2019, the CDC paid for VL testing in St. Vincent & the Grenadines.

In addition to procuring commodities, PPS also oversees service contracts for specialized laboratory equipment relevant to the HIV and TB response. The Global Fund is funding maintenance for GeneXpert and CD4 machines through 2022. All OECS member states have signed an MOU confirming that domestic resources will be used to maintain the equipment after 2022.[23] However, interviewees cite the high costs of laboratory machine maintenance and cartridges currently covered by Global Fund as a key sustainability risk; they are not convinced that governments will commit the resources to utilize this equipment effectively after external funding declines.

The PPS operates on a two-year cycle and assists member states in forecasting. PPS officials liaise directly with OECS states' Central Medical Stores (and MBS in Antigua & Barbuda) to determine orders. The PPS office facilitates the adjudication of manufacturer bids and oversees the processes of procurement and delivery to each member state. Countries pay manufacturers directly through a special bank account, but PPS employees monitor these accounts to ensure that they are sufficiently funded. Late payments are occasionally a problem, but PPS interviewees report that they not overly concerned that any country may fail to pay entirely. Some new HIV and TB supplies, like Cepheid cartridges for the GeneXpert machines, require prepayment, which may pose a financial challenge to the PPS and OECS member states when the Global Fund no longer supports the purchasing of these items.[24]

The PPS promotes sustainability in the HIV and TB response through its use of pooled procurement to secure lower prices for medications and other supplies. However, the PPS reports US$420,000 in expenditure on HIV and TB commodities annually in the OECS. Splitting this value evenly among the six countries yields a US$70,000 commodity funding gap for each country that will appear as the Global Fund withdraws from the region. The activities most likely to suffer from this withdrawal

[21] In-country interview.
[22] https://www.oecs.org/en/our-work/p/pharmaceuticals
[23] Regional interviewee.
[24] In-country interview.

include KP outreach—all condoms and lubricants purchased with Global Fund funding are directed towards KPs—and specialized laboratory services. Sustainability in HIV and TB commodity purchasing is only assured through increased domestic resource allocation to the PPS.

2.3: Financing

Overview

All six OECS countries are classified as small island developing states (SIDS). The OECS islands share a common currency, and OECS citizens may live and work freely in other OECS member states.[25] Antigua & Barbuda and St. Kitts & Nevis are considered high-income countries, while the other four nations are upper-middle-income.[26] Additional macroeconomic and general health financing information for each of the six OECS countries can be found in Chapter 5:Annex 5: and Annex 6:

External Funding for HIV and TB in the OECS

After rapid growth in worldwide development assistance for health and HIV and TB programs during the 2000s, the 2010s witnessed a stagnation of global assistance for HIV and TB programs.[27] Development assistance for HIV and TB to OECS member countries mirrored these trends.

Historically, the largest HIV and TB donors in the Caribbean region have been the German government through the German Development Bank (KfW), the United States government through PEPFAR, the World Bank, and the Global Fund. Significant funds have been channeled by these donors to finance the HIV response through prevention programs and the provision of ARV drugs, test kits, and condoms, capacity building aimed at strengthening government response, improving laboratory capacity, promoting regional CSOs devoted to the HIV and TB response, advocacy and policy actions to reduce stigma and discrimination, and knowledge generation. Other donors, such as UNAIDS, DFID, and the EU, participated in the regional HIV and TB response with smaller grants in the 2000s, and the Government of Brazil provided first-line ARV drugs in 2013. PAHO has provided sustained technical assistance and financial support to facilitate health systems strengthening efforts. However, all of these donors—with the exception of the Global Fund—are no longer active in financing the HIV and TB response in the region. UNAIDS and PAHO continue to provide technical assistance as needed.

Most grants and funds for the HIV and TB response for OECS member states have been channeled to Caribbean regional organizations. These entities, such as the OECS Secretariat, CARPHA and the Caribbean Community (CARICOM), either provide public goods for the benefit of all their member states or take advantage of economies of scale to design and implement interventions across participating countries. Because some of these benefits are indirect, it is not possible to quantify separately how much of this funding goes to each country. Annex 7: describes the main donors' HIV and TB grants to Eastern Caribbean States or to regional organizations that received grants for the provision of public goods that were to benefit the OECS member countries between 2000 and 2020.[28]

Looking at the funding trends, donor participation in the regional HIV and TB response can be characterized in four stages. In the first stage, from the onset of the HIV epidemic up until 2004, there

[25] European Union, 2016. https://eeas.europa.eu/headquarters/headquarters-homepage/4117/organisation-eastern-caribbean-states-oecs_tm

[26] World Bank, 2018.

[27] Institute for Health Metrics and Evaluation, (2019).

[28] Sources for this section come from: PEPFAR's regional strategic plans 2010-2014, 2015, 2017, and 2019. World Bank Group Finances https://financesapp.worldbank.org/en/summaries/ibrd-ida/#ibrd-len/, KfW https://www.kfw-entwicklungsbank.de/International-financing/KfW-Development-Bank/, Global Fund Data Explorer and grant agreements available in the Grant Explorer

was a minimal presence of donors in the region, and countries had small and scattered individual responses. During this stage, it became apparent that the small sizes of the OECS islands and the scarcity of health personnel that had to attend to multiple priorities made it inefficient to organize an HIV and TB response at the country level.[29] Additionally, given the high migration and population mobility in the OECS region, the effects of a lackluster HIV response in one country would ripple through the entire region.[30]

A second stage, between 2004 and 2011, began with the consolidation of a regional coordinating mechanism that started to emerge: The Pan-Caribbean Partnership against HIV/AIDS (PANCAP), which is an affiliate of CARICOM. During this stage, UNAIDS and the European Commission provided funding and strong technical support,[31] and the World Bank, the Global Fund, and KfW provided seed funds to jump-start PANCAP and the regional HIV response, as well as prevention programs.[32] The Eastern and Southern Caribbean region received funds for HIV in the amount of US$84.6 million between 2004 and 2011, mostly for regional capacity building and public goods with indirect benefits to the CARICOM member states, but little direct funding to the countries.

After the consolidation of PANCAP and advocacy efforts by international organizations on behalf of the region, a large flow of development assistance for HIV followed between 2011 and 2015. These funds were channeled mostly to regional organizations to benefit member countries through public goods and prevention programs. During this period, PEPFAR extended its activities to OECS countries, providing US$102.6 million for the Caribbean HIV response. As the Global Fund and PEPFAR increased their activities in the OECS, the World Bank, KfW, EU, and small individual donors began to transition out.[33]

Starting in 2015, regional HIV and TB donor funds for the region dwindled. In this new stage, the OECS countries have been expected to transition from donor support to increasing self-reliance. The World Bank supports programs in the OECS to strengthen public health response to disasters but is not allocating resources specifically for HIV or TB. Once the final implementation period of the KfW grant finished in 2015, the entity did not renew its initiative in the OECS. PEPFAR's directives for the 2014-2018 period shifted funding priority to tier I and II countries (the poorest and highest-burden nations) and away from the OECS countries, which are classified as tier III.[34] Since the mid-2010s, the OECS has received only technical assistance but no direct funds from PEPFAR. After 2016, only the Global Fund has provided HIV and TB grants benefiting OECS member states. The total of donor resources decreased by US$20 million between 2014 and 2019.

Global Fund Assistance to the OECS Region

OECS member states have received funding from the Global Fund only through regional grants. Two of these have exclusively benefited OECS countries (see Annex 7: OECS member states have also benefited from other Global Fund grants with a broader scope in the Caribbean where either the OECS Commission acts as a direct sub-recipient or other regional bodies acted as recipients of the grants, and

[29] UNAIDS (2004)

[30] UNAIDS Op. Cit.

[31] EU provide support through the Strengthening the Institutional Response to HIV/AIDS in the Caribbean Project (SIRHASC) See UNAIDS (2004).

[32] KfW financed a project called CARISMA. A phase II financed activities in the 5 OECS member states in 2011-2012. The recipient of the grant was Caricom. The Caribbean Community was selected as the program's implementing agency, and delegated the implementation of the program to PANCAP, which in turn contracted social marketing agencies for implementation. For the finale valuation of the charisma Phase II see: https://pancap.org/pc/pcc/media/pancap_project/FINAL-REPORT-OF-THE-CARISMA-II-PROJECT-2013.pdf

[33] Between 2012 - 2015, KfW financed condoms through Population Services International (PSI) and Caricom. See: https://www.kfw-entwicklungsbank.de/International-financing/KfW-Development-Bank/News/News-Details_313472.html

[34] See PEPFAR Caribbean Region Country Operational Plan 2014 https://www.state.gov/country-operational-plans/

the member states benefit indirectly from public goods provided at the regional level. It not always possible to estimate from the regional Caribbean grants that have reached specifically the OECS countries, as this are indirect investments in regional public goods, including technical support and capacity building.

Current Global Fund Grant: OECS Multi-country Strategic Response Towards HIV and TB Elimination

The principal recipient of the current Global Fund grant—OECS Multi-country Strategic Response Towards HIV and TB Elimination (QRB-C-OECS)—is the Organisation of Eastern Caribbean States. The total amount approved is close to $8.6 million over eight years. Up until the end of 2019, US$6.3M had already been disbursed. The grant has been divided into two implementation periods: the first period grant (2016 to 2019) was for US$5M and the second period (April 2019 – March 2022) is for an additional amount of US$3.5M (see Figure 2.9). This grant has had a poor performance rating due to a lack of progress demonstrated towards agreed upon programmatic outcomes and suboptimal management of grant funds.

Figure 2.9: OECS Multi-country Strategic Response Towards HIV and TB Elimination amounts signed and disbursements (US$)

Implementation period	Amount committed (USD)	Year	Disbursed	Cumulative	Grant performance
1 – April 1, 2016 to March 31, 2019	5,023,999	2016	1,169,948	1,169,948	-
		2017	2,326,509	3,496,457	B2 Inadequate but potential demonstrated
		2018	1,264,072	4,760,529	C Unacceptable
		2019	248,762	5,009,291	C Unacceptable
2 - Extension April 1, 2019 to March 31, 2022	3,550,000	2019	1,001,480	1,001,480	Pending publication
		2020	297,610	1,299,090	
		2021	TBC	TBC	
		2022	TBC	TBC	
Total	8,573,999	2016/20	6,308,381	6,308,381	

Source: The Global Fund Data Explorer and Global Fund grant agreements

Key populations (KPs) prioritized in the first implementation period include MSM, TG persons, prisoners, women including female partners of MSM, sex workers and migrant sex workers, and youth in these key populations. The second implementation period added the following KPs: people with TB, people with TB and HIV, and missing TB cases. Figure 2.10 shows investments by module. In both implementation periods, program management takes the largest share, and other large investment areas include prevention programs for key populations, treatment, care, and support, and health information systems strengthening.

Figure 2.10: Global Fund Investments by Module, USD (Source: Global Fund grant agreement for QRB-C-OECS)

Module	1st implementation Period	Percent of total commitment for Period 1	2nd implementation Period	Percent of total commitment of Period 2
Program management	1,174,067	23.4%	1,312,488	37.0%
HSS - Health information systems and M&E	988,397	19.7%	216,143	6.1%
Prevention programs for MSM and TG people	855,367	17.0%	570,884	16.1%
Treatment, care and support	770,378	15.3%	374,851	10.6%
TB/HIV	707,591	14.1%	207,145	5.8%
Prevention programs for SWs and their clients	305,986	6.1%	383,999	10.8%
TB care and prevention	166,863	3.3%	81,722	2.3%
Prevention programs for the general population	55,350	1.1%	-	-
RSSH: National health strategies	-	-	138,160	3.9%
RSSH: Integrated service delivery and quality improvement	-	-	128,379	3.6%
RSSH: Community responses and systems	-	-	75,000	2.1%
MDR-TB	-	-	61,228	1.7%
Total	5,023,999	100.00%	3,550,000	100.0%

Figure 2.11 shows current Global Fund investments by grant sub-recipients. Across the two implementation periods, the OECS Commission has managed 56% of the grant budget, while two regional organizations—the Caribbean Med Labs Foundation and the Caribbean Vulnerable Communities Coalition—have absorbed about 35% of funds. The Ministries of Health of the six OECS countries received the remaining resources. In the second implementation period, both MoH sub-recipients and the CVC were provided with significantly fewer resources: CVC receipt of funds shrunk from 29% to 5%, and OECS MoH allocations dropped from 2% each of the total grant to 0.33% each. Three-year OECS Commission and Caribbean Med Labs Foundation allocations from the Global Fund held steady at about US$2.5M and US$650,000 respectively.

Figure 2.11: Investments by sub-recipient (Source: Global Fund grant agreement for QRB-C-OECS)

By Recipients	Total allocated from 2016-2019 (USD)	Total allocated from 2019-2022 (USD)	Total allocated from 2016-2022 (USD)	Percent of total funding allocated from 2016-2022
Organization of Eastern Caribbean States	2,240,797	2,582,047	4,822,844	56.2
The Caribbean Med Labs Foundation	687,666	652,299	1,339,965	15.6
Caribbean Vulnerable Communities Coalition (CVC)	1,476,179	225,121	1,701,300	19.8
Ministries of Health in the six countries	619,356	90,534	709,890	8.3
Total	5,023,998	4,517,954	9,541,952	100.0

The Global Fund remains the largest financer of development assistance for HIV and TB in the region. In the upcoming 2020-22 period, the Global Fund has allocated a total of US$3.65M to the OECS, which will finance an HIV and TB grant from April 2022 to March 2025. However, substantial reductions in Global Fund funding to the OECS are expected as early as the 2023-25 allocation period, when some OECS economies may reach or exceed Global Fund eligibility thresholds. Current Global Fund eligibility

rules restrict grants to countries classified as low-income or having high disease burden. However, an exception allows middle-income countries with moderate burden classified as *Small Island States* to access Global Fund funds.[35] Although individual high-income small island states (such as Antigua & Barbuda and St. Kitts & Nevis) were not eligible to receive grants, they can still benefit from regional grants as long as 50% or more of the countries in the regional grant are eligible. Currently, four of the six OECS member states are middle-income countries, and thus all member states can benefit from Global Fund grants. However, Grenada and Dominica were projected to transition to high-income economies by 2022, and St. Vincent & the Grenadines were expected to become high-income by 2026. These projections suggest that, as soon as 2026, only St. Lucia will be eligible for Global Fund funding. Furthermore, starting in 2022, the six OECS member states may no longer be eligible for funding, as more than 51% of the countries may be ineligible.[36] The economic predictions about eligibility may change as the Covid-19 pandemic introduces negative economic shocks to the islands. Nevertheless, even if they remain eligible, there is no guarantee that they can access Global Fund funds and the need for early preparation for transition remains vital.

Domestic Financing of HIV and TB

Overall, domestic governments of the OECS finance the large majority of their national HIV programs. The largest sustainability risks related to financing involve the programmatic areas currently supported heavily by the Global Fund, especially KP outreach, PLHIV support, and health systems strengthening (see Figures 2.10 and 2.11 above). Moreover, the Covid-19 pandemic and its numerous negative economic effects introduce significant concerns in domestic governments' ability to pay for HIV and TB programs. A more detailed assessment of the economic and financial consequences of Covid-19 on HIV and TB financing can be found in Chapter 7.

Figure 2.12: Share of HIV expenditure financed with domestic resources

	Year	Percent financed with domestic sources	
		HIV total	Prevention total
Antigua and Barbuda	2017	93%	92%
Dominica	2019	98%	78%
Grenada	-	-	-
St. Lucia	2019	95%	-
St. Kitts and Nevis	2019	97%	0%
St Vincent and the Grenadines	-	-	-

Source: UNAIDS financial Data Dashboard

2.4: Governance and Institutions

Introduction

Governance of the HIV and TB responses in the OECS involves a complex set of national, regional, and global actors. This section describes the institutions directly involved in the current Global Fund grant—the Principal Recipient and all eight sub-recipients. Additional information about Caribbean-wide and global technical partners can be found in Annex 9: The interconnected and sometimes overlapping

[35] The Global Fund Eligibility List 2020, November 2019.
[36] The Global Fund Eligibility List 2020, November 2019.

governance structures of the regional response is an important and unique feature of the OECS HIV and TB context.

Regional Institutions: The Global Fund Grant Recipients

OECS: HIV and TB Elimination Project Office

The Organization of Eastern Caribbean States was founded in 1981 to promote political harmonization, social cooperation, and economic integration of the independent small island nations of the Eastern Caribbean. All six countries participating in the current Global Fund grant were founding members of the OECS.[37] The OECS Commission provides secretariat services to support the activities of the body.

The OECS Commission is the Principal Recipient of the current Global Fund HIV and TB grant in the region. The OECS HIV and TB Elimination Project (HTEP), situated within the OECS Commission's Health Unit, implements the Global Fund grant. HTEP's stated goals include the achievement of 90-90-90 targets for HIV and the elimination of TB in the region with a special focus on access to quality health services for key populations.[38] These goals are articulated in the OECS Regional Strategic Framework for the Holistic Response to HIV/STIs and TB (2015-2020). HTEP coordinated the development and validation of this framework along with the Regional Coordinating Mechanism in 2014.[39]

HTEP manages day-to-day Global Fund grant operations, monitors grant outcomes, and provides technical assistance and support to national HIV and TB programs. The office oversees the generation of regional public goods, such as infection control and treatment guidelines, training courses for health professionals, and up-to-date regional plans, such as a Key Population Strategy, Sustainability Strategies, and regional strategic frameworks.[40] HTEP also reviews and approves countries' budget requests for Global Fund assistance and offers support in achieving regional HIV and TB goals. For example, the HTEP offers technical consulting assistance to troubleshoot the implementation of the electronic case-based surveillance system (eCBS) in the six OECS countries. HTEP officials are responsible for monitoring and evaluating grant performance, including by collecting epidemiological data from national programs and tracking progress towards Global Fund grant targets. Finally, HTEP liaises and coordinates with other regional and international institutions to promote the regional HIV and TB response. These organizations include the Caribbean Vulnerable Communities Coalition and Caribbean Med Labs Foundation (Global Fund grant sub-recipients) as well as technical bodies such as PAHO/WHO, UNAIDS, and CARPHA/PANCAP/CARICOM.[41]

As the Principal Recipient of the Global Fund grant, the OECS Commission is estimated to manage US$2.5M of the US$3.5M grant amount (73% of all funds) over the period April 2019 - March 2022. Besides program management costs, the largest budget items implemented by the HTEP include PR monitoring visits and M&E activities over the course of the grant (~$175K), funds for the improvement of the eCBS (~$200K), and many consumables (such as condoms and rapid test kits) procured through the OECS PPS and distributed to the countries.[42]

The HTEP currently has four staff members: a project manager, technical specialist, M&E officer, and administrative assistant. The Global Fund currently funds HTEP staff salaries and program management overhead—including office rent and utilities—at a cost of about US$850,000 out of the total

[37] https://oecs.org/en/who-we-are/history
[38] https://oecs.org/en/our-work/h/health
[39] OECS Regional Strategic Framework for the Holistic Response to HIV/STIs and TB (2015-2020)
[40] https://drive.google.com/file/d/1fNRAcEvbSvIcRpCPoBNDsWmGrw1hECBM/view
[41] Interviews with OECS officials.
[42] Detailed Global Fund grant budget, 2019-2022.

three-year, US$3.5M grant (about 25% of the total award). The OECS Commission does not contribute to staff salaries but covers HTEP's insurance and building maintenance as needed.[43]

It is not clear how the HTEP office would be funded if the Global Fund transitions out of the OECS region. The Global Fund currently pays for HTEP staff salaries and overhead, visits of HTEP staff to the six countries to monitor progress, and the maintenance of key regional public goods like the eCBS. Per current Global Fund grant documentation, sustaining these activities would require at least US$350,000 per year in continued funding, a sum that the debt-burdened OECS countries may not be willing to pay. A major sustainability risk is therefore the possibility of HTEP's de-funding and dissolution. Without this body, there would be no regional institution devoted to monitoring progress towards HIV and TB elimination and supporting national HIV and TB programs through the development of trainings, guidelines, and regional frameworks. The dissolution of the HTEP may also result in the loss of institutional knowledge and key relationships with OECS officials and international organizations such as PAHO and UNAIDS that have bolstered the regional HIV and TB response thus far.

Caribbean Vulnerable Communities Coalition

The Caribbean Vulnerable Communities Coalition (CVC) is a network of community and CSO/NGO advocates for Caribbean populations at higher risk for HIV infection. These groups include MSM, SWs, TG people, people deprived of liberty (PDL), and vulnerable youths. CVC seeks to combat the stigma and discrimination facing vulnerable populations in the Caribbean and reduce HIV prevalence among these groups.[44]

CVC was incorporated in 2005 with founding representatives from the Eastern Caribbean as well as other English-, Spanish-, French-, and Dutch-speaking Caribbean islands. CVC continues to operate throughout the Caribbean region, not just in the OECS, and is currently headquartered in Jamaica. CVC has received considerable external funding from donors such as the MAC AIDS Fund, Robert Carr Fund, and UN Women to support CSOs throughout the Caribbean that serve populations vulnerable to HIV. CVC also hosts periodic regional knowledge-sharing meetings and conducts HIV-related trainings. In 2011, CVC was selected as a sub-recipient for a Global Fund grant to CARICOM, and in 2016, the organization was also named a sub-recipient of the Global Fund's OECS HIV and TB grant.[45] CVC became a principal recipient for a regional grant that ended in 2019, replacing UNDP which had previously been the principal recipient. Currently, the CVC is still a sub-recipient under the CARICOM grant.[46]

In the first implementation period of the Global Fund's OECS grant (2016-19), the CVC was allocated about US$1.5M in funding of the total US$5M. In the second implementation period (April 2019 – March 2022), this amount was decreased to only US$225,000 of US$3.5M.[47] The current CVC director reported that the organization has not used its grant allocation for the 2019-2022 period because it is awaiting the results of an ongoing Key Populations Strategy development. CVC's budgeted items for the current implementation period include workshops and trainings related to KPs as well as other capacity building initiatives.[48]

In addition to implementing Global Fund-funded activities in the OECS, the CVC financially supports multiple local CSOs, including Women Against Rape (Antigua & Barbuda), GrenCHAP (Grenada), United & Strong (St. Lucia), and VincyCHAP (St. Vincent & the Grenadines).[49] Interviewees from these

[43] Detailed Global Fund grant budget, 2019-2022.
[44] http://www.cvccoalition.org/content/who-we-are
[45] http://www.cvccoalition.org/content/cvc-history
[46] Interview with Global Fund official.
[47] Global Fund grant documents.
[48] Global Fund grant documents.
[49] Interviews with civil society.

organizations stated that they complete an application process to receive CVC funding, which is ultimately sourced from CVC's other international donors—not the Global Fund. The CVC director noted that it has become increasingly difficult for the organization to secure these large external grants because donors are transitioning away from higher-income countries—like those in the Eastern Caribbean—in favor of lower-income, higher-burden locations. Therefore, future CVC grants to CSOs in the OECS are not guaranteed.

As Global Fund support to the region declines, the CVC's role becomes unclear. The organization will likely continue to support Caribbean-wide knowledge sharing initiatives and host KP-related trainings that will benefit the OECS HIV response. However, with the potential loss of Global Fund funding and support from other HIV/AIDS donors, CVC may no longer have the financial capacity to provide grants to OECS CSOs and offer OECS-specific capacity building initiatives and workshops. Already, one interviewee from civil society suggested that the CVC was not as strongly focused on the OECS islands compared with other Caribbean countries like the DR and Jamaica, and therefore "they do not understand the OECS like we do." In a best-case scenario, if the CVC further reduces its support to the OECS region due to Global Fund transition or other factors, a homegrown OECS CSO will take its place as a leader in advocating for KPs in the region. In a worst-case scenario, the CVC's funding, trainings, and expertise in the region will not be replaced, and the benefits of a strong KP/HIV advocacy group will be lost.

Caribbean Med Labs Foundation

The Caribbean Med Labs Foundation (CMLF) is an NGO established in 2007 at the request of CARICOM Ministers of Health. CMLF is designed to develop and sustain high-quality medical laboratory services in the Caribbean "through an independent self-sustaining mechanism."[50]

CMLF was selected as a sub-recipient for the Global Fund OECS grant in 2016. In the first grant implementation period (2016-19), CMLF was allocated a total of US$690,000.[51] During this period, four of the six OECS countries received GeneXpert machines to enhance their laboratory capacity, and CMLF was tasked with supporting these countries in their use (the other two countries received GeneXpert machines in 2019). CMLF also conducted a study to identify barriers to laboratory use for KPs in the OECS. Based on this study's results, CMLF assisted the OECS countries in revising their national laboratory policies to address these barriers.[52]

In the second implementation period, CMLF's allocation remained fairly steady at $650,000. About 60% of Global Fund funding to CMLF is budgeted to develop regional mechanisms to support laboratory regulation, create national laboratory policies, and help the OECS countries' public laboratories achieve Tier 1 and Tier 2 status.[53] As of mid-2020, these efforts were still in the nascent stage. Only one public laboratory (MSJMC in Antigua & Barbuda) has achieved Tier 1 status, and no public laboratories have achieved Tier 2 status.[54] CMLF plans to develop a laboratory policy implementation plan with specific progress indicators for the OECS, to be completed by 2021.[55]

In addition to supporting laboratory development in the OECS, the Global Fund grant currently supports a large portion of CMLF's operating costs. In the 2019-2022 period, Global Fund funds were budgeted to cover 65% of CMLF's overhead expenses, such as rent and utilities. The Global Fund also allocated about $175,000 for CMLF staff salaries over three years. Combined, these two budget lines total $250,000 over the implementation period, or almost 40% of the total grant amount to CMLF. This

[50] http://cmedlabsfoundation.net/index.php/about-us
[51] Global Fund grant documents.
[52] http://cmedlabsfoundation.net/documents/CMLF-OECS-LAB-POLICIES-FINAL.pdf
[53] Global Fund grant documents.
[54] Interview with OECS official.
[55] http://cmedlabsfoundation.net/documents/CMLF-OECS-LAB-POLICIES-FINAL.pdf

organization's reliance on Global Fund resources for essential operations and personnel is a significant sustainability risk, as there is no clear funding alternative to support CMLF's important laboratory development work when Global Fund funding to the OECS declines.

Regional and National Global Fund Coordinating Mechanisms

Regional Coordinating Mechanism

The OECS Regional Coordinating Mechanism (RCM) was established in 2003 as a Global Fund-mandated body. The RCM is responsible for developing Global Fund grant applications and coordinating activities associated with the Global Fund grant.[56] In this role, the RCM suggests the Principal Recipient of each upcoming grant develops the financial proposal, obtains confirmation of support for Global Fund grant activities from each OECS recipient country, and oversees grant implementation. The RCM also serves as a multi-sectoral forum for knowledge sharing with representatives from government, civil society, the private sector, and donor partners.

The RCM is composed of one government representative and one CSO or private sector representative from each of the six OECS recipient countries. Regional organizations, such as the Caribbean Regional Network for People Living with HIV (CRN+), the Caribbean Sex Worker Coalition, and others, are also represented as voting members on the RCM. Non-voting members include representatives from the OECS HTEP, PAHO, UNAIDS, and USAID.[57] Four RCM representatives serve as members of the RCM Oversight Committee, which monitors progress towards Global Fund grant targets and identifies strategies to resolve challenges in grant implementation.[58]

The RCM has successfully applied for four rounds of Global Fund grant funding to the OECS in the years 2005-2011 and 2016-2022, with two implementation periods each. The Global Fund disbursed $8M under the first grant (2005-2011) and has budgeted up to $8.5M in the current grant (2016-2022). In the first years of Global Fund involvement in the OECS, the RCM secured an additional $2.3M from DFID (UK) to jumpstart the HIV response in the OECS region and successfully petitioned USAID for $30,000 to support the preparation of the regional Global Fund grant application for the period 2007-2011.[59] While the RCM did submit a proposal to the Global Fund for funding in 2010, the application was denied. The RCM was invited to resubmit a proposal and successfully was awarded a new Global Fund grant in 2015.[60]

The RCM receives funding through the Global Fund's CCM Hub to support necessary travel, Secretariat salaries, and key operational expenses. No other direct or indirect funding sources for the RCM were identified, and non-Secretariat RCM members do not receive compensation, though specific expenses may be reimbursed. One OECS RCM member cited Global Fund grant proposal development as a large expense that requires additional resources beyond the Global Fund's designated funding for the RCM. The RCM is currently seeking an international donor to support the preparation of the upcoming grant proposal.[61]

If the Global Fund leaves the OECS, the RCM will no longer be responsible for the expense of Global Fund grant application preparation. However, since the RCM came into existence by the mandate of the Global Fund, there is a risk that this body will dissolve in the absence of Global Fund funding for the region. According to interviewees, when the OECS's application for funding was denied in 2010, the RCM's activities were greatly reduced. The RCM Coordinator sustained the organization nearly single-handedly,

[56] http://www.theoecsrcm.org/index.php/en/the-rcm/about/about-rcm
[57] http://www.theoecsrcm.org/index.php/en/the-rcm/about/structure-and-membership
[58] http://www.theoecsrcm.org/index.php/en/the-rcm/about/governance-documents?task=document.viewdoc&id=5
[59] http://www.theoecsrcm.org/index.php/en/the-rcm/about/about-rcm
[60] Interview with RCM interviewee.
[61] Interview with RCM interviewee.

running meetings out of her home and maintaining relationships with key HIV stakeholders in the six countries. Thus, when the Global Fund invited the OECS to apply for funding in 2015, the basic structures of the regional HIV response coordination were still in place to facilitate this application.

RCM members may not be willing or able to maintain this body if the OECS permanently exits Global Fund eligibility in the coming years. A primary benefit of the RCM is its function as a regional knowledge-sharing and troubleshooting mechanism for OECS government and civil society leaders passionate about the HIV and TB response. This benefit would be lost if the RCM dissolved, as would a ready-made institution to prepare HIV and TB grant applications to other international funding sources. Currently, the RCM has a strong leader who is committed to its continued operation. However, in this absence of this person, the sustainability of the RCM is not certain.

Country Coordinating Mechanisms

Each OECS country also has its own Country Coordinating Mechanism (CCM). Like the RCM, the CCM is intended to bring together HIV and TB stakeholders from various sectors to oversee the implementation of the Global Fund grant in the country. Two of the CCM members from each country also serve on the RCM.[62] Based upon interviews with national government and CSO stakeholders, the CCMs do not play as large a role in Global Fund grant development and oversight as does the RCM. However, the CCMs formalize important relationships among national HIV and TB stakeholders from many sectors and promote regular meetings to discuss successes or challenges that arise in the national disease responses. While the Global Fund supports the OECS RCM's operations, it does not support the six participating countries' CCMs. CCM members do not receive compensation, but they may receive reimbursements for their travel and per diem expenses.

National CCMs may be easier to sustain in the long term than the RCM. CCMs have limited expenses, since domestic travel is inexpensive compared with inter-island transit for meetings or other activities. CCMs have also not been engaged in independent grant-writing so far and therefore are not responsible for this expense. In this context, the future of CCMs may be as an important forum for continued national discussion, engagement, and productivity. Even in the absence of Global Fund funding, CCM members who are passionate about their work are likely to remain engaged in the national HIV and TB response, and the existing CCM is an effective mechanism to bring together these stakeholders to sustain and build upon successes in the HIV and TB programs.

National Governments

The six OECS Ministries of Health are sub-recipients of the Global Fund grant. Annex 10: presents key characteristics for the government-led HIV and TB responses in each OECS country. The information in this annex is sourced from key interviews and documents received from interviewees. Main takeaways are summarized in the paragraphs below.

A strong National AIDS Program Coordinator (NAPC) is essential to successful national HIV governance. Effective NAPCs have built relationships with key figures in the Health Ministry and other government bodies to mobilize sufficient resources and staff members and obtain approval for innovative HIV-related activities or services. These NAPCs can then demonstrate strong program results to newly elected or appointed government officials to build and maintain bipartisan support for the HIV program, which is an important component of a sustainable response.

At least two well established and successful NAPCs in the OECS have left their positions in the past five years because of low levels of perceived political support from their superiors and insufficient resource allocations for their programs. These two individuals led their programs to improved outcomes over their tenure, and some of these gains were lost following their departures from the government. It

[62] http://www.theoecsrcm.org/index.php/en/the-rcm/about/about-rcm

is essential that high-ranking MoH officials—such as the Chief Medical Officer, Permanent Secretary, and Minister—recognize, support, retain high-performing NAPCs. Frequent turnover in NAP leadership, as has occurred in over half of the OECS countries in the past few years, erodes institutional knowledge and breaks down important relationships with key government officials, constituting a major sustainability risk.

Some islands of the OECS—such as Carriacou, Petite Martinique, the Grenadines, and Barbuda—do not have their own HIV governance structures and rely on national programs run in sister islands. Interviewees are not currently aware of a major HIV epidemic in these locations. However, residents of these islands have more limited access to HIV services (typically once a month or once a quarter) and must travel to a different location to receive specialized care. If HIV infections in these islands grow, or if an existing HIV epidemic is detected, there may not be adequate governance or service delivery structures in place to manage the response in these remote locations.

There are minimal governance structures in place for the TB response beyond a TB focal point, who usually has other responsibilities in the MoH. This arrangement may be acceptable at present because of the low TB incidence in most OECS countries. However, a growing TB epidemic in Dominica (see above: Epidemiology) threatens to expand to other OECS countries, at which point the limited TB infrastructure may prove to be a major vulnerability.

For a period of time in the mid-2010s, most OECS governments lacked national strategic plans to guide their HIV and TB responses. According to interviewees, PEPFAR funded the development of NSPs in the early 2010s, but they withdrew from the OECS region as the NSPs were expiring. Now, with support from PAHO, five of the six OECS countries have produced updated plans for progress to TB elimination. During the workshop with the country, St. Vincent & the Grenadines confirmed no plans exist to update the plans and cited their use of the Green Light Committee Initiative, a WHO program to end TB. Moreover, Dominica confirmed that it has completed its NSP for HIV and TB, but will change due to the 60% budget cut associated with the fiscal crisis of the Covid-19 pandemic. The NSP remains in progress for St. Kitts & Nevis, and HIV program leaders from the other countries stated that the development of an updated NSP was a priority. These workplans are important to agree on states objectives and specify metrics to evaluate progress. The development of an NSP can also enhance political commitment to the HIV and TB responses by bringing high-ranking health and government officials into the planning process.

There is evidence of a personality-based political culture in the OECS islands. Because of their small populations and limited number of civil servants, the opinions of a single high-ranking official can significantly alter the national HIV and TB response. Some countries, such as Antigua & Barbuda, have insulated themselves from this risk by building bipartisan political support for the HIV program and overcoming political stigma associated with KP interventions. However, in other islands a handful of officials—from the Health Minister to other Cabinet members—who are reported to be politically sensitive about KP- and HIV-related activities have limited the scope and progress of national programs. It is not clear from interviews the reasons behind such a complex context, but national program leaders should explore further to solve the root causes. A lack of robust, bipartisan political commitment to the HIV and TB responses in each country constitutes a significant sustainability risk, especially when governments are no longer obligated to track expenditures and outcomes for the Global Fund. If Global Fund-mandated regional and international monitoring programs decline in the OECS, certain politicians could de-prioritize and de-fund HIV and TB programs, especially for KPs.

2.5: Key Populations and Civil Society Organizations

Key Populations

The Key Populations (KPs) affected by the OECS HIV and TB epidemic, as identified in the 2019-2022 Global Fund grant agreement, are as follows: commercial sex workers (SWs), men who have sex with

men (MSM), transgender (TG) persons, people living with HIV (PLHIV), youth, people affected by TB or TB and HIV coinfection, and missing TB cases.[63] Of these KPs, national governments and CSOs focus most on interventions among MSM and SWs.

Men who have Sex with Men (MSM)

Gay men and other MSM are disproportionately affected by HIV in the OECS region. While general population prevalence of HIV is estimated at 0.8%, prevalence among MSM in the region is estimated at 4.6%.[64] Social vulnerability, antiquated laws, marginalization, social exclusion due to dominant heteronormativity, and other underlying social determinants of health such as homelessness continue to drive the HIV epidemic among the MSM population. MSM who are open about their sexuality report discrimination at work and harassment and rejection from family and community members. Some MSM have been victims of physical violence.[65] Under the threat of discrimination and social exclusion, many MSM carefully conceal their sexuality, and fear of someone "outing" one's closeted sexuality is strong.[66] The MSM safe spaces visited in-country were unmarked, and members typically gathered at night to avoid detection.

In addition to being social stigmatized, male same-sex intimacy is a criminal act in the Eastern Caribbean. The Buggery Act (covering anal intercourse) and the Gross Indecency Act (covering other male same-sex intimacy) are legacies of British colonial rule in the region. These laws carry prison terms of at least ten years for buggery and four to ten years for indecency. While interviewees report that police do not enforce these laws among consenting adults, they perpetuate a culture of discrimination against MSM, which often reduces MSM willingness to seek medical care and other government services, including for HIV. LGBTQ+ organizations such as CariFLAGS and ECADE have advocated for the elimination of the Buggery and Gross Indecency Acts at the regional level, and the MiRiDom organization in Dominica is currently filing a suit to overturn the national buggery law. While efforts to address the stigma faced by members of the LGBTQ+ community in the OECS are beyond the scope of this sustainability report, ongoing legal challenges may prove to be most successful at eliminating these discriminatory laws.

Sex Workers (SWs)

While SWs are known to be a KP in the OECS HIV and TB epidemic, their regional HIV prevalence (0.6%) is lower than that of the general population (0.8%).[67] Interviewees stated that SWs are typically knowledgeable about safe sex practices and utilize barrier methods and STI testing services offered by the national programs and CSOs, which could explain the lower reported prevalence. Alternatively, the testing sample of self-identified SWs may be those who are most aware and mindful of HIV risks.

There are two main types of SWs in the OECS, commonly referred to as commercial sex workers (CSWs) and people who exchange in transactional sex (TS). SWs in the OECS are usually immigrant women, often from the DR, Haiti, Jamaica, or Spanish-speaking countries in Latin America. According to interviewees, these SWs form tight-knit groups with other members of their ethnic communities and are effectively reached through a bilingual community animator. Male SWs are rare but do exist in small numbers, and CSO and national program interviewees report that male SWs are difficult to reach. Most CSWs work out of known locations, such as brothels or bars, and serve a mix of domestic and foreign clients. With the exception of a few locations (such as Carouan and Union Island in the Grenadines),[68] SW

[63] Global Fund Grant Confirmation, QRB-C-OECS. 2019.
[64] See Chapter 2.
[65] Human Rights Watch, 2018. *I Have to Leave to Be Me.*
[66] Human Rights Watch, 2018. *I Have to Leave to Be Me.*
[67] See Chapter 2.
[68] Valles, X. 2019.

activity is not strongly linked to sex tourism. On the other hand, TS is more common among local young women and adolescent girls, who occasionally engage in TS with older men to supplement income, especially during the low season for tourism or after natural disasters. These women typically do not consider themselves sex workers and are difficult to reach through SW programming because TS occurs so far "underground," according to interviewees. Valles (2019) reports that TS "has been neglected as a possible driver of HIV infection, especially among adolescent girls and young women" in the OECS.

Prostitution and other activities related to sex work are criminal offenses in the OECS with punishment of up to ten years in prison.[69] This law is rarely enforced and was not cited as a barrier for SWs to access HIV or TB services. However, the illegality of sex work may dissuade SWs from seeking assistance if they are victims of a crime, such as robbery or rape.

Other Vulnerable Groups

Global evidence suggests that transgender women are disproportionately affected by HIV.[70] TG persons are considered an emerging KP in the OECS region and there is need for education among the communities to understand the LGBTQ+ definitions. Only one country, Grenada, has programmed for this group by generating a list of TG-friendly doctors who will support hormone therapy. Most other LGBTQ+ CSOs in the region include TG persons under testing and general outreach services for MSM.[71] However, LGBTQ+ interviewees reported that the population of TG people in the OECS is currently very low.

Migrant populations may also be an emerging key population in the OECS TB response. Interviewees from Dominica, currently the site of a growing TB epidemic, speculated that the increased TB burden in the country was due to imported infections from countries such as the DR and Haiti. Migrants, especially undocumented individuals, may be reluctant to seek HIV and TB testing and treatment out of fear of deportation. For further discussion, see Chapter 2 on epidemiology.

Civil Society Organizations (CSOs)

Members of KPs and allies have formed legal entities with a mandate to serve their own communities. They typically form around a charismatic leader motivated by the need to address a gap in society towards a group or population. These CSOs are both non-governmental and non-profit. CSOs are usually able to penetrate vulnerable and hard-to-reach populations in the OECS countries more efficiently and effectively than their government counterparts because they are known allies or peers who have the trust of the community. This translates to the need for less resources and shorter times to reach these hidden groups. Key characteristics of the CSOs participating in the HIV and TB response in the six OECS countries are presented in Part 1:Chapter 1:Annex 11: with main takeaways described in the paragraphs below. A list of CSO "Best Practices" collected during in-person and remote interviews is located in Annex 11:

In most of the OECS countries, CSOs lead the HIV response among KPs, particularly MSM and SWs, as well as PLHIV. The exception is Dominica, where the national AIDS program employs a bilingual SW community animator to conduct outreach to this population. CSOs are active in all aspects of the HIV response: prevention through education initiatives and condom and lubricant distribution; treatment through VCT services, psychosocial support, adherence counseling; and continuity of care through peer-to-peer support and linkage to care. CSOs are acknowledged as strategic partners by national AIDS programs; for example, CSOs are invited to participate in the development of national HIV strategies, such as National Strategic Plans. In some instances (e.g., 3H in Antigua and Fouche La Vie in Dominica), CSOs operate out of the national AIDS secretariat/program office. A select number of CSOs record and share

[69] https://www.nswp.org/featured/caribbean-sex-work-coalition

[70] https://www.unaids.org/sites/default/files/media_asset/08_Transgenderpeople.pdf

[71] In-country interview.

HIV testing data with national and regional databases thus contributing to the achievement of national HIV targets. CSOs engage with government officials both through informal relationships and through the Country and Regional Coordinating Mechanisms.

CSOs typically receive commodities, such as condoms and lubricants, from national governments (that are funded at least in part by the Global Fund to support KP outreach activities. National AIDS programs strongly endorse CSOs as being able to provide effective HIV outreach, prevention, testing, care, and support services to KPs. However, beyond commodities, domestic financing support to CSOs is minimal, and CSOs must either self-fund programming or seek grants from external agencies. Because of this limited funding, many CSOs are operated mostly by volunteers, with just one or two paid staff members. Turnover among CSO staff, especially volunteers, is significant. Limited human resource capacity precludes many CSOs in the OECS from applying for external grants because they do not have the requisite structure, financial and M&E expertise to prepare successful proposals and document project impact and results. Many CSOs do not own their own physical offices, instead using staff members' homes or donated/shared space. Where paid space is available, the location is unmarked to avoid stigma and discrimination. Limited funding opportunities, few paid staff, and a lack of physical space renders many CSOs vulnerable to ad hoc implementation of programs and closure, constituting a key sustainability risk in the regional HIV and TB response.

There is historical precedent to the sustainability concerns of CSO financing and capacity. In the mid-2010s, major PEPFAR- and PSI-supported CSO-strengthening projects in the OECS region ended. (See 0for more information about the PEPFAR CHAA project.) As a result, numerous local CSOs folded or transitioned into the volunteer-based operations observed today. Unless governments increase their support for CSOs, the upcoming transition of the Global Fund—the last remaining HIV donor in the OECS—will similarly challenge CSOs to maintain their current KP outreach activities.

Some CSOs have sought partnerships to share operational costs and build capacity to apply for external funds. In Grenada, for example, GrenAIDS and GrenCHAP have formally merged. St. Vincent's Marion House offers a physical space for VincyCHAP, VincyCARE, and SVG Human Rights Association to meet and collaborate. AIDS Action Foundation in St. Lucia serves as an umbrella organization to support United & Strong (LGBTQ+), National Youth Council, Planned Parenthood, and Tender Loving Care (PLHIV). These partnerships can serve as an important tool to enhance CSO sustainability and leveraging best practices to a wider community base.

Within the last year, the International Planned Parenthood Association (IPPA), a major CSO involved in the regional HIV response, has scaled down operations in the region due to a reduction in U.S. funding for its SRH programs. This has left a large gap in VCT and other sexual and reproductive healthcare services in the countries of Antigua & Barbuda, Dominica, Grenada, St. Lucia, and St. Vincent & the Grenadines. The decline of Planned Parenthood, a previously well-funded and respected entity in the OECS, represents another setback for the sustainability of CSOs in the OECS. For example, many smaller CSOs formerly benefitted from partnership with IPPA to provide SRH and HIV/STI services for both the general population and KPs. To fill the gap in KP-friendly SRH services left by Planned Parenthood's absence, CSOs such as GrenCHAP are expanding their services to include SRH for MSM, SW, and PLHIV.

Social Contracting

Social contracting (SC) is defined in the Global Fund's *Social Contracting Diagnostic Tool* as the process by which government resources are used to fund non-governmental entities, such as CSOs, to deliver services. More information about the principles of SC can be found in Annex 13: SC can be used as part of a broader sustainability strategy for the national HIV and TB response by promoting CSO financial sustainability and ensuring that CSO services for KPs are continued. However, currently no country in the OECS utilizes SC to engage CSOs as partners in any sector, including HIV and TB. With our workshop with St. Kitts & Nevis, we learned that they are the exception as they have SC with CSOS working in cancer and

diabetes. St. Lucia has recently been approached by the PLHIV group, Tender Loving Care, to provide services through a performance-based mechanism. The parties are determining the mechanism, M&E and costing the workplan at the time of report preparation.

The Global Fund currently supports HIV and TB interventions among KPs through the funding of commodities, staff trainings, and services focusing on these communities. Many CSOs rely on the Global Fund-funded commodities or other in-kind support to conduct their KP outreach activities. However, with Global Fund funding expected to decline in the OECS in the coming years, there is significant risk that governments will not be able or inclined to fund and support services for KPs, including those currently provided by CSOs. National AIDS program staff across the countries expressed an understanding of the vulnerability of KPs and endorsed direct government support of CSOs to provide KP services. However, most interviewees felt that political leaders would not be interested in directly funding groups catered to individuals engaging in illegal and stigmatized activities, especially since the fiscal space in OECS countries is so limited by the Covid-19 pandemic.

Readiness for Social Contracting in the OECS

Several aspects of the current HIV and TB response in the OECS are conducive to initiating SC. This should be considered a solid mechanism to continue service provision to vulnerable communities and to maintain the gains made under the Global Fund support in the region. CSOs involved in the HIV and TB response (including those specifically catering to LGBTQ+ people, PLHIV, and SWs) are legally permitted to register and receive funds from government. Civil society is involved in planning and implementing HIV and TB interventions among the KPs they serve, and national programs seek out CSO feedback and input when designing national HIV and TB policies. Informal partnerships already exist between CSOs and national AIDS programs, such as collaborations in community outreach and testing. All interviewees had heard about SC as one of the tools in the arsenal of CSO sustainability options, even if there lacked a nuanced understanding of the differences between SC and other government support to CSOs.

Other factors in the OECS region may pose a challenge to SC implementation as part of the HIV and TB response. Following the departure of PSI and PEPFAR in the region, the number and capacity of OECS CSOs have declined. CSOs with minimal staff and limited administrative skills have difficulty applying for and meeting the terms of a SC arrangement. However, some remaining CSOs have merged with sister organizations to bolster capacity. For example, in Grenada, GrenAIDS and GrenCHAP have joined forces. Additionally, key SC structures are not yet in place. Countries interested in SC are advised to form a multi-sectoral SC mechanism to oversee the development of an implementation plan, provide capacity development where necessary to CSOs and NAPs, and to evaluate CSO applications. Ministries of Health must have M&E and financial officers to manage and monitor SC arrangements. The government will need agree on how the channel of funding whether through the Ministry of Health or NAPs. This may come from the existing allocation to the program or may require additional funding requests to parliament. Finally, high-level political support for SC is uneven across countries. Senior MoH management in Antigua & Barbuda and Grenada have expressed strong willingness to explore SC for the HIV response in their countries. St. Lucia is moving forward with a limited form of social contracting, but there are no standardized forms. As explained in the workshop in September 2020, the request for support came from the CSO and not via a national bid or request for proposal. Therefore, is it still too soon to determine if St. Lucia will indeed act on this SC bid. Each country should prepare for a cabinet submission and subsequent decision to guide this process smoothly. The OECS Commission Secretariat and the RCM have also endorsed these countries for implementing SC and will encourage such action within the next fiscal year, but the timeline remains quite unclear, especially now with a tightened fiscal space. Interest in SC for HIV is more limited among the other three countries' MoH leaders. Interviewees reported that a key roadblock is the limited domestic resources available for health generally and HIV specifically, especially given the recent decline in tourism revenues. Figure 2.13 below presents potential SC readiness by country based

on the observations and analyses of the authors. They have also been confirmed by our workshops in September 2020.

Figure 2.13: Potential Social Contracting Readiness by Country as per the Opinion of the Authors

Group	Countries	Details
1	Antigua & Barbuda Grenada	Ready for immediate assessment and implementation of SC structural needs, including for human resources and funding.
2	St. Kitts & Nevis St. Lucia	Hesitant to begin planning for SC because of limited human resource capacity, poor domestic funding availability, and perceived potential backlash from other government officials or the general population. Some aspects of support to CSOs are being explored.
3	Dominica St. Vincent & the Grenadines	Not ready for SC because of major constraints, including an ongoing restructuring of the AIDS program in St. Vincent, continued hurricane recovery efforts in Dominica, and significant perceived potential backlash from high-level political officials or the general population.

Alternatives to Social Contracting

Some OECS countries may be unwilling or unable to implement formal SC in the near term, especially facing the pressures of the Covid-19 pandemic. However, with the expected upcoming decline in Global Fund resources, CSOs will increasingly rely on governments to support their HIV and TB interventions, especially among KPs. CSOs are recognized as contributing to services for these communities but support will need to move from just commodities support. Some other options to enhance the sustainability of funding for HIV and TB CSOs include:

- Implementing a CSO subventions line in the recurrent expenditures budget for the national AIDS program to promote a steady annual CSO funding source. National AIDS programs could develop a standardized application form and review process for CSOs to apply for subventions. This may require building the capacity of the CSO to apply for and manage the funds.
- Offering small daily stipends from the national AIDS program budget to CSO members who currently volunteer as counselors or peer navigators in government clinics. St. Lucia is currently examining this possibility.
- Continuing to offer HIV commodities to CSOs to support KP outreach. For this option, national governments would have to devote sufficient domestic resources to cover the costs of HIV commodities (rapid test kits, condoms, lubricants) currently funded by the Global Fund to support KP interventions. This cost is about US$100,000 per year across the region, or about US$17,000 per year per country.
- Identify at least one CSO providing support to key groups in country and develop their organization to manage an aspect of the response specific to that population. This may include advocacy skills training and development of soft skills. This would be particularly useful for entities that may only include one or two persons and require a stronger accountability structure.

Each of these possibilities could also serve as intermediary steps towards full SC by developing key structures such as budget lines, standardized application and review mechanisms, and compensation agreements for specific activities performed.

2.6: The Novel Coronavirus

Introduction

The Covid-19 pandemic poses significant social, economic and health threats to the OECS region. The almost total halting of tourism and the lockdowns instated to control the epidemic are resulting in significant contractions of GDP, deterioration of the terms of trade, and increased government deficits. The recession and economic slowdown have led to rising unemployment and poverty and have required immediate mitigation measures to prevent long lasting social effects. Financing needs to cover the deficits will inevitably require taking on additional debt or/and budgetary reallocations, which could reduce funding for the HIV response.

Disruptions to the supply chains and the diversion of health professionals, infrastructure, and supplies towards the Covid-19 response could also result in increased cases of non-Covid-19 communicable disease including TB, HIV, and malaria. The lockdowns may further disrupt non-Covid-19 health treatments as people avoid seeking medical care for fear of contracting the novel coronavirus.

This chapter addresses the risks posed by the pandemic to the HIV response in the region. After a brief overview of the state of the epidemic in the Eastern Caribbean, we describe the macroeconomic and social impacts, and risks of the pandemic. The third section documents the current observed impacts and risks to the HIV response, and the last incorporates some specific ways that we have factored this ongoing pandemic into our key risks and recommendations.

State of the epidemic and future risks

Impacts

The islands reported their first Covid-19 cases between March 22 and April 3. After the first reported cases, all nations of the OECS reported community spread. However, this was interrupted soon after curfews and other restrictions were instated, with no new cases reported in four islands from early May until the end of June. St. Vincent & the Grenadines reported a spike in mid-May followed by no new cases until mid-July. Once the phased reopening began and tourism restarted, St. Vincent & the Grenadines, Antigua & Barbuda, and St. Lucia have seen small outbreaks. More, however, have begun in the fall 2020. As of November 2, 2020, the eleven member countries of the OECS had registered a total of 11,628 cases including 161 total deaths, and the six countries studied in this report had a total of 384 cases including 3 deaths.[72]

The six countries have reopened their economies while maintaining strict hygiene and social distancing guidelines and favoring the use of masks. Tourism has resumed with comprehensive protocols in place to prevent community spread. St. Lucia and Antigua & Barbuda opened early in June; St. Vincent and the Grenadines, Grenada in July; and St. Kitts and Nevis and Dominica remain closed. Countries require tourists to complete screening questionnaires, pass a screen test at the port of entrance, provide a PCR negative test taken within the 7 days previous to entry, take a new test upon arrival, and isolate for 24 hours until test results arrive. Those tourists found to be positive with Covid-19 are to be isolated in approved facilities. Hotels and resorts are required to be certified in Covid-19 safety protocols, and some protocols will require tourists to stay within the hotel or resort premises except for maritime trips organized by the resorts.[73]

Unfortunately, much of the Americas is currently experiencing a second wave surge in the autumn 2020. As of November 2, 2020, the OECS region has also experienced a recent uptick in cases. There is not yet enough data to determine if this will translate into a large second wave, but it remains a concerning

[72] https://www.oecs.org/en/coronavirus-covid19

[73] https://www.afar.com/magazine/first-caribbean-islands-to-reopen-for-tourism-in-june.

possibility. Overall, the region has experienced a 58% increase in total confirmed cases from September 1, 2020 to November 1, 2020.[74] Countries such as Dominica and St. Lucia both have increased by 150% at the high end, while St. Kitts & Nevis has increased by only 12% at the low end. Overall, the region has experienced a significant increase in cases at 58% that will evolve in the coming weeks and months. For comparison, the United States' cumulative cases increased by 51%, and Jamaica by 271% over the same two-month time period.

Figure 2.14: Confirmed cases of Covid-19 in OECS countries (as of November 1, 2020)

	1-Sep	1-Oct	1-Nov	% increase since Sept 1
Antigua & Barbuda	94	106	128	36%
Dominica	20	31	50	150%
Grenada	24	24	50	108%
St. Lucia	20	31	50	150%
St. Kitts & Nevis	17	19	19	12%
St. Vincent & the Grenadines	61	64	75	23%
Total six nation	236	275	372	58%

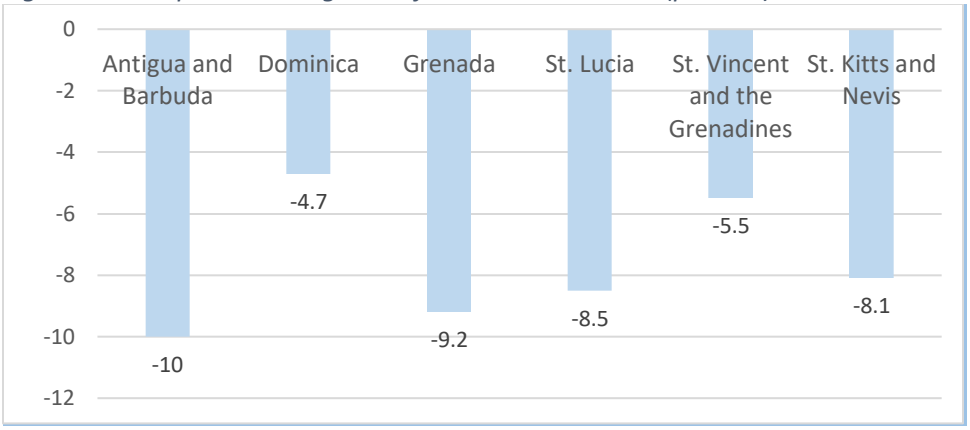
Source: OECS Covid-19 Data Hub

Macroeconomic and social impacts and risks

Impacts

Tourism, which accounts for 20 to 60 percent of GDP in the OECS countries, has been badly affected by the pandemic. Estimates from the summer showed an expected 50% reduction in tourism income for 2020. The contraction of tourism will trickle down to other sectors generating a sizeable impact on overall employment, which is expected to fall by 27%. According to the IMF (see Figure 2.15), overall GDP is expected to contract between 10% (in Antigua & Barbuda) and 4.7% (in Dominica).[75]

Figure 2.15: Expected GDP growth for 2020 in the OECS (percent)



Source: IMF

[74] WHO COVID-19 Dashboard.

[75] https://www.imf.org/en/Countries, last accessed August 2020.

Income losses from tourism coupled with a reduction in remittances from abroad have caused a deterioration in the balance of payments. Lower commodity prices resulting from the global slowdown of trade have not been enough to offset the losses. Deterioration of the terms of trade are making it hard for the countries to obtain foreign currency to pay for imports and service foreign debt. Government deficits have also soared, as governments have increased expenditure to address health and social protection needs, while facing lower revenues from reduced economic activity and tax breaks offered as part of economic recovery packages. Financing the balance of trade and the government deficits is expected to require significant increases in debt, which will put most countries above recommended debt-to-GDP ratio of 60%. Figures 2.16 and 2.17 contains the main macroeconomic impacts for the three OECS countries with published data.

Countries may expect negative effects on agriculture and potential food supplies shortages resulting from the international ban on exports, which may worsen if the virus spreads to agricultural workers. Disruption in supply chains due to halting of maritime imports has meant increased prices for the manufacturing sector, which is reliant on external raw materials and inputs and on more expensive air-freight. Non-essential construction, strongly tied to tourism infrastructure, has halted completely.

The large impact on health and employment has required packages of social assistance measures valued at up to 4% of GDP, and beneficiaries of social assistance and social protection programs have risen from 31,000 pre-pandemic to 87,000 today. Estimates of the impact of the pandemic on extreme poverty, which was below 5% in in all six states, indicate that it may triple to an average of 16.5% of the population (see Figure 2.16). Furthermore, school closures have prevented the 34,700 beneficiaries of school lunch programs from receiving nutritional assistance.

Figure 2.16: Impact of the Covid-19 on social indicators in the OECS

	Reduction in employment (percent)	Pre-Covid number of beneficiaries of public assistance	Post-Covid estimated number of poor in need of social assistance	Increases in extreme poverty (percentage points of total population)
Antigua & Barbuda	n/a	2,581	3,200	2%
Dominica	n/a	2,200	9,000	9.4%
Grenada	26%	9,352	20,000	16%
St. Lucia	27%	3,656	33,600	17%
St Kitts & Nevis	29%	3,828	9,000	16%
St. Vincent & the Grenadines	24%	10,000	13,000	9%

Source: OECS (2020)

Dominica has been the least affected country given its lower dependence on tourism. Grenada started from a good fiscal position that will help to buffer the Covid-19 shock and is expected to bounce back sooner once tourism restarts. The other countries have been hit harder and will see more prolonged effects. With an already higher debt level, Antigua & Barbuda face the largest economic contraction. Figure 2.17 below lists some of the macroeconomic impacts estimated for the countries with available data.

Figure 2.17: Macroeconomic impacts of Covid-19 (% of GDP)

St. Lucia

Change in revenue	-2%
Change in fiscal deficit	-5%
Balance of payment deficit:	+8%
Health and social assistance package	+2%
Projected increase in public debt	+12%

St. Vincent and the Grenadines

Change in revenue	-2.1%
Change in fiscal deficit	-2.7%
Balance of payment deficit:	17.5%
Health and social assistance package	+3.6%
Projected increase in public debt	+9.8%

Grenada

Change in revenue:	-0.5%
Increase in fiscal deficit (current account)	+7.5%
Balance of payment deficit:	+10%
Health and social assistance package*	+4.2%
Projected increase in public debt	+15%

Source: IMF, May 2020.[76] Changes refer to post-Covid projections in reference to pre-Covid projection. *Includes contingency package of 2.2% of GDP in case of worsening scenarios.

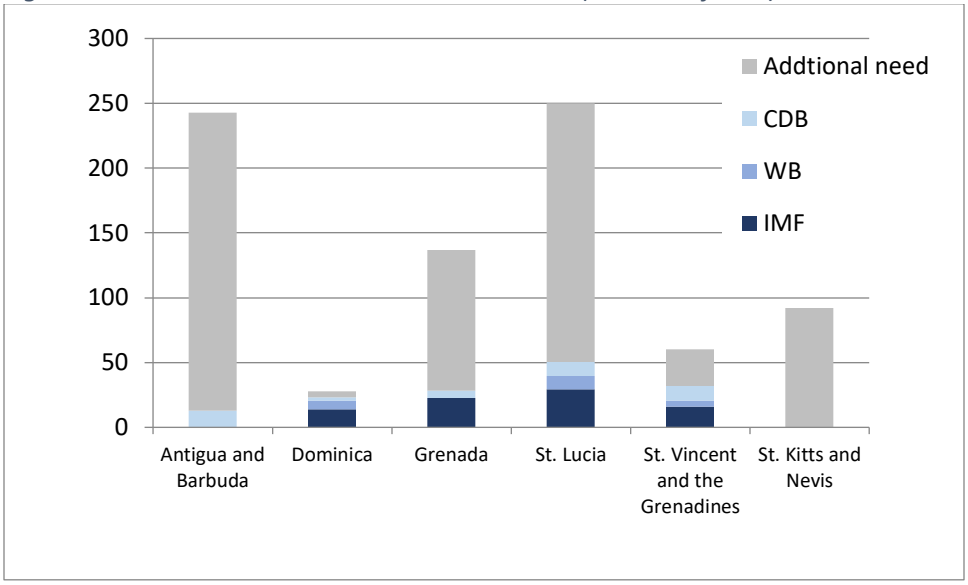
Risks

The immediate financing needs posed by the pandemic and its macroeconomic impact will require additional debt, drawdowns of government and foreign reserve surpluses, and reallocating government budget from less urgent priorities. Figure 2.18 shows the financing needs, as well as loans and grants approved to date.[77] As of October 2020, countries had accessed funds from the IMF Rapid Credit Facility, the World Bank by fast tracking the Contingency Emergency Response loan approved last year, and Caribbean Development Bank (CDB) concessional loans. Other World Bank loans are also under consideration. The Global Fund has reprogrammed grant resources and the OECS Commission has requested and received funds from the Global Fund through the Emergency Response Mechanisms (see below for more details).

[76] IMF, Country Report No. 20/157, 20/161, 20/179. May 2020.

[77] Financing needs differ substantially depending on methodology. Estimated need comes from https://unctad.org/en/pages/newsdetails.aspx?OriginalVersionID=2341. Other Estimation Available from IMF indicate needs of US$13 for St Vincent & the Grenadines, US$475 for St. Lucia and US$100 for Grenada.

Figure 2.18: Financial needs and current sources (millions of USD)



Source: Loans and grants: IMF, WB, CDB, August 2020. Estimated needs: UNCTAD.

It is clear that for all countries except Dominica which is least dependent on tourism, a large share of financing will need to come from domestic sources and additional private debt. The new loans from IADB, CDB and IMF mentioned above have been granted under concessional terms and have grace periods of up to 5 years. This will mean that servicing this new debt will not divert funds from social programs, at least in the immediate future. However, Eastern Caribbean countries are under pressure to restore debt to levels below 60% of GDP, which means that governments will nevertheless face a tightening fiscal situation.

According to IMF projections from August 2020, most OECS countries will not reach pre-pandemic GDP levels until 2022. Additionally, the projections assume that the world economy recovers, tourism returns to earlier levels by the end of 2020, and the number of Covid-19 cases in the Caribbean States remains low. However, if new cases surge and tourism resumes slowly or falters, growth prospects would worsen. It remains unclear how forecasted changes in GDP per capita will affect the eligibility of the OECS countries for future Global Fund grants.

All countries have already passed budget reallocations to bridge the gap in financing needs. For example, St. Vincent & the Grenadines has postponed a port project, agreed with labor unions to freeze wages for central government employees in 2021, limited growth of the wage bill to 2% percent per year through 2024 instead of the projected 4.5%, and reduced capital spending by EC$ 200 million (roughly 74.0 million USD) during 2020-2025.[78] Additionally, the countries face cuts to the health sector that will put pressure on their HIV and TB programs. During the workshops in autumn 2020, participants from Dominica cited 60% budget cuts and the team from St. Kitts & Nevis indicated that the health budget was being significantly revised. As of now, this has translated in disbursement delays to the HIV programs, but it is not clear yet how the cuts will ultimately affect the resources available for the HIV response. In the workshops Grenada and Dominica mentioned that roll-out and implementation of National Health Insurance will need to be postponed for at least a year and/or begin with a reduced benefit package.[79]

[78] IMF Country Report No. 20/179, May 2020

[79] From country consultations and workshops held in September 2020.

Health Sector and HIV response

Because of the existing constraints of the health system in the region, Covid-19 prevention measures have concentrated on social distancing protocols, mask use, contact tracing and testing, and quarantine and isolation, so far with good results. The OECS islands have limited critical and intensive care hospital capacity to deal with severe cases of Covid-19 illness. In addition to public hospitals, most countries have at least one private hospital, but patients have to cover 30% to 50% of the cost, and only 10% of the population has private insurance.[80].

The OECS countries already faced limited virus testing capacity pre-Covid-19, as most samples had to be submitted to the reference lab in Trinidad & Tobago.[81] St Lucia and Dominica have successfully increased RT-PCR testing, and St. Kitts & Nevis has testing available in the private sector, but most samples are sent to CARPHA due to restrictions on reagents and other inputs.[82] The GeneXpert test used for HIV was adapted for Covid-19 testing, and the September workshops with the six countries demonstrated that many health workers involved in HIV testing for HIV have been used to test for Covid-19. However, to avoid overburdening the equipment used for conducting TB and HIV viral load testing, the OECS Commission reprogrammed of 92,298 USD to procure 6 GeneXpert modules, 2,600 testing cartridges, and other supplies for conducting Covid-19 testing. Additionally, the OECS Commission received 162,947 USD through the Global Fund priority-1 C19 Emergency Response mechanism, and a new proposal has been submitted for an additional 109,755 USD. Funds obtained through the Emergency Response mechanism will be used for the introduction of HIV self-testing and additional GeneXpert testing supplies.

Initially all health personnel and resources were channeled to the Covid-19 response, but gradually other health services, including HIV prevention and promotion activities, have restarted.[83] Stakeholders in St. Kitts and Nevis, for example, mentioned that they were unable to continue outreach to KPs due to the lockdowns during the height of the Covid-19 restrictions. Since late summer, however, they have resumed community outreach. In Antigua & Barbuda, testing was initially halted, but rapidly returned to normal levels through a walk-in service and new WhatsApp communication system.

Covid-19 has thus far not affected the supply of ARVs, but the procurement partially funded with Global Fund grants has slowed down as the countries have struggled to find the cash needed to comply with the upfront payment required by the regional pooled procurement mechanism.

Implications

Overall, the Covid-19 pandemic has profoundly shifted short-term economic, social, and health conditions in the six countries. The situation continues to evolve and its long-term effects on HIV and TB remains uncertain. So far, the countries have shown resourcefulness and resilience in maintaining their HIV and TB programs, but additional challenges may arise. Accordingly, Covid-19 has been taken into account in identifying the key sustainability and transition risks in this report, and the recommendations have been recalibrated to the new post-Covid environment.

[80] OECS (2020)
[81] OECS (2020)
[82] Op. Cit.
[83] HTEP (2020) and September 2020 workshops.

Chapter 3: HIV and TB Sustainability Risks and Recommendations

3.1: Overview of Risks

To provide structure for the sustainability strategy and associated consultation meetings with key stakeholders, Pharos Global Health Advisors developed a framework to analyze HIV and TB sustainability risks in the OECS. This framework, validated through discussions with the OECS Secretariat, RCM, and Global Fund, is similar to those developed by Pharos in numerous other Sustainability and Transition analyses around the world. The key strategic areas of analysis, as identified through professional experience, research, and interviews, are *Health Systems, Financing, Governance,* and *Key Populations/Civil Society Organizations* (see Figure 3.1).

Figure 3.1: Sustainability Risk Analysis Framework, Pharos Global Health

The full matrix of HIV and TB sustainability risks for the OECS, classified into one of the four analytical categories shown above, is presented in Figure 3.1. The subsequent chapters elaborate upon this matrix, offering specific evidence to support these sustainability risks, detailing the consequences of each risk if not addressed, and suggesting solutions to address these risks.

Figure 3.2: Matrix of Sustainability Risks for the HIV and TB Response in the OECS

Risk Area	Risk
A. Health Systems	A.1: At least five of the six countries may not be able to **train and retain adequate public-sector health staff** to maintain and expand testing, treatment, and other essential HIV/TB activities, especially as such training is currently Global Fund-funded and the OECS countries continue to experience heavy staff turnover and brain drain. **Nursing vacancy rates** average to 40% across the Caribbean[84], and four of the six OECS nations have ratios of doctors per capita far below global and regional averages.
	A.2. Countries may not adequately **improve their HIV and TB strategic information systems** to record and track new infections, monitor disease burden, and identify gaps in prevention, testing, and treatment, especially among KPs.
	A.3. The six countries may face challenges in overcoming the barriers to an improved **HIV treatment cascade** from its low current levels to reach 90-90-90 targets, without which the countries will not be able to achieve HIV elimination.
	A.4. The **TB program responses** in the six countries are not adapting rapidly enough to respond to a potential surge in TB, especially cases imported through labor migration. **Political awareness, support, and national funding** for TB are not increasing quickly enough to meet this new reality.
B. Financing	B.1. Domestic funding may not be allocated in a timely way to sustain HIV and TB **laboratory maintenance and purchase of ARVs, VL reagents, test kits and condoms/lubricant,** especially because due to the fiscal strains of Covid-19, shifts of national budgets to other diseases, the expected phasing down of Global Fund grants in this area, and the occasional natural disaster.
	B.2. **UHC/national health insurance schemes** may not be implemented before Global Fund financing ends. Guaranteed benefits may not cover 100% of the population, such as low-income households and non-nationals. Covid-19 is likely to exacerbate this situation.
	B.3. The six countries may not appropriate adequate funds to pay for **KP programming**, directly or through public-private partnerships and social contracting mechanisms, resulting in incomplete HIV and TB services for KPs.
	B.4. Governments may not develop **adequate financial monitoring systems for HIV and TB programs**, especially as Global Fund support for M&E declines, resulting in insufficient accountability and reduced capacity to identify and plan for transition and NSPs.
C. Governance	C.1. The **RCM and HTEP**, which play an important coordination and technical assistance role in the OECS, may not continue to function with the departure of the Global Fund, with potential negative impacts on country responses. The lack of a plan to integrate the HTEP in the OECS Commission's health unit exacerbates this risk.
	C.2. **National leadership and political support for HIV and TB responses** may weaken or fluctuate in certain countries, especially with the competing demands of Covid-19, making it hard to sustain the HIV/TB responses during political cycles and changing governments.
D. Key Populations & CSOs	D.1. The six countries may not have the **legal/administrative frameworks and procedures** for conducting social contracting.
	D.2. **CSOs working in HIV and TB remain fragile and face challenges in developing adequate capacity to provide adequate, consistent, high quality services to all KPs.** Without increased capacity and the necessary skills and systems, social contracting may not be successful even with the appropriate government financing.
	D.3. The six governments may not be willing or able to **allocate budget funds for social contracting,** leading to a decline in CSO effectiveness in the OECS as the Global Fund winds down as a source of funding.

[84] Rolle Sands, S., Ingraham, K. & Salami, "B.O. Caribbean nurse migration—a scoping review." *Human Resources for Health* **18,** 19 (2020).

3.2: Risks by Country

Workshops were held with each of the six countries throughout August and September 2020. In these 3-hour workshops, the Pharos team presented a list of preliminary risks and recommendations that had been sent to the participants prior to the meeting, highlighting a subset of risks that seemed most relevant to the country's specific conditions. Countries tended to confirm these risks and added their special views, occasionally emphasizing other risks in the list. This helped to validate the preliminary findings and to increase stakeholder buy-in.

Figure 3.3 below shows the risks and recommendations that each country selected as priorities. Overall, every country highlighted concerns about financing, especially the importance of mobilizing more domestic funds for laboratory services, commodities, and KP activities. Countries also tended to focus on weaknesses in the health systems response to HIV and TB, especially in the treatment cascade and in information systems. There was a strong interest in social contracting and greater community engagement from three of the countries. Governance was also a concern, especially the uncertain and fluctuating political support from national leaders, which requires more advocacy and strategies to build sustainable political backing for HIV ad TB.

Figure 3.3: Key risks as selected by country

	Health Systems	Financing	Governance	KPs and CSOs
Antigua & Barbuda		B1, B3		D1, D3
Dominica	A1, A4	B1, B3, B4		
Grenada	A2, A3	B3		D2, D3
St. Kitts & Nevis	A1	B1, B4	C2	
St. Lucia	A2	B1, B2, B4		D1, D3
St. Vincent & the Grenadines	A1, A3		C1	

Source: Workshops, August to October 2020

The details of each risk and possible recommended actions follow in the next four chapters. Although a highly diverse set of risks, it appears that many of the most important solutions fall into three large categories: piloting social contracting, increasing advocacy, and striving HIV cascade improvements. In addition to the above listed risks, Pharos research suggests that the countries and the OECS region consider the risks associated with natural disasters and future pandemics, such as the ongoing Covid-19 pandemic. Each country is encouraged to develop contingency plans particularly for health systems and financing strategies for a variety of external shocks. In the chapters below, we provide further detail on the risks and recommendations made by Pharos.

3.3: Health Systems Risks

A. Health Systems
Risk A.1. At least five of the six countries may not be able to **train and retain adequate public-sector health staff** to maintain and expand testing, treatment, and other essential HIV/TB activities, especially as such training is currently Global Fund-funded and the OECS countries continue to experience heavy staff turnover and brain drain. Nursing vacancy rates average to 40% across the Caribbean[85], and four of the six OECS nations face below the world average rates for medical doctors per capita.
Selected as a key risk: Dominica, St. Kitts & Nevis, St. Vincent & the Grenadines
Evidence for this risk: **Training of health professionals:** • Thus far, governments have relied on external funding for HIV and TB training for health workers. Interviewees reported that their governments would be unwilling to take on this expense. • For the period April 2019 to March 2022, the Global Fund allocated over US$500,000 of the total US$3.5M OECS grant for training-related expenses. Interviewees indicate that the Global Fund is the main funding source for HIV and TB training in the region. Global Fund funding for training is directed to the PR and all eight SRs. • Global Fund money for training also reaches the OECS through wider Caribbean grants such as QRA-H-CARICOM. Prior to the Global Fund's involvement in the OECS, USAID funded most HIV and TB training activities in the region. • Some national program coordinators stated that they would seek other sources of assistance—such as the CVC and PAHO—because they were not optimistic about receiving increased domestic funding for HIV and TB trainings if the Global Fund leaves the OECS. • Conducting in-person trainings in the OECS is expensive. A one-day training conducted in-person in each of the six countries, with a workshop of 20 participants per country is estimated to cost over US$11,000. Interviewees report that cheaper web-based trainings are not a viable option because of intermittent Internet access in the islands. • HIV care and sensitization trainings are not standard in regional health professional schools. Some institutions offer these trainings if a knowledgeable volunteer emerges to design and teach the lessons, as Julie Frampton (a former NAPC) has done in Dominica. • Health care providers are not held accountable for incidences of discrimination, including breach of confidentiality or not providing care to members of KP. Victims of discrimination report fear of additional discrimination or retaliation by perpetrators. **Retention of health professionals:** • There is poor retention of health professionals in the OECS. Many trained nurses, doctors, and college-educated program staff accept higher-paying positions in the U.S. or elsewhere abroad. • A lack of providers translates to understaffed HIV and TB clinics. Respondents reported that PLHIV have become discouraged when they devoted time and resources to attend a clinic appointment and could not see a provider. These experiences contribute to the high rates of LFU patients and poor 90-90-90 treatment outcomes for HIV. • Many public-sector health professionals interviewed across the region reported feeling overworked and underappreciated by higher-ranking government officials. • Staff shortages in the National AIDS Programs were commonly cited as the key reason for poor 90-90-90 target achievement, limited usage of online data collection systems, and high rates of

[85] Rolle Sands, S., Ingraham, K. & Salami, "B.O. Caribbean nurse migration—a scoping review." *Human Resources for Health* **18,** 19 (2020).

patients LFU. For example, the St. Kitts AIDS Program reported needing at least six or seven more staff members to oversee a robust HIV response.

- Issues of staff shortages and turnover extend even to leadership positions in national AIDS programs. Two countries have had rapid turnover in the role of NAPC, and another has had the position vacant for over a year. Accordingly, the position's full-time responsibilities have been added to the mandate of the Director of Community Health Services. Two well respected NAPCs departed the Ministries of Health in St. Kitts and Dominica in the past five years because of reported high workloads and limited support from governmental leaders.

Consequences if this risk is not addressed:

- An understaffed HIV and TB program will be unable to fulfill its stated responsibilities and goals. Patients who visit an understaffed clinic may not receive the care they seek, contributing to LFU patients. In the OECS, inadequate staffing contributes to continued challenges in meeting 90-90-90 and TB elimination targets; there is not enough staff and support to monitor and follow up with every patient, conduct contact tracing, enter data into an eCBS, etc.
- Heavy staff turnover results in a loss of both institutional knowledge and important relationships built with HIV and TB patients and key government officials (such as the CMO, Health PS, Health Minister, and Finance Minister) over time. High turnover also costs MoHs more money for trainings and onboarding for new staff.
- Without sufficient staff training in the specific needs of HIV and TB patients, low ART adherence, high rates of patients LFU, and perpetuated stigma and discrimination among health professionals may persist.

Possible solutions:

- To augment MoH capacity, assign and formalize roles for CSOs in adherence counseling, patient follow-up, and VCT in public facilities. Their participation would reduce the burden on the limited number of MoH employees to perform these tasks, and they may also help to support PLHIV in remedying stigma and discrimination from health providers. Many CSO members are trained and certified to provide certain HIV testing and counseling services and can fulfill these duties. Ultimately, CSO members could be compensated through social contracting, but in the meantime, the government could provide daily stipends to CSO workers, as has been proposed in St. Lucia. Members of CSOs are well versed in the challenges facing HIV patients and have produced strong results in ART adherence and patient follow-up in both public and private settings (e.g. TLC in St. Lucia). CSO members who are embedded in the HIV and TB patient community may be less likely than an average health professional to seek alternative employment opportunities domestically or abroad.
- Establish a partnership among the HTEP, National AIDS Programs, and health professional schools in the OECS to develop and implement HIV and TB sensitization and care training for new healthcare workers. Consider requesting Global Fund funding to develop and implement a pilot curriculum as part of the next grant.
- Develop a standardized HIV and TB in-service training program to meet the specific needs of each OECS nation. Possible options to explore include the reintroduction of the master trainer model, the engagement of local CSOs to provide periodic in-person trainings to health professionals, and the use of cross-training to ensure that all health team members are familiar with basic HIV and TB care. Consider a matching funds arrangement with the Global Fund to develop and implement a pilot training program as part of the next grant, with national programs gradually increasing their contribution to trainings over the grant implementation period to reach 100%.

Risk A.2: Countries may not adequately **improve their HIV and TB strategic information systems** to record and track new infections, monitor disease burden, and identify gaps in prevention, testing, and treatment, especially among KPs.

Selected as a key risk: Grenada and St. Lucia

Evidence for this risk:

Limited epidemiological data available currently:

- Current published data on the HIV and TB epidemics in the OECS is limited and frequently contested. For example, of the 14 indicators for treatment cascade in the UNAIDS AIDSinfo database, only five indicators have data for each of the six countries. St. Vincent & the Grenadines is the only country to report progress towards the first 90 and HIV prevalence among SWs. Grenada is the only country to report HIV prevalence among MSM. Only St. Kitts & Nevis reports HIV expenditures for 2018.
- National and regional officials contest the validity of UNAIDS Spectrum modeling, but there is currently not a better system in place to estimate key epidemiological features of the HIV and TB epidemics in the OECS region and in the individual countries. A large Global Fund-funded study (Waters et al. 2018) to determine the size of KPs in each OECS country is widely disputed by national AIDS program coordinators, who contend that the population size estimates for MSM, SWs, and TG women are too large.

Efforts to improve monitoring are experiencing challenges:

- Implementation of an eCBS to improve regional HIV and TB monitoring was a key goal of the Global Fund grant. However, full utilization of this system across the OECS is not yet achieved. Some national programs, such as those in Antigua and Grenada, consistently upload testing results. Others have not entered data regularly, citing inoperability or other technical issues (see below). Only select CSOs contribute directly to the eCBS system: United & Strong, SKN CARE, and GrenCHAP. Antigua's national program uploads data from CSOs 3H and WAR. There is almost no contribution to the eCBS from private sector unless the physician volunteers to share this information.
- Interviewees from St. Lucia report that the eCBS is not compatible with their national HMIS. In order to upload information to the eCBS, an MoH official must copy the data from the national online system. A Global Fund-funded consultation to rectify this interoperability issue is pending.
- Some testing facilities record HIV testing results on paper. (Interviewees in Dominica, for example, explain that they use paper records because many health facilities do not have Internet access.) Once recorded, testing centers send these documents to the national AIDS office, where an MoH official must copy this data into the eCBS and to the national system, if applicable.
- A final technological issue is the requirement of countries to pay a fee for cloud-based eCBS data storage. At one point in 2019, Grenada failed to pay for this service and was unable to access the system.
- Currently, the data collected via the eCBS is not comprehensive, either for an individual or for a country and its current use can result in misleading generalizations about the conditions in the country. The eCBS is used to record encounters (e.g., an individual HIV test), but national programs have yet to use the system to document cases fully (capturing all testing records including VLs, other bloodwork, medication doses, etc. for a single patient). Moreover, at the country level, limited data reporting to the eCBS results in unhelpful national statistics. For example, Dominica's reported HIV prevalence rate for MSM in 2017 was 16.7%, the highest in the region. However, this value comes from four positive results out of 24 self-reported MSM

tested. Meanwhile, St. Vincent's HIV prevalence rate for MSM was 0%, because none of the 36 self-reported MSM they tested in 2017 happened to be positive. If presented without context, these statistics can mislead and result in poor decision-making.

- Some national program employees, such as in Dominica, reported that they have not been adequately trained in the use of the eCBS, computers are not available at testing sites to upload data, or that they do not have the staff capacity to upload data.

Consequences if this risk is not addressed:

- If the OECS region and states do not have a reliable source of epidemiological data, it is impossible to monitor program performance or make evidence-based plans for the HIV and TB responses. Because of small data samples reported to online systems, national programs may vastly over- or underestimate disease burden in certain KPs and in the population as a whole and thus may target resources and programming ineffectively. Reliable data is key to improving service coverage and quality.
- The continued use of a paper-based HIV and TB testing records system impedes progress towards improved infectious disease monitoring. Paper-based records are more at-risk for loss, damage, or illegibility such that the data is not fully recorded online or contains inaccuracies, and there may be a significant lag time before paper results are uploaded to the eCBS. Using a fully electronic system with a known patient "coding" formula also reduces the likelihood of double-counting HIV-positive patients during testing and inflating HIV prevalence estimates—a commonly cited problem with paper-based systems across the region. Lastly, the use of paper to record results also generates more work; an MoH employee must spend already limited time entering records online.
- The lack of interoperability between a national HMIS and the regional eCBS generates more work for MoH employees, when it would be ideal for an entry into one system to upload directly to the other.
- A failure to utilize the eCBS system represents a missed opportunity to monitor individual patients ("cases") over time. The eCBS can record results for various tests so that healthcare providers can monitor viral load and other indicators in one place. Improved use of the eCBS will help to pinpoint gaps in treatment and identify patients who may not be adhering to their medication.

Possible solutions:

- Deploy Global Fund resources as planned to resolve the interoperability challenges between existing country health databases and the eCBS. Consider using discretionary eCBS funds to purchase laptops for testing sites where needed, with the matching requirement that national governments supply Internet services at the sites.
- Develop an education and communication plan to bring private practitioners on board to participate fully in the eCBS. Policies could require private practitioners to upload HIV and TB data to the eCBS. Currently only a handful of private physicians and labs share data with national health programs, in part because of their patients' desire for confidentiality. This lack of reporting results in incomplete disease burden information. Each country must develop an approach that ensures patient privacy while giving national officials the information they need to effectively implement HIV and TB services and achieve national goals.
- Explore the possibility of a region-wide patient coding system. Currently, only PLHIV possess a patient ID code; upon seeing a code, healthcare providers know that the patient is HIV positive. If all individuals in the region were assigned a unique ID, PLHIV would not be stigmatized with a code, and it would be easier to track patients/cases over time even if they migrate to other OECS islands.

- Investigate alternative methodologies to estimate population sizes of KPs and national/regional HIV and TB burdens. If no suitable alternative is identified, the results of the most recent PSE and UNAIDS Spectrum models should be accepted by national and regional program officials. If other methodologies are to be teste, the next Global Fund grant could be tapped for this purpose. The objective should be to use routine M&E tools to estimate population sizes so that high cost one-off studies do not need to be repeated.

Risk A.3: The six countries may face challenges in overcoming the barriers to an improved **HIV treatment cascade** from its low current levels to reach 90-90-90 targets, without which the countries will not be able to achieve HIV elimination.

Selected as a key risk: Grenada, St. Vincent & the Grenadines

Evidence for this risk:

- Progress towards HIV 90-90-90 targets in the OECS is currently suboptimal. While the percent of the OECS HIV-positive population who know their status has improved from 53% in 2017 to 84% as of December 2019, the second 90 remains low at 46%, and the third 90 currently stands at 51%. The second and third 90s have not changed significantly from 48% each in 2017.
- Improving progress towards 90-90-90 targets was consistently cited as a top priority by all national programs. They universally acknowledged that their achievements, especially to the second and third 90s, were sub-optimal thus far.
- Since 2017, the Global Fund grant has received poor performance ratings (B2 and C categories). The OECS has made limited progress towards the grant's stated goals in KP outreach and treatment, which underlies the low coverage in the treatment cascade.
- According to interviewees, potential causes for suboptimal HIV treatment cascade outcomes are as follows: staff shortages in national AIDS programs; limited HIV sensitization and training for health professionals interacting with PLHIV, which impedes successful outreach, patient follow-up, and adherence counseling; societal norms against adherence to medications; and patients' fear of stigma and discrimination if HIV status is revealed through pharmacy pickups or medical appointments.

Consequences if this risk is not addressed:

- If the OECS countries do not make sufficient progress towards the 90-90-90 targets, HIV elimination (the goal of the current Global Fund grant) will not be possible, and the disease will continue to spread.

Possible solutions:

- Each country should develop plans to improve their HIV cascade, focusing on the bottlenecks that are impeding progress on each of the three 90-90-90 indicators. This plan should then be front and center in the national HIV program.
- Recruit, retain, and train more HIV staff including CSO members, especially those specializing in case finding (see Risk A.1). Other countries in the Caribbean region and elsewhere have developed effective case-finding programs. Lessons learned could be transferred and adapted to the OECS region.
- Train community health aids to respect patient confidentiality. Interviewees have cited incidences of informal and accidental breaches of confidentiality.
- Implement standardized health professional training in HIV and TB care, including sensitization to gender and sexual diversity and issues of confidentiality, as described in Risk A.1.
- Pilot a formal social contracting arrangement for peers/CSO members to conduct counseling and monitoring, especially for new patients and non-adherent patients to ensure they remain on ARVs and virally suppressed (thereby boosting the second and third 90s). Antigua & Barbuda

and Grenada expressed interest in conducting these pilots, while St. Lucia raised the idea of compensation CSO/peer counselors using daily stipends.
- Encourage patients who are currently lost to follow up to return to treatment through special incentives and connect them with a peer counselor as described above.
- Pilot pay-for-performance program to incentivize public hospitals, clinics, and CSOs to expand testing and linkage to care.

Risk A.4. The TB program responses in the six countries are **not adapting rapidly enough** to respond to a potential surge in TB, especially cases imported through migrant labor. **Political awareness, support and national funding** for expanded TB services will need to increase to meet this new reality.

Selected as a key risk: Dominica

Evidence for this risk:

- There has been a resurgence of TB cases in Dominica in the past 1-2 years. In 2019, Dominica reported 9 TB cases. As of March 2020, Dominica had 19 cases of TB. A Dominican TB official believes that these reports do not capture the full extent of the TB burden in the country. As a result of this resurgence, TB has moved "from the back burner to being a high-priority issue" in the country.
- National and regional TB experts hypothesize that the rising TB incidence is fueled by migrants who come from outside the OECS, particularly from the Dominican Republic and Haiti, though there are no published data to confirm this. There is no required TB screening of migrants. Many migrants, especially those who are undocumented, are reluctant to be tested for HIV and TB or seek medical treatment once they are in the OECS.
- There is limited MoH penetration into migrant communities in Dominica. (A notable exception is the successful employment of a Spanish-speaking SW community animator in the National AIDS Program. This individual liaises with the SW population about HIV/AIDS issues.) Migrants are highly mobile; Dominican TB officials report that it is difficult to follow up on testing with a migrant patient who is suspected to have TB.

Consequences if not addressed:

- Inter-island migration and travel in the OECS is high. An outbreak of TB in one country can quickly spread to others.
- The OECS is on the cusp of TB elimination, according to the WHO. The resurgence of TB as observed in Dominica (a sentinel country) jeopardizes this goal.
- Because TB is not currently a high priority in health outside of Dominica, MoHs may have difficulty scaling up TB services and allocating appropriate resources to the TB response in the event of a large outbreak.

Possible solutions:

- In Dominica and any other country experiencing a rise in TB cases, increase domestic funding for MoH outreach and TB testing in migrant communities, and employ community animators who speak the first language of the clients. (Note: Haitians typically speak and understand the Creole used widely throughout the OECS and many communities may require Spanish.) Migrants' rights should be protected regardless of TB status.
- Implement pre-migration TB screening throughout the OECS, as recommended by the Dominican MoH.
- Seek financial and technical support from PAHO/WHO to design a specialized TB surveillance and treatment program focused on migrant populations in the OECS, as part of PAHO's ongoing collaboration with the HTEP and the Global Fund.

3.4: Financing Risks

B. Financing

Risk B.1. Domestic funding may not be allocated in a timely way to sustain HIV and TB **laboratory maintenance and purchase of ARVs, VL reagents, test kits and condoms/lubricant,** especially because due to the fiscal strains of Covid-19, shifts of national budgets to other diseases, the expected phasing down of Global Fund grants in this area, and the occasional natural disaster.

Selected as a key risk: Antigua & Barbuda, Dominica, St. Kitts & Nevis, St. Lucia

Evidence for this risk:

- Global Fund funds have financed a large share of HIV and TB medical supplies in OECS countries: 55% in Antigua & Barbuda, 16% in Dominica, 65% in St. Kitts, and 29% in St. Lucia.
- Domestic fiscal space for increasing HIV and TB commodity expenditure is very low or nonexistent, as countries have significant debt to GDP ratio: In three of the islands this ratio is above 80%, and in two above 70%. Only St. Kitts and Nevis, with a ratio of 62% is close to the IMF recommended ceiling (60%).
- IMF has estimated an overall GDP contraction of 5-10% and a 50% reduction in tourist income in the OECS due to the Covid-19 pandemic
- IMF has identified substantial inefficiencies in the tax systems of the OECS and low tax compliance, and government payroll has been inflexible so that additional revenues from taxes seem unlikely. Moreover, requirements on beneficiaries and social welfare programs will increase, further indebting the governments.
- Scaling up the response to reach the 90-90-90 targets will require additional funds, which may be significant at a time of reduced financial security. Preliminary calculations, based on expenditure and coverage, indicate a need for additional resources to cover ARVs equivalent to 0.6% of MoH budget for Antigua & Barbuda, Dominica, and St. Kitts, and 2% for St. Lucia. Diagnostic and monitoring tests and condoms would require an additional US$1.5 million per year for the four countries.

Consequences if this risk is not addressed:

- Reductions of available ARVs and tests will translate in lower achievements in reducing new infections and lost gains in the 90-90-90 targets.
- More PLHIV will have to pay out-of-pocket for medications, with the possible decrease in the number of PLHIV on treatment, as well as decreased viral suppression.

Possible solutions:

- National funds required to replace Global Fund financing for HIV commodities (including supply management expenses) are a small fraction of current MoH budgets. Governments need to allocate these funds as part of Global Fund transition, and these commitments should be spelled out in transition agreements.
- Consider cost-sharing between national governments and the Global Fund as soon as possible for laboratory equipment, e.g. a 50/50 cofinancing strategy.
- National and regional experts should advocate with governments to pay for lab and other commodities, demonstrating the importance of these investments and how they have helped the OECS to build a resilient system for testing for Covid-19.
- Identify ways to increase efficiency and cost-effectiveness of laboratory services, setting specific targets for savings through e.g., product selection and procurement.

Risk B.2: **UHC/national health insurance schemes** may not be implemented before Global Fund financing ends. Guaranteed benefits may not cover 100% of the population, such as low-income households and non-nationals. Covid-19 is likely to exacerbate this situation.

Selected as a key risk: St. Lucia

Evidence for this risk:

- Of the six countries, only Antigua & Barbuda—which is planning the expansion of the current Medical Benefit Scheme—is in an advanced stage of NHI development. The other countries are either in the design stage or implementing limited pilot programs, and it is not expected that they will have a functioning NHI system in the next two years.
- Antigua & Barbuda covers HIV treatment under its current MBS insurance scheme. Countries at the design stage have all included HIV treatment in their benefit packages, but there is no guarantee that the final design will cover all aspects of HIV treatment and care for all people.

Possible solutions:

- Sustain ongoing advocacy for including HIV and TB in UHC packages.
- Communities of PLHIV and CSOs need to position themselves as important voices in the national dialogue on NHI. Consider the use of Global Fund grants to promote discussions within the community, create an advocacy group, and develop a position paper.
- Ensure HIV and TB testing, counseling, and treatment are free at point of care for all residents regardless of ability to pay, including non-nationals.
- Non-national residents should be eligible to opt into NHI, for example by paying the average cost of the package adjusted for age and gender.
- Explore earmarked levies on tobacco, alcohol, or luxury goods to finance HIV and TB components of NHI packages.

Risk B.3: The six countries may not appropriate adequate funds to pay for **KP programming**, directly or through public-private partnerships and social contracting mechanisms, resulting in incomplete HIV and TB services for KPs.

Selected as a key risk: Antigua & Barbuda, Dominica, Grenada

Evidence for this risk:

- The areas of the regional and national HIV and TB response most reliant on Global Fund funds (and therefore most at-risk for loss of funding) are KP outreach and prevention services, including the distribution of condoms and lubricants. The six countries received US$1.1M in the first implementation period (2016-2019) for prevention programs for KP (MSM, TG people, and SWs and their clients), and US$950K has been allocated for the second implementation period (2019-2022).
- Currently, there is no or little domestic funding for targeted programs for KP. Funding for KP services primarily comes from CSOs (including their external partners) and the Global Fund. The vast majority of outreach and prevention work targeted at KPs is carried out by CSOs.
- There is currently no formal public-private partnership or social contracting mechanism to engage CSOs in the KP HIV and TB response. There is little to no history of the use of social contracting in any government sector in the OECS. In-kind subventions are the most common form of government support to civil society.
- Interviewees were not optimistic that HIV and TB programs for KPs would be prioritized for additional funding when Global Fund resources decline. They stated that resources for KP services "will be missed."

Consequences if this risk is not addressed:

- The OECS HIV epidemic is concentrated among KPs, especially MSM. Without strong outreach and prevention services catered to these vulnerable communities, countries will not reach the 90-90-90 targets, and new infections and deaths from HIV could rise.

- CSOs conducting the bulk of KP outreach and prevention efforts currently rely on Global Fund-funded commodities and other external resources. As the Global Fund and other small CSO donors exit the region, CSOs may not have the financial capacity to continue their services without new support from domestic resources.

Possible solutions:

The narrative following this table describes each of these options in greater detail:

- Investigate new sources of financing such as private philanthropies and the private sector. Explore donor mapping exercises that have been successful in bridging the KP/CSO funding gap for HIV in other contexts.
- Explore the implementation of Debt to Health swaps where lenders forgive country debts, and in return, governments commit the freed debt repayment resources to KP programming.
- Develop volunteer and internship agreements with public and global health programs in the region and around the world to serve as an interim solution for a lack of skilled labor.
- Explore whether some HIV and TB programming, including for KPs, could be designed and administered at the regional level. The RCM and OECS HTEP could oversee such regional programming.

Risk B.4: Governments may not develop **adequate financial monitoring systems for HIV and TB programs**, especially as Global Fund support for M&E declines, resulting in insufficient accountability and reduced capacity to identify and plan for transition and NSPs.

Selected as a key risk: Dominica, St. Kitts & Nevis, St. Lucia

Evidence for this risk:

- No country regularly prepares an up-to-date report on HIV and TB revenues and expenditures; allocations are split among multiple budget lines and accounts and are difficult to parse out.
- Two countries (Grenada and St. Vincent & the Grenadines) were unable to provide data on domestic HIV spending. None of the countries could provide expenditure on human resources devoted to HIV and TB prevention and care, as these are lumped with overall MoH wages and emoluments.
- Reliable financial monitoring is a prerequisite for creating viable and sustainable NSPs, especially those that include separate budget lines for each disease. Many countries shared concern in workshops for NSP development, and financial monitoring is a key step.
- Countries do not have a budgeted M&E component in their HIV and TB National Strategic Plans.

Consequences if this risk is not addressed:

- Expenditure is one way to track the scope of the HIV and TB response. Without expenditure data, monitoring and evaluation of national and regional responses is hampered.
- In a resource-constrained setting with reduced fiscal space, such as the OECS, harnessing savings from efficiency gains is one of the only feasible options for scaling up a health response. Without knowledge of costs and expenditures, it difficult to understand the cost-effectiveness of the different interventions and to allocate resources to those activities which yield the highest gains.

Possible solutions:

- Countries should conduct annual HIV and TB budget and expenditure monitoring, drawing on a range of sources including national health accounts, program-based budgeting, records of national purchases of HIV and TB medical supplies through OECS pooled procurement, annual or quarterly time-surveys of health-workers, and hospital records of PLHIV hospitalized and outpatient care.

- Although comprehensive health accounting is the gold standard for the countries to implement in the coming years, the OECS could take intermediate steps right away by systematically recording national spending on HIV and TB medical supplies through OECS pooled procurement. This spending should be assigned to clear categories: ARVs and TB medications to "treatment," VL/CD4 testing equipment and other laboratory items to "laboratory," rapid test kits and other diagnostic tests to "testing," and other supplies to "promotion and prevention."
- Expenditure on health professionals can be estimated through annual or quarterly "time-surveys" in which a sample of providers is asked to report the hours per week estimated to devote to HIV and/or SRH promotion and prevention programs, treatment and care.
- To capture spending in the care of opportunistic infections, hospitals can record the number of PLHIV that are hospitalized or seek outpatient care for these infections. Alternatively, a rapid-survey of hospitalized patients can be conducted once per year. Once the number of persons is recorded, an estimate of total costs can be constructed using a simple calculation of average cost of hospital stay or consultation.
- Once social contracting is initiated, contracts should specify spending by program area to facilitate expenditure tracking and analysis, e.g., counseling and education, testing, stigma and discrimination reduction.

Options to Increase Domestic Allocations for HIV and TB and Improve Efficiency of Health Spending

There is wide heterogeneity in the share of donor financing for HIV that directly reaches the countries. Based on available data, Dominica is the least dependent on external funding (6% of HIV spending sourced from donor resources), and St. Kitts & Nevis is the most dependent (50% financed from external sources). Substituting these donor resources with domestic government funding will require additional fiscal effort. Dominica would have to increase its reported HIV spending by 7%, Antigua & Barbuda by 17%, St. Lucia by 25%, and St. Kitts & Nevis by 48%. (Note that no data was available for Grenada or St. Vincent & the Grenadines.) This increase in domestic spending translates to an additional US$20,000 annually in Antigua & Barbuda and between US$85,000 and US$100,000 annually in the other three countries. These additional resources represent a maximum of 0.5% of MoH annual expenditure.

The amounts detailed above would be sufficient only to maintain the status quo. If countries seek to scale up the response to reach the 90-90-90 targets, additional funds will be required. Back of the envelope calculations, based on current ART expenditure, coverage of ART, and viral suppression rates, suggest additional resource requirements for ARVs equivalent to 0.6% of the annual MoH budget for Antigua & Barbuda, Dominica, and St. Kitts & Nevis, and 2% of the annual MoH budget for St. Lucia. Condoms and lubricants, diagnostic tests, and VL/CD4 tests would require an additional US$1.5 million per year for the four countries.

As of the writing of this report in 2020, the countries of the OECS face significant challenges from the Covid-19 pandemic as detailed in Chapter 7. Countries in the OECS face annual GDP declines ranging from 4.7% to 10%. As of the workshops in fall 2020, stakeholders explained that they have already seen the destructive economic consequences of the virus, including a "frightening rise" in poverty and massive fiscal strains on health departments (e.g. Dominica faces a 60% budget cut across the board).[86] Accordingly, many of the national health leaders expressed concern that HIV and TB may not receive additional funds in the coming months and potentially over the next year.

[86] September 2020 workshops.

Given the fiscal constraint in OECS countries, especially with the conditions posed by Covid-19, a combination of strategies is suggested to prevent a scaling-down of the HIV and TB response in the short and medium-term: leveraging private resources, increasing health spending efficiency and reducing waste, and accelerating NHI implementation.

Leveraging Private Sector Resources

To increase the amount of funds for the national HIV and TB response, countries must leverage private-sector resources. An initial strategy should be to increase the grant-seeking capacity of CSOs involved in the response (see KP/CSO Risks below). While large donors such as PEPFAR no longer provide HIV and TB funding to OECS countries, other players in the philanthropic and development aid sector are increasing their participation. These funders include private foundations, oil-rich countries, and nations seeking a new presence in the Caribbean region. Among donors, there has also been a shift to favor financing effective and innovative grassroots programs (including CSO operations) to be scaled up. To illustrate, official development assistance to CSOs by OECD countries has increased 4 percentage points since 2010. In 2017, OECD countries gave US$20B directly to CSOs, of which US$1.3B went to CSOs in developing countries. Pallas and Sidel (2020) suggest that mapping national, regional, and other donor sources for countries transitioning away from Global Fund funds can help countries bridge anticipated financial gaps. The Global Fund program SHIFT resulted in Malaysian CSOs' successful transition away from traditional donors towards other external funders. Among the strategies employed was an exercise to facilitate CSOs' use of and access to strategic information on HIV/AIDS financing. Tapping into national sources of wealth, such as from well-off citizens or private firms, should also be explored.

Taking advantage of study abroad or development internships, which have gained popularity among college and graduate programs in global and public health around the world, can provide much-needed rotating skilled labor force for regional CSOs. Internships can also be coordinated through local universities to take advantage of synergies in research and network building. The disadvantage to this approach is the short-term nature of internships; however, this opportunity could serve as an interim stopgap solution to build CSO capacity.

Given the high debt of OECS countries, explore Debt to Health (D2H) relief programs. In these programs, lenders forgive country debts, and in exchange, the national governments commit to devoting the freed resources to health programs.[87] This arrangement would be a win-win strategy for the OECS and should be seriously considered. Some countries expressed interest in this option during workshops, though many were unfamiliar with this option.

Increasing Health Spending Efficiency and Reducing Waste

In a resource-constrained setting, allocating funds to the most effective interventions and generating savings from reducing waste is of paramount importance.

Programs aimed at identifying and reducing inefficiency and waste have proven very effective at freeing resources.[88] Replicating effective program delivery strategies that are being implemented around the Caribbean and in OECS member states is one step towards increasing efficiency. Such efforts can start with a benchmarking exercise and with an exchange of experiences among regional stakeholders. Once best practice programs or strategies have been identified, implementation partnerships can be established in which countries with successful programs mentor other countries in applying lessons learned.

[87] For more information about the role of the Global Fund in D2H initiatives, see, e.g.: https://www.devex.com/news/global-fund-relaunches-debt-to-health-swaps-after-six-year-hiatus-91642

[88] OECD, 2017.

Priority should be given to fully implementing the eCBS system that has been developed as part of the current Global Fund grant. Information is a prerequisite to lead an efficient response; it helps shift resources to the most effective areas and programs. In the medium term, once the eCBS system is fully operational, efforts to cost services should be the next step to target resources to the most cost-effective strategies. Costing exercises should take care to include all inputs, even those that are currently donated or obtained at below-market prices.

It is possible that some HIV and TB programming, including for KPs, could be designed and administered at the regional level to take advantage of economies of scale. Delivery and implementation can be performed with a combination of regional and country-specific resources. Overseeing regional initiatives could be a future mandate of the Regional Coordinating Mechanism and the OECS HTEP.

Finally, pay-for-performance programs in the primary care setting, such as those implemented in the program *Salud-Mesoamerica*, have shown significant improvements in outcomes without substantial increases in resource needs. These programs give moderate monetary incentives to primary care workers who reach targets in health screening and other outcomes. A pilot program for HIV and TB screening could be explored, and depending on the results, scaled up.

Accelerating National Health Insurance Implementation

In the medium run, accelerating the implementation of NHI is a priority. NHI, if done well, should improve coverage of and adherence to ART. NHI usually comes hand in hand with the development of information systems to manage claims and monitor health results.[89] The HIV monitoring and surveillance systems currently being designed have should be compatible with NHI health monitoring systems. CSOs should quickly position themselves to advocate for PLHIV during discussions of NHI design and implementation to guarantee that the interests and needs of PLHIV are meet and that CSOs are effectively incorporated as important actors in the response.

In the medium term, countries should continue with efforts to improve the efficiency of their tax systems, including serious consideration to raising taxes on alcohol, tobacco, and sugary beverages, which would provide both savings from lower disease burden and much-needed revenue. Temporary taxes face lower resistance than permanent ones, and if a temporary tax were earmarked to finance a tangible gain in a country's wellbeing, it might even be well-received.[90] Temporary (two- to three-year) taxes on wealth or luxury goods can also be considered to fund the investments needed to transition to NHI, such as information and monitoring systems, and design consultations.

3.5: Governance Risks

C. Governance
Risk C.1: The **RCM and HTEP**, which play an important coordination and technical assistance role in the OECS, may not continue to function with the departure of the Global Fund, with potential negative impacts on country responses. The lack of a plan to integrate the HTEP in the OECS Commission's health unit exacerbates this risk.
Selected as a key risk: Regional OECS and HTEP leadership, St. Vincent & the Grenadines
Evidence for this risk:

[89] Not infrequently, efforts to implement NHI emphasize financial resources and financial protection objectives and lose sight of the primary purpose, which is improving health outcomes. It is essential that monitoring and surveillance of health outcomes are embedded in the design and implementation to provide much-needed information to steer the health system.

[90] Colombia, for example, imposed a temporary wealth tax to fund its peace process, and the US used these during the Great Depression.

- The RCM serves as a forum for HIV and TB experts from government and civil society across the region to share knowledge and ideas, especially those relating to sustainability. RCM members also work together to coordinate the regional response and to support programs and CSOs that are experiencing financial or management challenges. When the Global Fund ended its first grant to the OECS region in 2011, the RCM remained in existence only through the will of its chair, who ran RCM meetings from her home. Without strong leadership and buy-in from the six countries' RCM representatives as transition approaches, the RCM may dissolve when the Global Fund fully withdraws from the OECS.
- The Global Fund currently funds HTEP salaries and other management costs at about US$850,000 over three years, out of the total US$3.5M grant. Without Global Fund resources, it would be challenging for the HTEP to continue providing support to the OECS countries. The HTEP currently oversees financial and technical assistance for HIV and TB programming in the OECS and liaises with international organizations such as the Global Fund, PAHO/WHO, and others. The HTEP also monitors regional progress towards HIV and TB elimination goals. While it was beyond this project's scope to analyze the performance of the HTEP and RCM mechanisms, there may be scope for further improvements in their efficiency and effectiveness, including through integration of HTEP with the OECS Commission's health unit.

Consequences if this risk is not addressed:

- If the RCM dissolves, this regional support network and knowledge sharing forum for national HIV and TB programs and key CSO leaders will be lost. The existence of an RCM is critical for writing regional grant applications, and in its absence, the region may be unable to apply for new funding opportunities.
- In the absence of the HTEP, national governments must tackle their national HIV and TB epidemics without the support and technical expertise offered by HTEP staff and global partners. The regional public goods stewarded by the HTEP would no longer be available. It is not clear how the eCBS would be maintained or its data utilized.
- The dissolution of the RCM and HTEP would be especially challenging for the OECS states with higher incomes that are ineligible or low-priority for international funding and technical support. Countries with lower incomes, such as St. Lucia, are expected to maintain eligibility for international assistance in the medium term and may have an easier transition to an individual country-led response.

Possible solutions:

- Integrate HTEP's functions in the OECS Health Unit, allocating OECS budget for this purpose. This would enhance the sustainability of the regional coordination, monitoring, information sharing, and technical assistance activities once Global Fund support ends.
- Investigate national sources of funding for HTEP activities from the six countries' domestic budgets. Options could include earmarked budget contributions and surcharges on HIV and TB/laboratory products procured through the PPS.
- Explore the idea of converting the RCM to a regional NGO. ECADE is an example of a successful regional NGO.

Risk C.2: National leadership and political support for HIV and TB responses may weaken or fluctuate in certain countries, making it hard to sustain the HIV and TB responses during political cycles and changing governments.

Selected as a key risk: St. Kitts & Nevis

Evidence for this risk:

- National program coordinators and CSO officials report that political support for the HIV response depends heavily on individual "personalities" of key leaders, such as the Minister of Health, PS of Health, and CMO. For example, interviewees in St. Vincent & the Grenadines report that their Minister does not agree that certain vulnerable groups (such as SWs or MSM) exist in the country. Under the leadership of such individuals, it is very difficult to address key segments of the population through government outreach, education, etc. In contrast, Antigua & Barbuda has built bipartisan support for the National AIDS Program, and so funding and high-level support for HIV and TB initiatives are not in jeopardy when new officials take office.
- There is a lack of accountability mechanisms to monitor political support for and domestic investment in HIV and TB. National Strategic Plans for HIV and/or TB are just beginning to be revised after expiring in the mid-2010s, so up-to-date national targets, against which current progress could be measured, are limited. Furthermore, some countries do not have a specific budget line for HIV or spread HIV funding across different line items. Where HIV funding is lumped into other health spending, officials can reduce funding for HIV with easy discretion. With notable exceptions, such as Antigua & Barbuda, expenditure reports for HIV and TB are limited or challenging to develop, so there is minimal accountability for sustained government spending in these areas.

Consequences if this risk is not addressed:

- National AIDS and TB programs have limited financial security if the national HIV and TB response is not fully embraced by all political parties. With changing governments and minimal expenditure monitoring mechanisms, program leaders may experience unexpected budget cuts from year to year, impeding medium- to long-term HIV and TB planning efforts.
- Support from high-ranking political officials is necessary to implement HIV and TB programming. If top political figures are uncomfortable with certain initiatives, such as those involving key populations, and there are no evaluative metrics to monitor program performance, they may refuse to support key HIV and TB outreach programs and services with minimal political repercussions.

Possible solutions:

- Establish dedicated budget lines for HIV and TB in all six countries' health budgets. Eliminate the practice of lumping HIV funds with other health line items. The development of these budget line(s) could be a condition for Global Fund grant support.
- Update the NSPs in each country with the assistance of PAHO, UNAIDS, and/or PANCAP. Engage all stakeholders to promote widespread and bipartisan support of the HIV and TB response. Use the NSPs to demonstrate the benefits and ROI of smart investments in HIV and TB.
- Examine pros and cons of realigning HIV and TB programs with other priority areas, including NCDs and climate change and health, to raise political visibility and sustainability. St. Vincent & the Grenadines has tied some health programming to climate change to improve external funding opportunities and enhance bipartisan support for health.
- Share documents and best practices on national strategic planning across countries.

3.6: Key Populations and Civil Society Organizations Risks

The three risks shown below and the proposed solutions are so closely interrelated that they should be considered together as a single package for adoption by the six OECS countries. Risk D1 covers the legal and administrative frameworks for social contracting; Risk D2 addresses the limited capacity of CSOs to manage social contracts; and Risk D3 focuses on mobilizing domestic financing to implement social

contracting. All three risks must be mitigated together and the proposed actions must be undertaken simultaneously to sustainably support CSOs in their critical partnership role with OECS governments.

D. Key Populations and Civil Society Organizations
Risk D.1: The six countries may not have the **legal/administrative framework and procedures** for conducting social contracting.
Selected as a key risk: Antigua & Barbuda and St. Lucia
Evidence for this risk: • Most government representatives were aware of social contracting (SC) as a sustainability strategy and were interested in learning more. SC is being promoted by the Global Fund and explored in other Caribbean locations such as Jamaica and Guyana. • Administrative frameworks for SC—such as an operationalization plan, key staff appointments in the relevant MoH unit(s), standardized application forms and evaluation processes, and the legal or policy documentation that supports SC, multisector oversight committee—are not yet in place. While there are some examples of CSO support by government in the past decade or more there is no known SC precedent in the OECS. MoH must build capacity to manage SC, including but not limited to open procurement processes to ensure transparency. However, to date, all MoHs in the OECS have supported HIV and TB CSOs through commodity/in-kind donations but not necessarily through direct monetary provision. • Several high-ranking MoH officials have stated a reluctance to conduct SC with KP-focused CSOs. These interviewees reported a fear that the public may perceive SC as endorsing illegal/stigmatized activities (such as same-sex intimacy and sex work). They may prefer politically "safer" CSO engagements such as sharing HIV commodities and collaborating on World AIDS Day events. • The CSOs that cater to MSM and SW operate in a context of legalized discrimination against their focus communities. Laws such as the Buggery Act and Gross Indecency Act inhibit LGBTQ+ individuals and SWs from reporting abuse and other crimes, including those committed by health providers.
Consequences if this risk is not addressed: • Countries will be inhibited from using SC as a mechanism to support CSO engagement as HIV and TB service providers, especially for KPs. Because the HIV epidemic in the OECS is concentrated among KPs, the regional treatment cascade may suffer. • Without formalized legal frameworks and policies for SC, incoming politicians who disapprove of the use of public funds to support KP-focused CSOs may easily dismantle the SC program. • SC is way to promote sustainability in CSO financing. As Global Fund and other external donors depart from the OECS region, CSOs will look increasingly to the government for financial support to carry out HIV outreach and prevention activities. If this support is not forthcoming the number of cases could increase due to the communities going further underground and loss of gains made. SC, an important tool to promote CSO financial sustainability, may not be implemented without formal administrative and legal frameworks. • CSOs that rely on grants or subventions from government are necessarily beholden to political considerations; if the CSO does something to anger the MoH, their subvention may be withdrawn without any recourse. However, when CSOs and the MoH are connected through formal SC mechanisms and frameworks and these applications are assessed by an independent multisectoral body, CSOs can maintain an outspoken advocacy role without worrying as greatly about political and financial ramifications.
Possible solutions:

- Develop steering committees in interested countries to design national social contracting policy, prepare plans, sensitize stakeholders, and secure budgets. (Examples of steering committees in other parts of the Caribbean are the Civil Society Bureau in Barbados and the national sustainability and transition high-level committee in Jamaica.)
- Use Global Fund grant resources to analyze and improve legal frameworks and regulations for social contracting. Antigua & Barbuda and Grenada have expressed an interest in these pilots.
- Disseminate best practices to the six countries drawing on experiences from nearby countries with successful social contracting (e.g. Mexico, Guyana).
- Phase in government contracting of CSOs (using national budgets) as part of the co-financing requirements of the next Global Fund grant.

Risk D.2: CSOs working in HIV and TB remain fragile and face challenges in developing adequate capacity to provide adequate, consistent, high quality services to all KPs. Without increased capacity and the necessary skills and systems, social contracting may not be successful even with the appropriate government financing.

Selected as a key risk: Grenada

Evidence for this risk:

- CSOs in most OECS countries are small and informal, with few staff who mainly work as volunteers. (For example, SKN CARE has one staff member who is a volunteer, and MESH in Antigua is run by two volunteers.) It may be difficult to professionalize these CSOs and prepare them to submit proposals, monitor outcomes and finances, and report their results, as will be required to obtain funding through formal SC.
- PEPFAR previously supported CSO capacity building in the region, including financial management, proposal writing, and project implementation monitoring training, but these programs ended upon PEPFAR's departure in the mid-2010s. Other donors, such as the Global Fund and small foundations, that emerged to fund the regional HIV and TB did not focus as strongly on CSO development, and many local CSOs folded or lost significant human resource capacity. High staff turnover and minimal M&E reporting resulted in loss of institutional memory. This historical precedent foreshadows the challenges that current CSOs will face as the last external funders exit the OECS region.

Consequences if this risk is not addressed:

- CSOs will not have the capacity to bid for RFPs or participate for SC, even if the country governments were to find funding, as the SC application process would require proof of capacity and structure.
- Fragile CSOs that cannot obtain funding or develop human resource capacity may be at risk of closing and therefore would not be able to continue their important KP outreach and prevention services.

Possible solutions:

- Form an umbrella CSO in each country to promote strategic partnership among existing CSOs. (For example, AAF in St. Lucia is already such an umbrella organization, working with four CSOs in the country.) Where relevant, small one- or two-member CSOs may merge into a larger entity (e.g., GrenAIDS and GrenCHAP), while others may choose to stay separate but affiliate with the umbrella entity (e.g., the NGOs associated with St. Vincent's Marion House).
- Allocate a combination of Global Fund grant financing and national budgets to support CSOs with capacity building in management, financing, and administration, and with office space. (The St. Lucia Child Development Center, funded by the MoH, could be an example.)
- Strengthen a pan-OECS network of CSOs.

Risk D.3: The six governments may not be willing or able to **allocate budget funds for social contracting,** leading to a decline in CSO effectiveness in the OECS as the Global Fund winds down as a source of funding**.**

Selected as a key risk: Antigua & Barbuda, Grenada, St. Lucia, St. Vincent & the Grenadines

Evidence for this risk:

- The required reporting of KP-related indicators to the Global Fund has been a catalyst for governments to focus on, and plan for, HIV and TB outreach and services in vulnerable communities. Without an external mandate by the Global Fund to focus on these groups, governments may not prioritize funding for partnerships with CSOs focusing on KPs in the future.
- In addition to identifying domestic funds to pay CSOs for services through SC, national MoHs must allocate resources to develop SC administrative structures. Staff will need to be trained in the full SC process of preparing a standardized application form and process, preparing a Request for Proposals, evaluating applications, issuing contracts, and monitoring progress. Other critical MoH activities include the identification of what activities need to be outsourced and the costing of these services.
- The countries fall into three categories of SC readiness: ready to move forward with SC (Antigua & Barbuda and Grenada); willing to explore it (St. Kitts & Nevis and St. Lucia); and not ready for SC in the near term (Dominica and St. Vincent & the Grenadines).
- Despite the expressed eagerness of the national AIDS programs in Antigua & Barbuda and Grenada to implement SC, no SC proposal has yet been put into writing. A formal proposal, approved by each country's Cabinet, will be necessary to budget public funds for CSOs. However, national AIDS program officials have succeeded in recruiting senior MoH officials to champion SC, an important first step.

Consequences if this risk is not addressed:

- An important benefit of formal SC is that by paying for CSO-delivered HIV and TB services with domestic funds, the governments demonstrate an assumption of responsibility for their health program outcomes and sustainability. A failure to assume this responsibility demonstrates to the international community a lack of growth in the national HIV and TB response.
- If all external funders withdraw and the domestic resources are not made available to support CSO provision of services to KPs (including through SC), then these entities may cease to provide these services, to the detriment of 90-90-90 targets and other health goals.

Possible solutions:

- Task the National AIDS Program and CSOs in interested countries with making a proposal for Social Contracting to senior officials in health, finance, and the Prime Minister's Office. The current Global Fund grant could help to pay for this.
- Countries would at the same time begin to allocate budgets for Social Contracting. Global Fund grant resources could be used to match national allocations, say on a 50/50 basis as part of agreed cofinancing.
- Country governments must determine which HIV and TB services they will outsource to CSOs under the Social Contracts, and estimate the unit and total costs so these can be included in performance-based agreements between government and CSOs.
- Secure the needed domestic funding to implement the SC pilot, including MoH management and monitoring and payments to the CSOs for the services they deliver in HIV and TB.

- Based on pilot results in the first year, governments should continue to phase in contracting of CSOs (via dedicated budget line), expanding the MoH budget for this purpose and reducing the matching funds from the Global Fund.
- The RCM/HTEP could serve as a regional sponsor and knowledge hub for SC.

Chapter 4: Implementation of Sustainability and Transition Actions

The above sections detailed the thirteen key sustainability and transition risks and each nation's chosen key risks. In the chapters that followed, we presented detailed evidence of the risks across the six countries, consequences if the risks remain unaddressed, and possible solutions. This chapter includes some steps that could be taken by the individual country governments, the regional secretariat and HTEP, and by the Global Fund to implement chosen solutions.

With one more year remaining in the current grant and a new 3-year grant on the horizon, the countries of the OECS and the Global Fund have at least a four-year timeframe for creating and carrying out sustainability and transition "action plans." While this may seem like a long time, the four years will pass quickly, so it is important that the six countries, the RCM, and HTEP be ready on January 1, 2021 to carry out selected actions.

National Action Plans

It is suggested that each of the six countries develop, through a rapid stakeholder consultation process led by the national HIV/TB manager, a brief action plan of roughly 2 pages that details the 3-5 key sustainability and transition actions the country intends to pursue during 2021-24, with special focus on the first 24 months. This can be completed during an NSP process, but we urge the six countries to develop these action plans during November-December 2020 and to have them finalized by March 1, 2021 when the upcoming funding request will be submitted to the Global Fund.

To compile this brief action plan, each country can use a standard matrix such as the one attached below in Figure 4.1. The plan should ideally include: (1) the proposed action, (2) the lead and supporting agents, (3) the steps that need to be taken for implementation, (4) the timeline, and (5) the estimated costs if known. Figure 4.1 is an example of a portion of a completed action plan from another country in the LAC region.

A draft template for each country has been prepared in Annex 14, based on the workshops held in the autumn of 2020. The draft solutions and risks are the ones chosen by each country. Each country can add or remove rows to customize to its own needs. Once completed, the action plan should ideally be endorsed by stakeholders and adopted by the MoH as its commitment to sustainability and transition. The action plan can also assist the NAPCs as advocacy materials in meetings with senior leadership.

Throughout this process, the RCM and HTEP can provide critical support to countries, in the form of technical assistance, coordination, and sharing of lessons across countries.

Figure 4.1: Example of National Action Plan for Country X

Mitigation Action	Lead Agent	Supporting Agents	Implementation Steps	Timeline				Estimated costs
				1st half 2021	2nd half 2021	1st half 2022	2nd half 2022	
1. Finalize the NSP for HIV and TB and obtain buy-in from government officials	NAPC	MoH, CSOs, private sector	1. In close alignment with the NSP review process, facilitate stakeholder meetings and a workshop to confirm the vision, targets, and main activities of a sustainable HIV program	X				USD XX,XXX
	NAPC	MoH, government officials	2. Develop and implement an advocacy strategy to brief and convince senior officials to support the NSP	X	X			USD XX,XXX
2. Develop and implement policy and performance-based framework for contracting CSOs for relevant services	NAPC	CSO partners	1. Conduct an assessment of the CSOs best suited to delivering different HIV services	X				USD XX,XXX
	MoH	NAPC, CSO partners	2. Based on the findings of the assessment, develop a policy and procedures to contract CSOs to deliver those services		X	X		USD XX,XXX
	MoH	MoF, NAPC, CSO partners	3. Allocate national budget to pay CSOs as part of a social contracting pilot schemes			X	X	USD XX,XXX

Global Fund Grants

The Global Fund can enhance the implementation of HIV and TB sustainability strategies and national action plans in several ways. First, the Global Fund can engage in policy dialogue with the regional bodies (OECS Commission and RCM) to encourage the design and implementation of the action plans. Second, while the purpose of the plans is ultimately to reduce dependence on outside funding and facilitate a smooth transition to 100% domestic financing, Global Fund grants can also be catalytic in the adoption of sustainability activities by the countries. Reprogrammed money from the final year of the current grant (April 2019 – March 2022) could be used for example to design social contracting pilots, accelerate adoption of electronic case-based reporting system, and develop advocacy plans. The new 3-year grant (2021-23) can also incorporate activities to promote sustainability, for example by co-financing the Social Contracting pilots and by backing the full integration of HTEP within the OECS Commission's health office. For example, if Antigua & Barbuda or Grenada commit to 50,000 USD to pilot social contracting, the Global Fund could match this contribution for another 50,000 USD doubling the overall impact of the nation's investment.

Chapter 5: Conclusions

The nations of the OECS have made substantial progress over the past decades in the fight against HIV and TB, making strides toward achieving the 90-90-90 targets and the elimination of TB. These efforts must be sustained and further strengthened.

This Sustainability Strategy report provides a framework to understand the complex contexts of the countries, especially during the unprecedented challenges posed by the Covid-19 pandemic. It identifies the strengths and weaknesses of the national HIV and TB programs and highlights the 13 key risks that could prevent the six OECS countries from putting in place an effective and sustainable response to the two infectious disease, especially as the Global Fund and other donor financing is waning and will finish in the coming years. It also proposes specific priority actions that the six countries can take to improve their chances of overcoming HIV and tuberculosis and keeping a lid on the two diseases using predominantly national funding and other resources.

Ultimately, to eliminate HIV and TB, the OECS countries must expand their budgetary support for the national disease programs; intensify focus on overcoming stigma, discrimination, and other barriers; use public, private, and CSO resources in a seamless partnership that draws on the strengths of each set of national institutions; and most importantly, build and maintain political backing from top officials from all political parties. If the OECS implements this framework of mitigating actions, the six countries can forge a smooth transition from Global Fund financing to sustainable self-financed HIV and TB responses.

Annexes

Annex 1: Selected List of Documents Reviewed

Epidemiology, Surveillance, and Key Populations

- D'Auvergne, C. OECS TB/HIV Epidemiology Profile. OECS Commission, 2017.
- Waters, J., et al. Estimation of Key Population Size of MSM, Transgender Women, and FSWs in the Eastern Caribbean. Caribbean Vulnerable Communities Coalition and the University of Alabama at Birmingham, 2018.
- Valles, X. Measurement and analysis of key population programs in Eastern Caribbean countries. Global Fund & OECS Commission, 2019.
- Human Rights Watch. (2018). "I Have to Leave to Be Me: Discriminatory Laws against LGBT People in the Eastern Caribbean." Retrieved from: https://www.hrw.org/report/2018/03/21/i-have-leave-be-me/discriminatory- laws-against-lgbt-people-eastern-caribbean
- Rolle Sands, S., Ingraham, K. & Salami, "B.O. Caribbean nurse migration—a scoping review." *Human Resources for Health* **18,** 19 (2020).

World Bank Documentation

- World Bank. IDA Project Appraisal Document to St. Lucia for a Health System Strengthening Project. World Bank, 2018.
- World Bank. IDA Project Appraisal Document to Dominica, Grenada, St. Lucia, St. Vincent & the Grenadines, CARPHA, and the OECS for an OECS Regional Health Project. World Bank, 2019.

Global Fund Documentation

- QRB-C-OECS Budget. April 2019-April 2022. Global Fund, 2019.
- Kerr, T. Performance Letter Progress Report for QRB-C-OECS. Global Fund, 2019.
- Global Fund (2019) "Projected transitions from Global Fund support by 2028" (Nov. 2019). https://www.theglobalfund.org/media/9017/core_projectedtransitionsby2028_list_en.pdf
- Global Fund (2020), Projected transitions from Global Fund country allocations by 2028: projections by component, January 2020 update.
- The Global Fund (2020). *Audit of Global Fund Capacity and Technical Assistance*. https://www.theglobalfund.org/media/9504/oig_gf-oig-20-009_report_en.pdf?u=637319003559270000

Country HIV Investment Cases and External Analyses

- Sanders, Rachel and Lisa Tarantino. December 2014. Sustaining the HIV/AIDS Response in Antigua and Barbuda: Investment Case Brief. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
- Abt Associates. October, 2014. Sustaining the HIV/AIDS Response in Dominica. Bethesda, MD: Health Finance & Governance and SHOPS Projects, Abt Associates Inc.
- Hamilton, Matthew, Josef Tayag. December 2014. Sustaining the HIV and AIDS Response in Grenada: Investment Case Brief, Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
- Kukla, Matthew, Matt Hamilton and Elizabeth Conklin. November 2014. Sustaining the HIV and AIDS Response in St. Vincent and the Grenadines: Investment Case Brief. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

- Hamilton, Matthew and Laurel Hatt. November 2014. Sustaining the HIV and AIDS Response in St. Kitts and Nevis: Investment Case Brief. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
- Hamilton, Matthew and Stephen Musau. November 2014. Sustaining the HIV/AIDS Response in St. Lucia: Investment Case Brief. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
- Health Finance and Governance. HFG Eastern and Southern Caribbean Final Report: 2012-2018. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

Regional Strategies

- PANCAP. Caribbean Regional Strategic Framework on HIV and AIDS: 2019-2025. CARICOM, 2019.
- OECS. Strategic Framework for the Holistic Response to HIV/STI and TB in the OECS: 2015-2020. OECS, 2015.
- OECS RCM. Monitoring and Evaluation Multi-Country Plan for HIV/AIDS and TB: 2019-2021. OECS, 2019.
- OECS. Strategic Plan for Tuberculosis: 2018-20. OECS, 2018.
- CARICOM. Caribbean Regional HIV and Aids Partnership Framework, 2010-2014. "Five year strategic framework to support implementation Caribbean regional and national efforts to combat HIV and AIDS.

Country-Specific Literature

- Antigua & Barbuda. National Strategic Plan for Health: 2016-2020.
- Antigua & Barbuda. Recurrent and Development Estimates: 2019.
- Antigua & Barbuda. HIV/AIDS Country Progress Report: 2015.
- St. Kitts & Nevis. Situation Analysis for the National Strategic Plan on HIV, TB, and SRH: 2019-2024.
- St. Kitts & Nevis. Mid-Term Evaluation of the National HIV/AIDS Strategic Plan: 2010-2014.
- St. Lucia. Estimates of Revenue and Expenditure: 2019-20.
- St. Lucia. National HIV Policy: 2019-2022.
- St. Lucia. National HIV/AIDS Strategic Plan: 2011-2014.

Financing

- Acevedo, S., Cebotari, A., & Turner-Jones, T. (2013). Caribbean small states: Challenges of high debt and low growth. Washington, D.C.: International Monetary Fund.
- Caribbean Development Bank (ND). *2017 Caribbean Economic Review and 2018 Outlook*. https://www.caribank.org/publications-and-resources/resource-library/fact-sheets/2018-caribbean-economic-review-and-2019-outlook
- Cevik S, Nanda V. Riding the storm: fiscal sustainability in the Caribbean. International Review of Applied Economics. 2020 April 9:1-6
- Cover-Kus, H. (2019) Weighing Up Second Passport Power in Small States: A SWOT Analysis of the Citizenship-by-Investment Industry. Small States Matter (1) 201.9 Economic Social and Sustainable Development Directorate, Commonwealth Secretariat.
- Foucade, A., Metivier, C., Gabriel, S., Scott, E., Theodore, K., & Laptiste, C. (2018). The potential for using alcohol and tobacco taxes to fund prevention and control of non-communicable diseases in Caribbean Community countries. *Revista Panamericana de Salud Publica - Pan American journal of public health*, *42*, e192. https://doi.org/10.26633/RPSP.2018.192
- Institute for Health Metrics and Evaluation (IHME). *Financing Global Health 2018: Countries and Programs in Transition*. Seattle, WA: IHME, 2019.
- Kaiser Family Foundation The U.S. President's Emergency Plan for AIDS Relief (PEPFAR). https://www.kff.org/global-health-policy/fact-sheet/the-u-s-presidents-emergency-plan-for/ Published: Nov 25, 2019

- Medical Benefit Scheme, "Latest National Health Insurance Updates http://www.mbs.gov.ag/v2/media/news-2/nhi/#1581538554106-2c532277-3f5e
- Mohan, P., & Watson, P. K. The Impact of the Financial Crisis on CARICOM countries. https://sta.uwi.edu/salises/pubs/documents/TheImpactofFinancialCrisis.pdf
- OECD (2019). Aid for Civil Society Organizations. *Statistics based on DAC Members' reporting to the Creditor Reporting System database (CRS), 2016-2017. January 2019*
- OECD (ND). *Residence/Citizenship by investment schemes*. https://www.oecd.org/tax/automatic-exchange/crs-implementation-and-assistance/residence-citizenship-by-investment/
- OECD (2017). *Tackling Wasteful Spending on Health*, OECD Publishing, Paris https://doi.org/10.1787/9789264266414-en.
- Pallas, C. L., & Sidel, M. (2020). Foreign Aid Reduction and Local Civil Society: Recent Research and Policy Guidance for Donors and International NGOs, *Nonprofit Policy Forum* (published online ahead of print), 20190045. DOI: https://doi.org/10.1515/npf-2019-0045
- Rodriguez, M., O'Hanlon, B., Vogus A., Feeley, R., Narcisse, C. and Charles, J., January 2012. Saint Lucia Health Systems and Private Sector Assessment 2011. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.
- Rodriguez, Michael, Taylor Williamson, Abigail Vogus, Elizabeth Macgregor-Skinner, Donna-Lisa Pena, Wilson, Anneke, Sharon Nakhimovsky. 2012. Saint Vincent and the Grenadines Health Systems and Private Sector Assessment. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.
- UNAIDS financial Data Dashboard. https://hivfinancial.unaids.org/hivfinancialdashboards.html#. Retrieved Nov 3, 2020
- Waithe, K., Gomez Osorio, C., & Blenman, S. (2017). *Together For Prosperity in the OECS: Growth, Development, and Adversity in Small Island Developing States*. IDB Monograph (Country Department Caribbean Group); IDB-MG, 541.
- World Bank (2018) Organization of Eastern Caribbean States Systematic Regional Diagnostic. World Bank. Report Number: 127046-LAC, June 27, 2018.

Covid-19

- IMF Country Report No. 20/157, May 2020
- IMF Country Report No. 20/161, May 2020
- IMF Country Report No. 20/179, May 2020
- Matthews, Lyndsey. (2020). "This is When Caribbean Islands Are Reopening for Tourism." Afar Magazine. August 20, 2020. https://www.afar.com/magazine/first-caribbean-islands-to-reopen-for-tourism-in-june.
- OECS Covid Hub (2020). "OECS Response to Covid-19." Last accessed October 5, 2020. https://www.oecs.org/en/coronavirus-covid19
- UNCTAD (2020)."Impact of Covid-19 on Tourism in Small Island Developing States." https://unctad.org/en/pages/newsdetails.aspx?OriginalVersionID=2341

Other

- Alemnji, G., Edghill, L., Guevara, G., Wallace-Sankarsingh, S., Albalak, R., Cognat, S., Nkengasong, J., & Gabastou, J. M. (2017). Development and implementation of the Caribbean Laboratory Quality Management Systems Stepwise Improvement Process (LQMS-SIP) Towards Accreditation. *African journal of laboratory medicine*, *6*(1), 496. https://doi.org/10.4102/ajlm.v6i1.496

Annex 2: Institutions Represented and Individuals Interviewed for this Report

Institution	Individual Interviewed
Global Interviewees	
Abt Associates	Lisa Tarantino, Senior Associate
UNAIDS	Otilia St. Charles, PANCAP and Global Fund Advisor
U.S. Centers for Disease Control & Prevention	Varough Deyde, Caribbean Regional Office Director
World Bank	Neesha Harnam, Health Specialist, Caribbean Region
Regional Interviewees	
Caribbean Vulnerable Communities Coalition	Veronica Cenac, Co-Chair and Legal Advisor John Waters, Director
OECS Commission/HTEP	Morris Edwards, Technical Specialist Lynette Hardy, M&E Officer Tricia Leo, Project Manager Letitia Nicholas, M&E Officer
OECS Commission/ Pharmaceutical Procurement Service	Brenda Cox, Program Officer Abraham Weekes, Program Officer
OECS Regional Coordinating Mechanism	Joan Didier, Coordinator
PANCAP	Dereck Springer, Director
University of the West Indies	Karl Theodore, Director, Health Economics Unit
Antigua & Barbuda Interviewees	
Central Medical Procurement Unit	Yvelle Charles Jenkins, Senior Pharmacist
Health, Hope, and HIV (3H)/ Men's Health Efficiency Network	Karen Brotherson, 3H Director Rickenson Etienne, Director of Men's Health
Medical Benefits Scheme	Kester Gibbs, Pharmacist
Meeting Emotional and Social Needs Holistically (MESH)	Alverna Innis, Director
Ministry of Finance	Tracelyn John, Sector Planner Cordelle Weston, Senior Budget Analyst
Ministry of Health	Alfred Athill, Director of Pharmaceutical Services Anetta Dowe, AIDS Secretariat Senior Accounts Clerk Ena Henry, Permanent Secretary Ms. Mason, Health Finance Maria Periera, HIV Clinical Care Coordinator Delcora Williams, National AIDS Program Coordinator Oritta Zachariah, TB Focal Point
Mt. St. John's Medical Center	Olsheath Bowen, Emergency Department Physician and Chair Vonetta George, Critical Care Physician Tansy Wade, Quality Department
Private Sector	Yuliecia Harris, HIV Clinical Care Nurse
Women Against Rape	Alexandrina Wong, Director
Dominica Interviewees	
Central Medical Stores	Jasmine Lambert, Director
DomCHAP	Sylvester Jno. Baptiste, Director

Fouche La Vie	Clemencia Boyer, Director
Ministry of Health	Irving McIntyre, Minister of Health Shalauddin Ahmed, Epidemiologist Judy Archibald, NHARP Counselor Lynora Fevrier Drigo, TB Focal Point Lester Guye, National AIDS Program Coordinator Cherusetta Joseph, HIV Clinical Care Coordinator Gilda-Nesty Tonge, Acting Director of Primary Healthcare Kerlani Paul, NHARP Counselor Cleona Peters, District Medical Officer and Infectious Disease Clinic Physician Lujan Taveras, NHARP Community Animator
Minority Rights Dominica (MiriDom)	Daryl Philip, Founder and Director
Other	Julie Frampton, Former NAPC Rennata Langlais, Project Field Officer at Habitat for Humanity
Grenada Interviewees	
GrenAIDS/GrenCHAP	Kerlin Charles, Director
GrenCHAP	Ajani Benoit, Project Coordinator Danielle Greer, Project Officer Kerlin Charles, Board of Directors
Grenada National Council for the Disabled	Carlene Pezar, Secretary
Ministry of Health	Jonell Benjamin, HIV Program Coordinator Shawn Charles, HIV Director, TB Focal Point, Epidemiologist E. Francis Martin, Chief Medical Officer
St. Kitts & Nevis Interviewees	
SKN CARE	Joseph Richardson, Director
St. Kitts Ministry of Health	Dwain Archibald, TB Focal Point Nurse Blanchard, Community Nurse Mary Caines, Community Nurse Sylvester Belle, Health Planner Kishma Cranstoun, Finance Officer Keisha Liddie, Director of Community Health Services, Acting NAPC Londya Lennon-Hanley, M&E Officer Rafael Rosales, Epidemiologist Lucine Pemberton-Vaughn, HIV and Health Educator Joycelyn Blanchard, HIV Case Manager Garfield Alexander, Clinical Care Coordinator Glenville Liburd, Chair National HIV/AIDS Advisory Council
Nevis Ministry of Health	Nadine Carty-Caines, Health Promotion Unit Coordinator Judy Nisbett, HIV Clinical Care Coordinator
Private Sector	Kathleen Ferdinand, PLHIV Care Provider
Unaffiliated	Gardenia Destang-Richardson, Former NAPC
St. Lucia Interviewees	
Ministry of Finance	Kimbert Evans, Economist Alison Griffith McDiarmes, Representative
Ministry of Health	Keisha Anthony, St. Jude Hospital SRH Staff Carnetta Antoine, Victoria Hospital SRH Clinic Staff Sharon Belmar-George, Chief Medical Officer Linda Berthier, Victoria Hospital SRH Clinic Nurse

	Francine Boston, St. Jude Hospital SRH Staff Concessa Charles-Tayliam, Pharmacist Jenny Daniel, Deputy Permanent Secretary Kensley Emanuel, Health Accounts Unit Gail Gajadhar, National AIDS Program Coordinator Ira Isaacs, Quality Assurance Manager Lauren James, Health Planner Junette Joseph, Vieux Fort SRH Staff Delia Peters, St. Jude Hospital SRH Staff Kenyatta Samuel, Ezra Long Laboratory Staff C. Felix St. Hill, Permanent Secretary Lorna Wilson, Infectious Diseases Unit
Private Sector	Stephen King, Physician, Former CMO, Former CMLF Chair Marie Grandison-Didier, Physician, Former NAPC
Tender Loving Care (TLC)	Lisa Albert, Peer Navigator and VCT Provider Tamara Felicien, Communications Focal Point Albina James, Peer and Adherence Counselor Nila Simeon-David, Member
United & Strong	Milly Moses, Educator Adaryl Williams, Director
St. Vincent & the Grenadines Interviewees	
Country Coordinating Mechanism/Marion House NGO Network	Jeanie Ollivierre, Director
Ministry of Health	Charmaine Bailey Rogers, Medical Epidemiologist Lisa Gould Browne, Deputy Health Planner Jose Davy, HIV Clinical Care Coordinator Donna Joyette Bascombe, HIV/AIDS Administrator Simone Keizer Beache, Chief Medical Officer Isolin Thomas, Senior Assistant Secretary for Accounts Cuthbert Knights, Permanent Secretary Mr. Elliot Samuel, Chief Laboratory Technologist
SVG Human Rights	La Fleur, Representative
VincyCHAP/SVG Care	Odinga Louis, Representative
Other experts	Dr. Jose Davy, Clinical Care Coordinator/ Infectious Disease Specialist Ms. Tamara Bobb, Epidemiologist Sr. Gleaver Williams, Clinical Care Nurse

Annex 3: Main Findings from Validation Workshops

Antigua & Barbuda August 28, 2020	
Participants: Alexandrina Wong, Delcora Williams, Yuliceia Harris, Karen Brotherson, Oritta Zachariah, Ricketson Etienne, Joan Didier, Morris Edwards, Letitia Nicholas, Kimbely Mills, Tricia Leo, Robert Hecht, Sandra McLeish, Catalina Gutierrez, Nathan Isaacs	
Finance	Covid-19 has reduced fiscal space. Funds that had originally been assigned are no longer being disbursed. May or may not ease in coming months
	Donations have arrived; NAPC uses Citizens by Investment (CBI) policies
	There is a need to integrate HIV into other disease management and services to synergies and compensate for budget cuts.
	Special concern of KP funding, but aware that CSO contracting can help push this: List steps, budget and cost services to estimate needs, strengthen CSO capacity, high level advocacy, broader services beyond HIV and TB, create investment case
Covid-19	Money that may have been disposable is now going to Covid-19 response. NAPC expresses that they can continue as is for 6 months if things do not change
	Mixed opinions on whether Covid-19 has changed HIV testing rates. NAPC explains testing has been more efficient so no decline in test numbers, but some CSO experts may disagree
	Overall consistent ARVs. Testing is now walk-in and have implemented WhatsApp communication.
	Social distancing has made outreach more difficult
	Antigua created a new facility in the airport that includes a mini lab, inspection room, nurses' station
	Government has provided PPE for Secretariat to continue work, e.g. WAR has gotten support
Social contracting	Strong national interest in SC. Would like to create a budget line for SC for HIV and health systems at large
	Do not yet have a template to work with CSOs, but would like one
	Requests advocacy at the highest levels of government like the impact of Ernest Messiah in 2009/2010
	Potentially to reconsider HIV as a chronic disease, but against this recommendation, CSO could offer broader services than HIV/TB, like chronic, reproductive to expand potential financing sources
	Consider performance-based funding mechanism from other places in the region
	Multisectoral committee or evaluation body to be identified with broad stakeholder involvement. They will oversee development of processes, forms, templates and guidelines. There is an existing multisectoral committee, but not functioning properly.
	As part of their Global Fund project, CVC is presently conducting an assessment of CSOs to ascertain their capacity and needs to start small projects
	If Antigua is to move ahead within the next year with social contracting for the national HIV response, the NAPC wants to focus on services to KPs: SW, MSM, transgender persons, and PLHIV. Specifically, NAPC would like to expand the present prevention services to KPs to include support, care, and treatment. Ultimately, she envisions CSOs as a one-stop-shop to provide HIV services

Dominica September 21, 2020	
Participants: Lester Guye, Gilda-Nesty Tonge, Daryl Phillip, Clemencia Boyer, Rennata Langlais, Lujan Taveras, Kerlanni Paul, Joan Didier, Morris Edwards, Letitia Nicholas, Kimbely Mills, Tricia Leo, Robert Hecht, Sandra McLeish, Catalina Gutierrez, Nathan Isaacs	
Finance	Dramatic 60% cut of funding for most departments. This will affect the NSP and the service provision for HIV and TB.
	National Health Insurance is being revised completely due to budget cuts and will likely need to be postponed, and the benefit package revised.
	Will need to realign HIV program with other priorities such as health system strengthening and emergency response to pool resources
Covid-19	"Frightening" level of poverty emerging caused by Covid-19 pandemic and economic crisis
	Concerned that the fiscal tightening will make SC more difficult right now.
Social contracting	CSOs very important for KPs, especially MSMs. Government and social system treat MSMs as criminals
	Not just funding for CSOs, but also capacity. Only 1 or 2 persons in any organization who volunteer their time. Unclear how to the CSOs will have capacity even with funding.
	It is no ongoing support for SC, not a lack of framework per se
	Key representatives from many CSOs are volunteers and have day jobs
	Clinics remain small and lack privacy for PLHIVs. LGBTQ+/MSM have particular challenges with this system, as laws still declare homosexuality illegal.
	Capacity building activities: NAPs partners with MIRIDOM on skills development programs and sensitization e.g. for young LGBTQ+ and SW on time management, PrEP, career planning, negotiating safe sex, adherence, etc. Funded by CVC and MAC AIDS.
	They have also branched into supporting general public as well. CSOs want to revisit the present legal framework so that public knows there are consequences to negative treatment of community members.
	Would support the RCM to become a hub of information on SC.
Other	NSP had included HIV and TB, but will be revisited due to budget cut
	NHI still on the books, but unclear how it will move forward with Covid-19 fiscal crunch.
	Better internet access has allowed greater adoption of eCBS, but construction ongoing at health center halting progress on eCBS
	Lack of space at health centers has led to lack of privacy, which can be of concern for HIV patients
	Brain drain has occurred, e.g. many nurses have left
	Aligning TB with climate change is moving forward to increase opportunities for funding

Grenada September 8, 2020	
Participants: Jonell Benjamin, Francis Martin, Kerlin Charles, Shawn Charles, Joan Didier, Morris Edwards, Letitia Nicholas, Kimbely Mills, Tricia Leo, Robert Hecht, Sandra McLeish, Catalina Gutierrez, Nathan Isaacs	
Finance	Discussion on whether budget for KP is at risk. Some see it as a risk, others find that there is a lot of interest in having SC or CSOs working with KPs. A participant commented that as soon as NHI kicked in, there would be no need for CSO contracting.
	Budget for ARV and testing is not a risk, country can absorb it.
	Issue of financial monitoring is a problem for the whole health sector not just HIV.
	Several participants identified NHI as a major risk, because Covid has delayed everything and impacted the budget. Most likely country will have to start with a reduced benefit package which might not contain HIV.
Covid-19	Covid has halted NHI plans completely, so it will be delayed at least one year. Everything is under review including benefit package and finance.
	Covid initially impacted HIV services and procurement of supplies for viral load testing. But most were short term problems, Covid has not had such a big impact.
	Concern that Covid-19 may have stalled talks on SC implementation
Social contracting	HIV cascade is a problem, but CSOs can help keep PLHIV on ARVs and direct them to treatment.
	CSOs providing the human resources and essential program support. NAPC calls them "the strength of the program." They will need case management training if expanded.
	The nation has considered Public Private Partnerships (PPPs) in many health areas, so it is a good time to advance discussions on social contracting despite Covid-19.
	They have already integrated other areas and now want to integrate HIV into health care instead of a stand-alone program.
	Next steps • They are seeking more conversations on SC, especially detailed operations. • Need for stronger national accounts to bring out the cost of services • Develop program and ID process (mechanism, MOUs) • Audited statements from CSOs • Refer to Financial Management Act 2015 with procurement guidelines and existing non-clinical contracts by MOH e.g. IT, construction
Other	Need for increases staff capacity and more staff covering different areas of the response

St. Kitts & Nevis September 4, 2020	
Participants: Keisha Liddie, Joycelyn Blanchard, Judy Nisbett, Nadine Carty-Caines, Garfield Alexander, Glenville Liburd, Joseph Richardson, Londya Lennon-Hanley, Kathleen Ferdinand, Rafael Rosales, Kishma Cranstoun, Slyvester Belle, Joan Didier, Morris Edwards, Letitia Nicholas, Kimbely Mills, Tricia Leo, Robert Hecht, Sandra McLeish, Catalina Gutierrez, Nathan Isaacs	
Finance	Participants agreed that SK&N is reliant on Global Fund for ARVs but not for most of HIV finance (they cite 50-50 external-domestic financing for HIV overall)
	There is a need to increase certainty about budget. Possible actions include: • Estimate budget needs (costing) and assign a budget line. • Use NSP to cost and define budget and advocate for budget lines • Group HIV program with other programs that have support from foreign sources, like maternal or disaster management, health system strengthening.
	Find solutions for attracting and hiring talent, experiencing a skeleton staff problem; challenge with salaries. There seems to be a problem with budget estimates and more positions need to be created e.g. Adherence Coordinator. Particular problem with finding the right people, not just financing of the positions.
Covid-19	Initially, HIV response halted, particularly CD4 testing and outreach programs, but quickly returned to normal activities.
	Budget allocation is being completely revised, but not yet clear how it will impact HIV budget.
	Lockdowns have increased risky behavior among KP, e.g. already an increase seen in requests for abortions
	Countries were unable to make required up-front payments for HIV/TB pooled procurement supplies, so countries had to use Global Fund for those payments and Commission is waiting for countries to pay back.
	Reprograming of Global Fund funds needs to be done by the Commission not at the country level. Commission has reprogramed Global Fund funds for GenXpert machine and rapid tests, Covid kits (600 per country), and proposed to increase HIV self-tests.
Social contracting	There is some SC in country, but not in HIV. For example, cancer and diabetes associations linked to CSOs have been recognized as strategic partners. They have stronger executive structures in place compared to HIV organizations. While they receive limited support from government, they have links to private sectors and members. Note that other line ministries may offer them support.
	It was stated that there was political will in supporting CSOs, but is more towards space, supplies, and commodities.
Other	The Strategic Plan is progressing slowly but having it costed and mentioning social contracting would help to advance discussions. It is being started by PAHO.
	Recommendation to integrate HIV into other programs such as NCDs and COVID response. Note NCDs are attracting more resources.
	Presently HIV is incorporated into disaster management and sustainable development. On its own, it is not perceived as important to development outside of the MOH. There is need to be strategic.

St. Lucia September 9, 2020	
Participants: Gail Gajadhar, Delia Peters, Lauren James, Tamara Felicien, Charles Miriam, LabFront Representative, Joan Didier, Morris Edwards, Letitia Nicholas, Kimbely Mills, Tricia Leo, Robert Hecht, Sandra McLeish, Catalina Gutierrez, Nathan Isaacs	
Finance	NHI has been impacted by Covid-19, and they are thinking of a partial benefit package due to smaller fiscal space.
	Budget expenditure monitoring is a problem, but they are hopeful that the Health Accounts exercises will help.
Social contracting	Need for SC may be lower due to NHI, which will be rolled out using a phased approach.
	Government expressed willingness to work with CSOs, but need proposal to decide if this is something they can support now or need new funding request. These must be approved by cabinet.
	Government considering daily stipends to CSO workers
	Tender Loving Care (TLC) requests to use social contracting model now. TLC requested government to do social contracting. NAPC requested costed workplan and indicators for 1 year. This will require a new spending request by government for next year. This demonstrates a readiness to SC that should be further explored.
	Areas of consideration: Peer navigation, adherence issues, LTFU, identifying new clients and keeping them in care.
	NAPs interested has been further strengthened now that they know PANCAP is leaning towards Social Contracting.
Other	Results of interoperability study with eCBS by October
	High priority to update the NSP to adapt for Covid-19 changes and to include SC

St. Vincent & the Grenadines October 19, 2020	
Participants: Simone Keizer Beache, Cuthbert Knights, Donna Bascombe, Jose Devy, Gleaver Williams, Tamara Bobb, Elliot Samuel, Joan Didier, Morris Edwards, Letitia Nicholas, Kimbely Mills, Tricia Leo, Robert Hecht, Sandra McLeish, Catalina Gutierrez, Nathan Isaacs	
Finance	NHI remains out of reach for foreseeable future
Covid-19	Maintained the number of PLHIV who receive AVT and those who are virally suppressed (the second and third 90s, as pharmacies dispensed 4-6 months of medications to PLHIV)
	Facing local spread, but dengue fever outbreak even more pressing
Social contracting	Some mechanisms exist for SC, such as with Marion House. The government currently subsidizes the youth programs at Marion House. They also lend support to VincyCHAP
	Government already using public resources to assist CSOs, such as workspaces to CSOs and food supplies to the vulnerable
	CSOs should work independently to build structures to make decisions
Other	Conversation on political will and support for KPs

Annex 4: Health and HIV and TB Service Delivery Characteristics by Country

Country	Health and HIV and TB Service Delivery Characteristics
Antigua & Barbuda	• **Public-sector points of care:** 25 health clinics and one reference hospital, Mount St. John's Medical Center • **Public-sector HIV care:** The public-sector HIV clinic at MSJMC is open twice per week. The clinic is shared with other outpatient services, so there is no way to identify PLHIV at clinic appointments. HIV testing is available in community clinics throughout the country on a rotating basis as well as at the AIDS Secretariat. • **Public-sector TB care:** No data avaiable • **Public-sector HIV andTB care cost for patient:** ARV drugs and key testing (such as VL and CD4 count) are provided for free to all patients. PrEP and PEP are not free. Specialized services and care for related conditions, like opportunistic infections, are also not free. MBS (national insurance) members pay a small copay for these services, and non-members pay full cost. TB treatment is free for all patients. • **Private sector:** Patient must pay for visit, but ARVs are still free. Estimated 15% of PLHIV in the country see private physicians. Patients may pay for private laboratory work as well.
Dominica	• **Public-sector points of care:** 52 health centers, two district hospitals, and a newly built reference hospital, the Dominica-China Friendship Hospital • **Public-sector HIV care:** Centralized system with one HIV clinic for the island, located in Roseau. While other health programs share the HIV clinic space, some patients and providers perceive stigmatization of the location as only for PLHIV. Some PLHIV also report financial hardship in coming to the clinic. Because of this, there is some discussion of integrating HIV care into PHC. However, PLHIV reportedly appreciate the continuity of physicians and nurses in the specialized clinic as opposed to rotating providers in community clinics. HIV testing is conducted at the national program office and in five of the country's seven districts. • **Public-sector TB care:** Integrated into primary healthcare. • **Public-sector HIV and TB care cost for patient:** All HIV and TB care is free for all people. This includes clinic visits, laboratory work, and medications. There may be a small fee for specialized imaging if it is necessary. • **Private sector:** Some private physicians are known for providing HIV care. Most patients seeking private care are concerned about confidentiality breaches in the public sector. Private practitioners also typically utilize private laboratory services to ensure confidentiality. Patients must pay for private visits and laboratory work.
Grenada	• **Public-sector points of care:** 36 medical stations and clinics and four hospitals, including General Hospital in St. George's • **Public-sector HIV care:** HIV care occurs centrally at the NIDCU clinic, located in a designated building at the General Hospital. The specific building for PLHIV can create confidentiality and stigma problems. There is a robust HIV outreach and testing program in local communities, and testing is also available at the NIDCU building. • **Public-sector TB care:** Diagnosis at local clinic, DOTS at main hospital, and follow-up at local clinic. • **Public-sector HIV and TB care cost for patient:** All HIV and TB care is free for all people through national health insurance. This includes clinic visits, laboratory work, and medications. There may be a small fee for specialized imaging or care if it is necessary. • **Private sector:** Some PLHIV choose to see private providers and pay for HIV care OOP due to confidentiality concerns or long wait times in the public sector. Private laboratory services are also available.

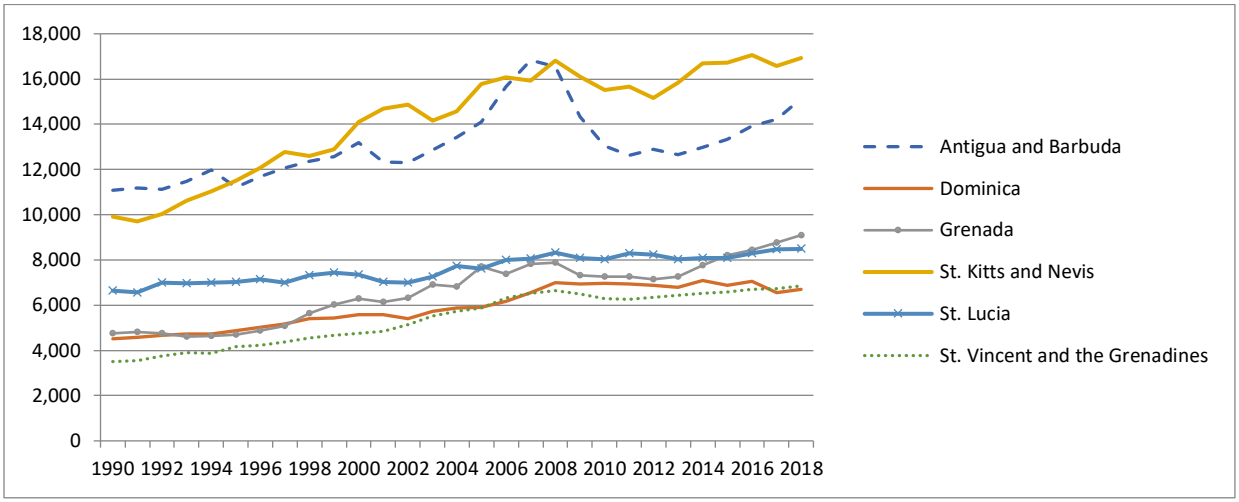
St. Kitts & Nevis	• **Public-sector points of care:** 11 district health centers in St. Kitts and two in Nevis, plus four public hospitals; Joseph N. France General Hospital is the main reference facility • **Public-sector HIV care:** Completely decentralized and integrated into primary healthcare, with HIV testing and care offered at all district health centers in St. Kitts & Nevis. JNF Hospital also offers both outpatient and inpatient testing. There is no dedicated HIV care setting, which limits stigmatization associated with a single clinical location for PLHIV. • **Public-sector TB care:** Also decentralized; diagnosis, treatment, and follow-up occur at the community level. • **Public-sector HIV and TB care cost for patient:** All HIV and TB care is free for all people, including medications, visits, laboratory work, and counseling. • **Private sector:** There are five preferred private providers in St. Kitts. In Nevis, there are no preferred providers, so PLHIV see the physician of their choice. There are not many PLHIV who utilize private services because PLHIV tend to be of lower socioeconomic status.
St. Lucia	• **Public-sector points of care:** 36 health facilities and two hospitals, including the main reference facility, Victoria Hospital • **Public-sector HIV care:** Conducted at two SRH clinics, one at Victoria Hospital (daily) and one at Vieux Fort in the south (weekly). Because these clinics occur at known locations and times, there is some concern surrounding confidentiality. There is also an occasional SRH/HIV clinic at Bordelais Correctional Facility. ARVs are distributed at four public pharmacies. The pharmacies are not located near the clinics and/or are not open at the same time, requiring PLHIV to make multiple trips to receive care and medication. There is some discussion of integrating HIV care into PHC at the community level. • **Public-sector TB care:** Treatment provided at Victoria Hospital after referral from community center. Follow-up occurs in the community. • **Public-sector HIV and TB care cost for patient:** HIV and TB care is free for all people. Medications and clinic visits for HIV and TB will remain free under any emerging NHI scheme. • **Private sector:** There are about five preferred providers for HIV care. ARVs are distributed at one private hospital. Private laboratory services are readily available. With the exception of ARVs, patients must pay for these services OOP.
St. Vincent & the Grenadines	• **Public-sector points of care:** 39 primary care clinic and one reference hospital, Milton Cato Memorial • **Public-sector HIV care:** Highly centralized system with one HIV clinic on St. Vincent, which is associated with Milton Cato Memorial Hospital. The specific building for HIV care can create confidentiality and stigma problems, which is a significant concern among PLHIV in the country. There is some public-sector HIV testing available in community clinics but these services are limited. There is limited access to public-sector HIV services in the Grenadines. • **Public-sector TB care:** Diagnosis at community level, treatment at reference hospital, and follow-up in community. • **Public-sector HIV and TB care cost for patient:** Direct HIV and TB care and medications are free for everyone. Other medical care is fee-for-service, but costs are waived for the poor and specific vulnerable groups like prisoners and the elderly. • **Private sector:** There are about two preferred private practitioners for PLHIV. Typically, PLHIV who see private physicians are very concerned about confidentiality. Private practitioners pick up ARVs for their patients to eliminate privacy concerns at the pharmacy. Patients pay for visits and laboratory services conducted in the private sector but not medication.

Annex 5: Macroeconomic Outlook for the OECS

The six OECS member states have integrated fiscal and monetary policy, and agreements are in place to allow free movement of persons, goods, and services across countries.[91,92] The service sector is the main economic engine in the region, accounting for more than 60% of GDP in all countries, with tourism contributing nearly half of this amount and providing between 25% and 50% of employment. Real estate fostered by Citizen by Investment Programs has also fueled growth in the service sector. Agriculture supplies less than 10% of GDP in each country.[93]

Between 2000 and 2008, OECS countries witnessed an average economic growth rate of 4.3% per year, among the highest in the Caribbean region. Trade opening, economic integration, and a transition away from agricultural production and towards the services sector fostered this growth. Since 2009, however, the international financial crisis, environmental shocks, a deterioration of the terms of trade, and other domestic factors compounded to slow growth to 0.8% per annum. As a result, GDP per capita growth stagnated in most countries and even decreased 25% in Dominica (see Figure 6.1).[94]

Figure 6.1: Growth in per capita GDP by country, constant 2010 US$ (Source: World Bank World Development Indicators)



High debt is a major macroeconomic concern in OECS countries. Debt has been rising steadily since the late 1990s and is now above the IMF sustainable threshold of 60% of GDP for all six countries. In half of the countries, debt is above 80% of GDP. High dependence on a small number of cyclical industries, extreme vulnerability to environmental shocks, and a series of domestic financial difficulties has contributed to this trend.[95] Dependence on cyclical industries like tourism means that, in the face of external shocks, countries need to rely on debt to make up for lost revenue, as there are no other productive sectors that might buffer the shock. Offshore banking, another important economic sector in the OECS, is also highly susceptible to changes in regulation and to the growth performance of industrialized economies.[96]

[91] Waithe, Osorio, & Blenman, 2017.
[92] https://www.oecs.org/en/homepage/about-us
[93] World Bank, 2018.
[94] Waithe, Osorio, & Blenman (Op. Cit.)
[95] Moody's, 2016.
[96] Moody's (Op. Cit.)

Natural disasters can have a domino effect on the OECS economies, beginning with damages and losses that directly reduce GDP. Then, reconstruction efforts require imported materials, which pushes the demand for foreign currency, negatively affecting the terms of trade. Reconstruction and emergency assistance often need to be financed with debt, reducing the fiscal space for investment and increasing domestic interest rates.

A series of shocks and domestic circumstances in the late 1990s and the 2000s compounded to raise debt. In 1997, the Caribbean countries lost preferential access to European markets for bananas and sugar, when the WTO ruled that these preferential agreements violated trade rules.[97] Soon after, the Asian financial crisis was felt through the region as lower commodity prices and, in 1998, Hurricane Georges struck the region, followed by Hurricane Lenny one year later. Weak financial and prudential regulation of the private sector and mismanagement of the government-owned sugar industries resulted in the OECS governments having to bail out several private- and public-sector companies.[98] In order to finance reconstruction efforts and be able to assume the private sector debt in the midst of low growth and reduced revenue, countries had to rely on debt.

A similar set of events in the 2000s pushed debt to its current levels. The 2007 financial crisis reduced remittances from abroad, negatively affected the demand for exported goods, caused a decline in commodity prices, and a reduced foreign direct investment in the region.[99] The financial crisis also affected weak, large insurance and banking companies in the Caribbean, requiring government intervention. Environmental disasters between 2004 and 2015 caused an estimated US$1.58 billion in total damages in OECS countries, furthering the need for additional debt.[100, 101]

The costs of recovery from subsequent natural disasters (Hurricane Erika in 2015, and Hurricanes Irma and Maria in 2017) made it hard to reverse this trend. The World Bank (2018) also points to declining Official Development Assistance (ODA) to OECS countries as a factor contributing to higher debt levels in the OECS. As ODA received by OECS declined from an average of 6.4% of GNI in 1977–89 to an average of 2.1% in 2000–16, governments shifted to public debt to finance their investment programs.

Because fiscal policy has been pro-cyclical, government payroll inflexible, and tax compliance low, the OECS countries have been unable to accumulate savings to buffer economic downturns or disasters.[102] A set of current macroeconomic indicators for the six OECS states is presented in Figure 6.2.

Figure 6.2: Macroeconomic indicators for the OECS states (source: World Bank, World Development Indicators)

	Antigua & Barbuda	Dominica	Grenada	St. Kitts & Nevis	St. Lucia	St. Vincent & the Grenadines
GDP, current thousands US$ (2018)	1,610,574	550,892	1,185,925	1,010,822	1,921,848	811,300
GDP per capita, current US$ (2018)	16,727	7,691	10,640	19,275	10,566	7,361
Income Classification	High-income	Upper-middle-income	Upper-middle-income	High-income	Upper-middle-income	Upper-middle-income
Central government debt, total (% of GDP) (2016)	87	81	71	62	72	81
Population, total (2018)	96,286	71,625	111,454	52,441	181,889	110,210
Tax revenue (% of GDP) (2017)				18	20	25

[97] Acevedo et al., 2013.
[98] World Bank (Op. Cit.)
[99] Mohan and Watson
[100] See https://blogs.iadb.org/caribbean-dev-trends/en/surviving-the-storm/
[101] World Bank (Op. Cit.)
[102] World Bank (Op. Cit.)

Fiscal sustainability in the OECS will be contingent on reversing growing debt, but with low growth prospects, inefficient tax systems, and inflexible government expenditure, this will prove challenging. The ongoing Covid-19 pandemic has weakened the financial and fiscal standing of all six island nations and will present significant barriers in the short, medium, and long terms. Fiscal health will require improving tax collection, constraining government payroll, and broadening the tax base rather than increasing tax rates. Citizen by Investment (CBI) Programs, which provide much-needed resources for the OECS states, have come under scrutiny as tax evasion and money laundering schemes. The OECS countries need to increase transparency and compliance with reporting standards to continue to utilize this source of revenue.[103]

Vulnerability to environmental shocks will continue to pose a substantial threat to economic sustainability and development. The six OECS countries are ranked among the top 10 most disaster-prone nations in the world.[104] The economic effects of these events can be devastating; for example, Dominica was hit by two category five hurricanes in 2017 that generated losses of up to 225% of GDP.[105] Health and tourism infrastructure were particularly affected, with the latter sector facing significant setbacks: 19 of the 50 health facilities were left non-operational, and the Princess Margaret Hospital intensive care unit was destroyed.[106] Most certainly, the Covid-19 pandemic has left the six countries with economic turmoil detailed in Chapter 7 above.

[103] Only St. Vincent & the Grenadines does not offer a CBI program, and the other countries' CBI programs are on the OECD list of CBI schemes that pose a high risk for tax evasion and corruption. Being in the list of high-risk schemes may limit their potential to collect revenue.

[104] Acevedo, Cebotari, & Turner-Jones, 2013.

[105] World Bank (Op. Cit.)

[106] See: PAHO Situation Update Hurricane Maria Impact on Dominica, October 5, 2017, and https://www.nbcnews.com/news/weather/hurricane-maria-damages-dominica-s-main-hospital-leaves-war-zone-n803711

Annex 6: Health Financing in the OECS

Figure 6.3 presents the main health finance indicators for each OECS country as well as the LAC regional average. Health expenditure as a percent of GDP ranges from 3.6% in St. Vincent & the Grenadines to 5.7% for St. Kitts & Nevis, placing OECS countries well below the 8.5% average for the region. There is a wide variation in out-of-pocket (OOP) expenditures for health, with Grenada, St. Kitts & Nevis, and St. Lucia displaying very high OOP payment levels.

Figure 6.3: Health Finance Indicators by Country (Source: World Bank World Development Indicators. Accessed 2020.)

	LAC Average	Antigua & Barbuda	Dominica	Grenada	St. Kitts & Nevis	St. Lucia	St. Vincent & the Grenadines
Current health expenditure per capita, current US$ (2016)	689.9	623.1	419.4	516.4	930.8	489.8	250.2
Current health expenditure as % of GDP (2016)	8.5	4.3	5.3	5.2	5.7	5.3	3.6
Domestic general government health expenditure as % of current health expenditure (2016)	47.2	60.6	64.3	41.3	43.2	42.0	76.8
External health expenditure as % of current health expenditure (2016)	0.4	0.0	5.4	0.9	0.0	3.7	0.6
Out-of-pocket expenditure as % of current health expenditure (2016)	36.6	32.2	29.1	57.8	51.5	48.7	20.5

All six countries finance their national health systems from general taxation. Budgets are allocated by the Minister of Finance and approved by the Parliament. Budgetary requests by the Ministries of Health are based on historical expenditures and anticipated new projects. The Ministries of Health are responsible for all regulatory and surveillance functions as well as for the finance and provision of health care (see the Health Systems section below). Only Antigua & Barbuda has an insurance scheme, the Medical Benefits Scheme (MBS). The MBS is financed through payroll taxes, and it covers 11 medical conditions and reimburses beneficiaries for diagnostics and doctor visits.

In all countries, except for Dominica, primary care management is centralized in the Ministries of Health. In Dominica, administration of the primary care network is decentralized and under the responsibility of the center's nurses and the Director of Primary Care.

In some of the islands, private health providers play an important role in the provision of healthcare, primarily for specialist office consults, pharmacy services, laboratory work, and diagnostic services. For example, Abt Associates (2012) found that 49% of patients used private doctors as the primary source of care in St. Kitts & Nevis, 46% in St. Lucia, and 21% in St. Vincent & the Grenadines. In Grenada, the private sector is the sole provider of CT scans, dialysis, and x-rays. Information on private health expenditure is scant, and the sector is mostly unregulated. Private health insurance is available in all of the member states; most are employer-sponsored plans and cover between 10% and 20% of the population, mostly the better off.[107] External funds finance a small share of current health expenditures, but budget reports show that external funds are the main source for capital expenditures for health.

Public-sector health professionals are paid wages directly by the central government, and allocation of funds to institutional providers for supplies and pharmaceuticals is based on historical

[107] See Abt Associates: Health Systems and Private Sector Assessments, 2011.

budgets. Public hospitals receive fees from private health insurance companies for services provided to their insured, but it is not clear if the fees cover the full cost of provision, as there is little to no costing of services.[108] Fees paid by the patient represent a small share of expenditure (from 0.2% in St. Lucia to 3.7% in Dominica).[109] In Antigua & Barbuda, the main referral hospital receives a subsidy directly from the central government based on a capitated payment. Pharmaceuticals in all countries are procured through the OECS Pooled Procurement Services, which guarantees lower costs due to volume discounts.

National Health Insurance in OECS Countries

All OECS member countries have made commitments to reach universal health coverage, mainly through the creation of national health insurance (NHI) programs. Debates on how to accomplish and set NHI schemes have been taking place in the OECS for at least the past ten years.[110]

The six OECS countries are at different stages in the development of NHI programs. Antigua & Barbuda is designing the expansion of their current Medical Benefits Scheme into a universal health coverage program.[111] Dominica launched a pilot program of national health insurance for single mothers under the age of thirty-five who are pregnant or have children aged three years or younger. In 2018, the pilot was extended to all children under 16.[112] The results and evaluation of this pilot program will feed into the design of a national health insurance scheme. Still, at this stage, there is no definite date as to when universal coverage will be reached in Dominica. Grenada has completed the design of a benefits package and conducted the necessary actuarial estimations. The country has also defined the financing mechanism: the insurance system will be financed by premiums from workers and employers (including the self-employed) and government transfers. Grenada is currently in the stage of public consultations, and once the feedback from this consultation process is incorporated, legislative debate and approval will take place. The system will be financed by premiums from workers and employers (including the self-employed), and from government transfers. St. Lucia has finished an initial design and costing of a benefits package and identified potential sources of finance. The Ministry of Health and Wellness of St. Lucia secured EC$20 million in domestic funding for the implementation of NHI in the 2019-2020. External consultants are completing the final design of the NHI scheme. St. Kitts & Nevis has finalized the design and costing exercise of a benefits package and is pending stakeholder consultations, which are expected to continue once a new administration takes office. Elections in St. Kitts have been postponed due to the Covid-19 pandemic, so it is unlikely that implementation of NHI begins before the end of 2020. All of the proposed benefit packages in the OECS countries will include TB and HIV prevention and treatment as well as tertiary services for HIV and TB not provided on the island. Finally, St. Vincent & the Grenadines is in the initial discussion stage of NHI development.[113]

Existing studies indicate that NHI is financially viable for the OECS states. According to local experts, the cost of NHI is less than the total sum of current public and private expenditure in health.[114]

---

[108] See Abt Associates: Health Systems and Private Sector Assessments, 2011.

[109] Budgetary appropriations reports of each country.

[110] See Abt Associates: Health Systems and Private Sector Assessments, 2011.

[111] See http://www.mbs.gov.ag/v2/media/news-2/nhi/#1581538554106-2c532277-3f5e

[112] https://www.dominicavibes.dm/lifestyle-247847/

[113] Personal communications with Professor Karl Theodore (April 2, 2020) and Dr. Stephen King (March 28, 2020).

[114] Available information for St. Lucia estimates a cost of around EC$200 million. Presently government contributions are EC$120 million, and there is some consensus towards increasing social security contributions and earmarked taxes on alcoholic drinks and cigarettes to provide another EC$76 million. However, a share of the budget will need to be devoted to public health and other MoH regulatory and administrative functions.

Annex 7: External Grants and Loans for the HIV and TB Response in the OECS: 2000-2020

	Recipients (countries and regional bodies)	Years	Total signed (millions)	Components
PEPFAR				
Caribbean Regional HIV and AIDS Partnership	OECS countries + 4 other CARICOM/ PANCAP members	2010-2014	US$ 102.6	Prevention Strategic information Laboratory strengthening Human capacity development Sustainability
KfW				
HIV/AIDS prevention and promotion of reproductive health in the Caribbean	OECS countries + 7 other CARICOM members	2005-2012	€ 27.0***	Prevention through social marketing (CARISMA project) Health System Strengthening
Global Fund				
Multicountry Caribbean CARICOM-PANCAP	OECS countries + 11 CARICOM members via the CARICOM Secretariat	2004-2011	US$ 10.3	Promotion and prevention for KP Reduce stigma and discrimination Strengthen procurement and supply chains for pharmaceuticals and medical products Service delivery and lab strengthening
The Caribbean Network of PLHIV	OECS countries + 9 CARICOM member states/ The Caribbean Regional Network of PLHIV	2005-2010	US$ 2.5	Reduce stigma and discrimination Strengthen community response
Multi-country Americas OECS	OECS countries via the OECS Secretariat	2005-2011	US$ 8.0	Prevention and treatment for PLHIV
Fighting HIV in the Caribbean: A Strategic Regional Approach	OECS countries + 9 CARICOM member states via the CARICOM Secretariat	2010-2016	US$ 24.7	Improve access to treatment for PLHIV (ARVs for 5 years) Reduce stigma and discrimination Capacity building for surveillance Laboratory strengthening
Sustainability of services for key populations in the Caribbean	OECS countries + 11 CARICOM member states* via the CARICOM Secretariat	2016-2022	US$ 11.5	High-level advocacy and policy to eliminate stigma and discrimination Community and service delivery strategies to reduce human rights-related barriers to HIV services
OECS – Multi-country Strategic Response Towards HIV and TB Elimination	OECS member states via the OECS Secretariat	2016-2022	US$ 8.5	Prevention programs and treatment for KP (including ARVs) Health information system strengthening Laboratory strengthening
World Bank**				
HIV Prevention and Control Project - PANCAP	PANCAP	2004-2010	US$ 8.5	Advocacy and policy to reduce stigma and discrimination Strengthening prevention programs for PLHIV Strengthening laboratory and system response
Grenada HIV Prevention and Control Project	Grenada	2002-2009	US$ 2.6	Programs to reduce stigma and discrimination Prevention and treatment for PLHIV Strengthening the health system response

St. Lucia HIV Prevention and Control Project	St. Lucia	2004-2010	US$ 6.2	Strengthen and finance CSO for HIV response Cross-sector collaborations for HIV Promotion and prevention
St. Vincent & the Grenadines HIV Prevention and Control Project	St. Vincent & the Grenadines	2004-2010	US$ 6.5	Scale-up prevention programs for key populations Scale-up treatment of PLHIV Reduce stigma and discriminations Strengthen institutional capacity of MoH and other institutions
St. Kitts & Nevis HIV Prevention and Control Project	St. Kitts & Nevis	2003-2009	US$ 3.3	Advocacy and policy to promote a rights-based approach for PLHIV. Identify PLHIV and start them on treatment Upgrade services for treatment Improve monitoring and surveillance systems

* Second implementation period only includes Antigua & Barbuda in the OECS, plus 4 other CARICOM members
**Disbursed amounts. Countries did not receive grants.
***Approximately US$36.7
Sources: PEPFAR's regional strategic plans 2010-2014, 2015, 2017, and 2019. World Bank Group Finances https://financesapp.worldbank.org/en/summaries/ibrd-ida/#ibrd-len/, KfW https://www.kfw-entwicklungsbank.de/International-financing/KfW-Development-Bank/, Global Fund Data Explorer and grant agreements

Annex 8: Domestic Financing of HIV and TB by Country

Antigua & Barbuda

In Antigua & Barbuda, health expenditure is channeled through three administratively independent bodies: i) the Ministry of Health and the Environment, which receives an appropriation defined by Parliament, has regulation and administrative functions, and is in charge of providing primary health services. Primary health services are provided by 25 health clinics distributed throughout the country.[115] ii) The Medical Benefits Scheme (MBS), which is a statutory body that covers prescription drugs, diagnostics, and treatment for a list of 11 conditions to beneficiaries. Although HIV is not among the 11 diseases, the MBS covers ARV medication. MBS is currently funded by a 3.5% contribution deducted from employees' earnings and matched by an equal amount from employers. The self-employed pay a 7% contribution. Family members of workers are not covered but can enroll by making the required contributions. Non-contributors to MBS may also access support under exceptional circumstances and upon certification by a medical practitioner.[116] iii) Mount St. John's Medical Centre (MSJMC), which is the only secondary/tertiary care hospital and is owned by the state. The Ministry of Finance provides a subsidy directly to the institution based on a capitation calculation. MBS contributors accessing services at the hospital pay a subsidized fee, while non-contributors are billed at the full rate. These three bodies also procure pharmaceuticals with the Ministry of Health purchasing through the OECS Pooled Procurement Services (PPS). They can also procure their supplies outside the PPS at usually higher prices.

The MoH finances HIV counseling and education through the Health Ministry. HIV follow-up care is provided through the primary health clinics, and hospitalization for opportunistic infections occurs at MSJMC. Because HIV-related primary healthcare and hospitalization expenditures are lumped with other services, there is no tracking of outflows that are specific for HIV. ARVs are financed both through MBS and the OECS PPS, which shows resources devoted to HIV and TB from the Antigua & Barbuda MoH budget and resources paid through the MBS. It does not include other HIV-related health care expenditures financed through health clinics and hospitals. According to the 2020 budget, spending from the AIDS secretariat accounts for 1.3% of total MoH health spending.

Foreign funds account for 7% of total HIV and TB spending, and 8% of spending in promotion and prevention activities.[117]

Dominica

In Dominica, the Ministry of Health is responsible for the provision and financing of health care services. The MoH provides mainly primary and secondary health services, while tertiary services have to be provided off-island. Health services within the country are made up of a network of 52 health centers and two district hospitals. The Princess Margaret Hospital is the national referral hospital and provides curative and rehabilitative as well as other complex medical services.[118] The hospital accounts for half the budget of the MoH, which is financed mainly through general taxation. Fees for services also cover a very small share of revenue; for 2020, there are US$1,800 forecasted in fees.[119] Primary care administration is completely decentralized under the responsibility of the health center's nurses and the Director of Primary Care within the MoH. Services are provided free of charge at primary health centers.[120]

[115] Sanders and Tarantino, 2014.
[116] Sanders and Tarantino (Op. Cit.)
[117] UNAIDS financial Data Dashboard. https://hivfinancial.unaids.org/hivfinancialdashboards.html#. Retrieved Nov 3, 2020
[118] Abt Associates, 2014.
[119] Ministry of Finance of Dominica.
[120] Abt Associates (Op. Cit.)

The government purchases supplies and materials for the HIV response. For the 2019-2020 budget, HIV appropriations represented 1% of the total budget of MoH. This share has remained relatively stable since 2016. Since HIV prevention, counseling, care, and treatment are supplied through health centers and the hospital, salaries for providers of HIV services are lumped in total wages and salary data is not disaggregated for HIV. Data for care of opportunistic infections in Princess Margaret Hospital is not available. ARVs are procured through the OECS PPS. External financing accounts for only 2% of total HIV expenditure. However, most is concentrated on prevention activities, so that international sources finance 22% of expenditure in HIV prevention.

Grenada

Grenada has a universal health system with low or no fees at the public primary care facilities. Vulnerable groups, children under 17, and adults over 60 are exempt from charges, and according to Laurel et al. (2011), "Many people who could pay are nonetheless exempted from fees."[121]

Primary and secondary services are provided through public medical centers, and private clinics. Three district hospitals provide secondary care, and a General Hospital in St. George's is the main referral hospital. Every household is within a three-mile radius of the nearest point of care. Tertiary services must be procured outside of the island at high out-of-pocket costs.[122] The Ministry of Health oversees health regulation and manages the budget. Health centers do not have decentralized control over the budget. Health is financed from general taxation. The private sector plays an important role in health provision, and, as mentioned above, it is the only provider of CT scans, dialysis, and x-rays in the country.[123]

St. Kitts & Nevis

The islands of St. Kitts and Nevis have two distinct health systems with two budgets and two independent health ministries. In both islands, the Ministries of Health are the central regulatory and surveillance authorities and are in charge of provision, organization, and financing of health care. Public providers are the main source of health care. Primary care is provided through a network of 11 public health centers in St. Kitts and Nevis and is free at the point of service. Two public hospitals in Nevis and two district hospitals in St. Kitts offer inpatient care and secondary services. Tertiary care must be provided off-island. General revenues and taxation are the primary source of health finance.[124] For 2019 user fees financed around 9% of the health budget.[125] The administration of all health facilities is centralized. Anyone can buy in to private insurance, and both large employers and government workers have access to employer-sponsored health insurance. Around 30% of the population has private health insurance.[126] Private provision of services is small but still significant: 21% of the population used private providers as the first source of care, and OOP expenditure is 51% of total health spending, mainly for private health and off-shore services.[127] Pharmaceuticals are procured through the OECS PPS.

According to available data, St. Kitts & Nevis's Finances 97% of HIV spending with domestic resources (private and public). However, 100% of spending in prevention activities is financed from international sources.[128]

---

[121] Laurel et al., 2011, p. 38.
[122] Hamilton and Tyag, 2014.
[123] Hamilton and Tyag (Op. Cit.)
[124] Hamilton and Hatt, 2014.
[125] Ministry of Finance, 2019.
[126] According to country officials
[127] Hamilton and Hatt (Op. Cit.)
[128] UNAIDS financial Data Dashboard. https://hivfinancial.unaids.org/hivfinancialdashboards.html#. Retrieved Nov 3, 2020

St. Lucia

St. Lucia's health services are funded primarily through a government-consolidated fund financed from general revenues. The Ministry of Health is responsible for the administration, financing, and provision of public health services. Primary care is free at the point of service and provided through 36 health facilities within easy reach of the population, while secondary health care services are offered through two public hospitals. Tertiary services must be provided off-island. The MoH pays health professionals through wages or temporary contracts. Institutional providers are assigned budgets for supplies based on historical expenses.[129] Pharmaceuticals are procured through the OECS PPS.

Twenty percent of the population has private health insurance (mostly the better-off), either through individual or small-group premiums or through large employer-sponsored plans.[130] Out-of-pocket payments are 47% of total health expenditure, mainly for private health services, off-island care, and private health insurance premiums.[131] Private providers play a significant role in health care: 46% of people reported it as their primary source of care.

According to available data, St Lucia finances 95% of total HIV expenditure from domestic sources.[132]

St. Vincent & the Grenadines

St. Vincent & the Grenadines has a national health system in which the government is responsible for regulating, organizing, providing, and financing care. Primary health care is delivered through 39 public primary care clinics and five rural district hospitals. The Milton Cato Memorial hospital offers secondary-level health care services. Tertiary services need to be obtained off-island. Primary and secondary services are financed from general government revenues.[133] Four private health insurers cover 10% of the population through employer-sponsored plans, while out-of-pocket expenditures represent 20% of total health expenses.[134] Health workers are paid wages, and institutional providers receive budget transfers based on historical spending. St. Vincent & the Grenadines obtain pharmaceuticals through the OECS PPS.

[129] Hamilton and Masau, 2014.
[130] Rodriguez, O'Hanlon, et al., 2012.
[131] World Bank World Development Indicators and Rodriguez et al. (Op. Cit.)
[132] Source of data: UNAIDS financial Data Dashboard. https://hivfinancial.unaids.org/hivfinancialdashboards.html#. Retrieved Nov 3, 2020
[133] Kula et al., 2014, and Rodriguez, Williamson, et al., 2012.
[134] World Bank – World Development Indicators, and Rodriguez, Williamson et al. (Op. Cit)

Annex 9: Other International Institutions Involved in the OECS HIV and TB Response

PAHO

The Pan-American Health Organization is the World Health Organization affiliate for the Americas region. PAHO's engagement in the OECS is outlined in the PAHO/WHO Multi-country Cooperation Strategy for Barbados and the Eastern Caribbean: 2018-2024.[135] This strategy has five focus areas, including health systems strengthening, the reduction of the communicable and non-communicable disease burdens, addressing preventable maternal and childhood diseases, and building capacity to confront health-related challenges stemming from climate change and natural disasters.

PAHO provides mainly technical support to the HIV and TB response in the Eastern Caribbean, with a special focus on TB. This support includes continuing medical education for HIV and TB and periodic staff trainings.[136] PAHO has assisted in the preparation of infection prevention and control guidelines, contact tracing manuals, and other technical documents for the region. The PAHO Regional Green Light Committee assesses OECS TB program performance biannually.[137]

Occasionally, PAHO offers direct funding for specific projects in the OECS. For example, in multiple OECS countries, PAHO has recently funded the development of frameworks and workplans to achieve the elimination of TB. PAHO also coordinates with other international health partners, such as the Global Fund, UNAIDS, and the CDC, to address acute challenges and build health capacity in the region.[138] In the previous Global Fund grant implementation period, for example, PAHO encouraged the Global Fund to bolster OECS laboratory capacity—an essential element to achieve HIV and TB elimination—through the funding of GeneXpert machines.[139]

PAHO is expected to remain active in the OECS region for the long term. Although it is not a major funding mechanism for the OECS HIV and TB response, PAHO offers valuable technical assistance and conducts important independent monitoring of programmatic outcomes. With an expanded M&E mandate in the region, PAHO could potentially adopt some of the Global Fund's current monitoring activities if the Global Fund transitions from the region.

UNAIDS

UNAIDS is not a major player in the current OECS regional HIV response, but the organization provides some technical assistance to the Eastern Caribbean. According to a UNAIDS staff member, the Global Fund and the Caribbean Office of UNAIDS have a warm working relationship, and the Global Fund often asks for UNAIDS's technical advice. UNAIDS assists OECS countries and regional organizations to update strategies and frameworks; currently they are supporting the revision of the OECS regional HIV and TB strategy.[140] UNAIDS also conducts routine M&E for national HIV programs, including through the Global AIDS Monitoring reports. Regional and national HIV burden estimates are conducted through the UNAIDS Spectrum modeling software. UNAIDS provides little to no direct financial assistance to the OECS countries; typically, their engagements are funded by an external donor such as the Global Fund.[141]

[135] https://www.paho.org/en/documents/pahowho-multi-country-cooperation-strategy-barbados-and-eastern-caribbean-countries-2018
[136] Country interviewee.
[137] Regional interviewee.
[138] Partner interviewee.
[139] Regional interviewee.
[140] Partner interviewee.
[141] Partner interviewee.

PANCAP

PANCAP is the Pan-Caribbean Partnership Against HIV/AIDS. Its members include all OECS countries except Dominica. PANCAP is a coordinating body for the HIV response throughout the Caribbean, governed by the Caribbean Regional Strategic Framework for HIV/AIDS.[142] Like UNAIDS, PANCAP offers HIV trainings, webinars, and workshops for OECS staff members. Funding for these activities comes from external donors such as USAID and the Global Fund. PANCAP is a recipient of a separate, Caribbean-wide Global Fund grant, through which the OECS states have received some benefits, such as meeting and workshop participation and the development of regional strategies.

PANCAP was a leading supporter in the effort to create the OECS PPS to pool purchasing of pharmaceuticals and obtain lower unit costs for the region. PANCAP also serves as an advocacy organization to transform the HIV response into a bipartisan political issue in the Caribbean. PANCAP anticipates that funding for the HIV response in the Caribbean will decline considerably in the coming years, and so the organization has recently focused in on the topic of sustainability. PANCAP is currently supporting the implementation of social contracting to provide HIV services in select Caribbean countries outside the OECS.[143] As Global Fund and other external funding for HIV declines in the Caribbean, PANCAP's activities may become more limited. However, even in the absence of donor funding, PANCAP has the potential to remain a valuable platform to connect HIV stakeholders across the Caribbean region and promote a coordinated response to HIV, including through political advocacy.

CARPHA is the Caribbean Public Health Agency, supporting regional surveillance of infectious diseases and promoting the development of regional medical laboratory capacity, including in the OECS.[144] The **U.S. Centers for Disease Control and Prevention (CDC)** was previously involved in laboratory development and infectious disease monitoring in the OECS but has since transitioned out of the region.[145]

[142] https://pancap.org/who-we-are/about-pancap/history-of-pancap/
[143] Regional interviewee.
[144] https://carpha.org/Who-We-Are/About
[145] Partner interviewee.

Annex 10: Characteristics of the Government-Led HIV and TB Responses in the OECS

Country	HIV Governance Structure	TB Governance Structure	National Strategies	Impressions of Political Will Surrounding HIV and TB*
Antigua & Barbuda	• The AIDS Secretariat coordinates the public-sector response and is a department within the Ministry of Health, Wellness, and Environment • There is one National AIDS Program Coordinator, and she is well established in the position • The AIDS Secretariat also oversees the HIV response in Barbuda; Secretariat staff travel to Barbuda to provide services about once per month	• There is a TB focal point within the MoHWE; she is also a Medical Officer for Health	• There is a National Strategic Plan for Health: 2016-2020. This document specifically mentions HIV, STIs, and other infectious diseases as a focal point of investment but has limited HIV and TB-specific objectives, costs, or monitoring indicators • The AIDS Secretariat has developed an HIV Priority Areas framework for 2019-2023 with specific strategic objectives and progress indicators • Current National Strategic Plans (NSPs) specifically for HIV or TB have not been identified. The most recent NSP for HIV expired in 2016	• The AIDS Secretariat appears to enjoy strong political support. High-ranking political officials, such as the PS of Health, were familiar with the ongoing activities and past successes of the AIDS Secretariat • The PS confirmed that she and other leading MoHWE officials look favorably upon new requests for HIV funding because the Secretariat staff always provides strong evidence to support such proposals • The NAPC reported that commitment to the national AIDS program is bipartisan
Dominica	• National HIV and AIDS Response Program (NHARP) coordinates the public-sector response and is a division within the Ministry of Health and Wellness • There is one NHARP director, and he has recently taken on the position	• There is a TB focal point within the Ministry of Health and Wellness; she is also a District Medical Officer • TB governance and funding are integrated into the primary healthcare delivery structure	• There is a National TB Workplan for the period 2018-2023 • A new National Strategic Plan for HIV, STIs, and Viral Hepatitis for the period 2020-2025 is currently in draft form	• Dominica has a new Minister of Health who has expressed his commitment to improving HIV care and laboratory capacity in the country. He is a private practitioner who has cared for PLHIV and is therefore familiar with challenges facing this community • Government officials shared their concern that, even with a strong champion in the new Minister, other Cabinet members may be less receptive to the HIV cause, limiting funding opportunities • Due to the recent increase in TB cases in Dominica, political will to address this disease is high

Grenada	• HIV/AIDS programming falls under the National Infectious Disease Control Unit (NIDCU) of the Ministry of Health • There is no specific HIV/AIDS program, but HIV is a focal point of NIDCU • There is an HIV program head and an HIV program coordinator, and both have recently taken on these roles • The NIDCU HIV program also oversees the HIV response in Carriacou and Petite Martinique; there is a rotating system for CSOs and NIDCU to travel to these islands to provide services	• TB also falls under the National Infectious Disease Control Unit (NIDCU) of the Ministry of Health • There is a TB focal point in NIDCU, who is also the HIV program head	• There is a National TB Prevention and Control Plan for the period 2018-2023 • The NIDCU develops an Action Plan for HIV for each calendar year. These plans include strategic objectives, responsible parties, funding sources, and monitoring indicators • A current National Strategic Plan for HIV has not been identified	• At the highest levels of government, the HIV program in the NIDCU appears to enjoy moderate political will; officials recognize the importance of limiting new infections, especially among KPs • The current CMO is a strong champion of the HIV program, as he was formerly the HIV program head. He and current NIDCU staff are interested in implementing social contracting to improve the HIV response in Grenada
St. Kitts & Nevis	• St. Kitts and Nevis have independent HIV/AIDS governance structures. Both are run through the Health Promotion Unit/Community Health Services of the Ministry of Health, and they share data and some facilities • St. Kitts National AIDS Secretariat currently lacks a leader; the St. Kitts Acting Director of Community Health Services has taken on the responsibilities of the National AIDS Program Coordinator until a new director is found • Nevis AIDS Coordinating Unit governs the HIV response in Nevis; this body has multiple established staff members • A National Advisory Council on HIV/AIDS exists but has declined in function; there are plans to restart this body	• There is a focal point for TB within the St. Kitts Ministry of Health, who also holds other positions in the national health program • There are so few cases of TB in St. Kitts & Nevis that there is minimal governance in this area	• St. Kitts & Nevis is in the drafting stage of a new National Strategic Plan for HIV, TB, and SRH: 2019-2024 • The previous NSP for HIV expired in 2014	• Interviews have pointed to a perceived lack of political commitment to the HIV response in St. Kitts • Multiple respondents stated that high-ranking MoH officials in St. Kitts have verbally supported the HIV program but have not followed through in action. For example, requests for additional resources and staff members have been ignored. The Ministry's failure to hire a new NAPC for over a year demonstrates lack of political will • There is perceived strong political will for the HIV program in Nevis. The two leads of the NACU have good relationships with key officials to seek new resources and implement new activities. Nevis representatives expressed frustration with HIV program "bottlenecks" at the federal level
St. Lucia	• The National AIDS Program resides within the Infectious Diseases Unit of the Ministry of Health and Wellness	• The Infectious Diseases Unit of the Ministry of Health and Wellness also	• There is a National TB Plan for the period 2018-2023 • St. Lucia developed a revised National HIV Policy for 2019-	• The national AIDS response appears to have moderate political support. While health was identified as a major government priority, HIV does not

	• The National AIDS Program Coordinator is a Senior Medical Officer in the Infectious Diseases Unit, and she has recently taken on the position • There has been high turnover in the NAPC post in St. Lucia in the past five years	manages the national TB response • Within this unit, there is a TB focal point and a TB program manager	2022, which is intended to feed into a new National Strategic Plan for HIV • The most recent HIV NSP expired in 2014	appear to be prioritized within the health sector • Former MoH staff stated that the high numbers of patients LFU and other poor performance indicators from recent years reveal a lack of political will on this issue; to improve outcomes, leaders can devote more resources to the HIV response and recognize high-performing program staff • Respondents were concerned that political will and relationships built with the current government could erode following a new round of elections
St. Vincent & the Grenadines	• There was formerly a National AIDS Secretariat operated under the Ministry of Health, Wellness, and the Environment • The National AIDS Program Coordinator recently retired and has not been replaced • The AIDS program has since been restructured as part of the Health Security Unit of the MoH to better integrate HIV care with other infectious disease programs and primary healthcare services • The Health Security Unit approaches healthcare through the lens of climate change and seeks external funding for health as a component of climate resiliency • The national AIDS program technically oversees the HIV response in the Grenadines, but HIV services in these islands are limited	• TB is also a component of the new Health Security Unit and is being integrated into primary healthcare delivery	• There is a National Health Sector Strategic Plan for 2019-2025. Reaching 90-90-90 targets for HIV care is a key goal within this plan, which includes specific interventions and outcome measures to assess progress. This plan notes the continued risk of TB but does not list TB-related objectives or outcomes. • Improved HIV care is also a feature of the National Economic and Social Development Plan: 2013-2025 • A current National Strategic Plan for HIV and/or TB has not been identified	• There is perceived politicization of the HIV response in St. Vincent—that is, most politicians do not want to be strongly associated with the HIV response • CSO representatives reported feeling excluded from the national response because of this politicization. They continue to contribute to the HIV response through work with KPs and in the Grenadines but have not formally collaborated as much as they would like with the government • The current Minister of Health has not demonstrated strong support for the HIV response and is not convinced that KPs such as MSM and SWs are present in the country

Sources: Interviews and documents received from interviewees.
*These impressions are the authors', based upon interviews with key interviewees and document review.

Annex 11: CSO Best Practices

The following table describes several best practices observed by the Pharos Global Health team in consultations with regional CSOs throughout the course of this analysis. These best practices could be replicated across countries and throughout the Caribbean region.

Country	Best Practice
Antigua & Barbuda	WAR (Women Against Rape) provides culturally appropriate avenues for women experiencing gender-based violence to get information and seek help. They have received funding for a hotline in two languages to support both the English- and Spanish-speaking communities in the country.
	The 3H (Health, Hope, and HIV) group has a strong partnership with the National AIDS Secretariat. The NAS offers its offices to be a safe space and hosts 3H support groups and Friday evening events. As a continuation of the holistic approach to health care for these vulnerable populations, the NAS provides commodities to support testing and outreach as well as vitamins and other direct support for vulnerable individuals. All the persons who work for the Secretariat are welcoming and open to 3H's focus communities.
	3H and the NAS have cultivated a relationship with one of the public-sector pharmacists. This pharmacist assists a 3H representative in collecting ARVs and other medication on behalf of persons who are unable to do so, whether due to concerns about stigma and discrimination, transportation challenges, or time availability. This relationship supports PLHIV in adhering to their treatment regimen, reducing LFU rates.
	PEPFAR and PSI began to withdraw support from Antigua & Barbuda early in the 2010s. The objective of one successful PSI project was to increase understanding of reproductive rights and promote condom use. Employees of this PSI program saw the value of the work they were doing and sought to continue it even after PSI's departure. Thus, the CSO MESH was formed in the same model. MESH volunteers determine the community's favored brands of condoms and encourage vendors to supply them. MESH also receives commodities from the NAP and use these items to teach proper condom use and other SRH lessons. MESH's success is a sign of continuity and sustainability of the program. MESH is currently operated by three volunteers who work other jobs to support themselves. They have expressed that, if they could be paid to work for MESH, this would be their employment of choice.
	Some of the countries of the OECS have seen an increase in foreign SWs who are Spanish-speaking. One of the major hurdles in reaching these people is the Spanish language barrier. The National AIDS Secretariat has a bilingual case worker who supports this process.
Dominica	Dominica's national AIDS program employs a Sex Worker Animator who is bilingual in English and Spanish and who has built up social capital within the Spanish-speaking SW community. In a country where SW is considered very "underground," it is important to be able to reach this community effectively for outreach and services.
	Fouche La Vie, a PLHIV group, provides social and psychosocial support as well as nutritional support. The group has provided micro funding to support group members in developing backyard gardening projects. The national AIDS program employs Fouche La Vie's director and allows their offices to be used for activities of the group, including on weekends.
Grenada	GrenCHAP, an umbrella CSO providing support to LGBTQ+ people, has developed a list of KP-friendly doctors from different fields to support their members. This list includes physicians willing to provide TG-friendly care. In settings where stigma & discrimination is prominent and is a major factor in high LFU rates and poor health seeking behavior, this information allows members of the LGBTQ+ community to still seek care in a professional and friendly environment.
	Recognizing the challenges faced by the LGBTQ+ population including limited employment, GrenCHAP has a food bank to support members in need. Access to food also promotes adherence to ARVs among PLHIV.
	GrenCHAP and its partner GrenAIDS have sought strategic alliances with non-traditional partners such as academia. Their staff have completed the Training and Certification process of MoH, but they are now seeking to complete master training with St. George's University.

St. Kitts & Nevis	The St. Kitts & Nevis AIDS programs have adopted one of the broadest definitions of key and vulnerable populations, including PLHIV, SWs, MSM, vulnerable youth, prisoners, and migrants. Most national programs only focus on PLHIV, SWs, and MSM.
	In smaller communities, it is difficult for LGBTQ+ people to remain anonymous and to trust healthcare providers. The CSO SKN CARE has promoted safe gatherings of small groups of MSM together in a relaxed recreational setting. In this format, the trusted CSO volunteer can offer information about HIV testing and even conduct tests if participants are willing. The testing data collected is then shared with the NAP.
	St. Kitts has a list of "preferred" doctors that provide HIV care to a suitable standard.
St. Lucia	A strategic alliance exists between Tender Loving Care, a PLHIV-focused CSO, and private doctors. Four private doctors in the country call upon TLC members (who have been trained by the MoH and/or who are PLHIV themselves) to support newly diagnosed patients. These peer relationships help new patients with medication adherence, coping skills, and logistics such as filling prescriptions.
	The MoH intends to expand HIV-related training to include both CSO members and private doctors.
	The MoH is considering a proposal to better engage CSO members and PLHIV in the public-sector HIV response. CSO members trained in VCT, peer counseling, and other areas can work at HIV clinics to fill personnel gaps when providers are unavailable and can offer peer support to clients. This proposed partnership may encourage more PLHIV to remain in treatment and may reduce perceived stigma & discrimination in health clinics. The current proposal suggests tracking patients seen by CSO animators and conducting an evaluation of the partnership after three months.
	AAF is the umbrella HIV CSO consortium for St. Lucia and harmonized CSO activities with the public-sector response. Affiliated organizations include: United and Strong (LGBTQI+), National Youth Council, Planned Parenthood (women, SRH), and TLC (PLHIV). AAF mentors and represents the groups as necessary. AAF successfully wrote a proposal to secure a bus to support affiliated groups' activities. This vehicle is shared with the Ministry of Youth.
St. Vincent & the Grenadines	Marion House is funded by the Catholic Church and owns its own building. Rent from the building brings in income for the organization. Marion House is an umbrella network for the CSOs VincyCHAP, Planned Parenthood, VincyCARE, and SVG Human Rights Association. These groups offer PLHIV and KP support, general health services, education, sensitization in schools, and HIV testing, including of youths.
	At the public-sector HIV clinic in St. Vincent, Marion House members provide HIV and adherence counseling and offer support for psychosocial issues in partnership with the social worker. CSO members are an accepted part of the public-sector treatment team. This strong relationship speaks to the length of CSO-government partnership in the national HIV response and CSO members' record of providing valuable services at the national clinic.
	Marion House and its affiliated network are also accepted as partners of the Ministry of Education and the Ministry of National Mobilization because of their work with youth, women, and those in need of public assistance. While HIV-focused CSOs typically have a relationship with the MoH, it is not as typical for these groups to have strong partnerships with other ministries. These relationships offer the opportunity to advocate for HIV concerns to be integrated into other arms of government.

Annex 11: Characteristics of CSOs Involved in the OECS HIV and TB Response

CSOs	Population Served	Number of Staff		Own space?	Funding source	Share Data with NAP?	Type of Services Offered						Type of Support Offered from Government			
		Paid	Un-paid				VCT, psycho-social support	Peer Navigation (link to care, adher-ence)	Prev-ention	Advocacy/ Human Rights	Social Pro-tection	Educa-tion	Subvention	Ad hoc Project Sup-port	Commod-ities from NAP	Housing/ Safe Space
Antigua & Barbuda																
3 H Foundation (HIV, Health and Human Rights)	SW, MSM	0	2	NO	From projects	YES	YES	YES	YES	YES	YES	YES	YES; subvention utilized for rent	YES	YES	YES
MESH (Meeting Emotional and Social Needs Holistically)	General Pop., MSM, SW, PLHIV	0	3	NO	NONE	YES	NO	YES	YES	YES	Unknown	YES	NO	NO	YES	NO
WAR (Women Against Rape)	SW	1	20	YES	UN Women; Outright Int'l, CVC, Robert Carr Found., MAC AIDS	YES	YES	YES; hotline in two languages.	YES	YES	YES	YES	NO	YES	YES	NO
Dominica																
Dominica Planned Parenthood	General Pop.	YES	0	YES	IPPA but reduced greatly	Un-known	Yes, SRH	YES	YES	YES, in partner-ship with others	YES	YES	NO	NO	NO	NO
Fouche La Vie	General Pop., PLHIV	Lead works with NAP	4	NO	Grants	YES	YES, nutritional support	YES	YES, PHDP	YES	YES, provides micro grants	YES	NO	NO	YES	YES, NAP offers venue for Support Group
MiRiDOM	MSM	1	YES	NO	Grants	NO	Unknown	NO	YES	YES	YES	YES	NO	YES	YES	YES, training events and mtgs.
DomCHAP	MSM, TG	1	4	NO	Grants - AMFAR	NO	YES, VCT	YES	YES	YES, IEC material	YES	YES, peer educ. and to NAPC on men's health	NO	YES	YES	YES, training events and mtgs.
Grenada																

GrenCHAP (merged with GrenAIDS less than 12 months ago)	PLHIV, SW, MSM, TG, LGBTQI+	2.5	8 on Board+ others	YES	Grants - CVC, Open Society, USAID, Legacy Fund	YES	YES, SRH & STI screening	YES	YES	YES, S&D reduction training for MoH	YES	YES	NO	YES, WAD, testing drives, mobile clinics	YES, condoms	NO
St. Kitts & Nevis																
SKN CARE and works closely with SKN Alliance	MSM, PLHV, FSW	0	1	YES	Self	YES	YES, testing	YES, collect meds	YES	YES	YES	NO	NO	YES	YES	NO
St. Lucia																
United and Strong	LGBTQI, SW, women and girls	5	25	YES	Grants – Open Society Foundation and Outright International in US; Positive Action in UK; CVC in Jamaica; COC in Netherlands	YES	YES, VCT & SRH	YES	YES	YES	YES	YES	NO	YES, WAD project with hotels; training	YES	NO
Tender Loving Care	PLHIV	1	3	YES	Grants – micro enterprise	YES	YES, Psycho-social	YES	NO	YES	YES	YES	NO	NO	YES	NO
AIDS Action Foundation	PLHIV, Vulnerable pops, general pop	3	2	YES	Unknown	NO	NO	YES, Training VCT, Adherence, Human Rights	YES	YES	YES	YES	YES	NO	YES	NO
St. Vincent & the Grenadines																
Marion House umbrella site: Vincy CHAP, IPPA, Vincy CARE, SVG Human Rights Association	General Pop., PLHIV, LGBTQI+, MSM, youth, women, drug users, ex-convicts	1+	Un-known	YES	Catholic Church, rental of part of property, CVC	YES, quarter-ly	YES, HIV and Syphilis testing; counselling	YES, collect meds	YES	YES	YES, food packages	YES	YES, Marion House and Planned Parenthood get subvention	YES	YES	NO

* The authors sourced this table from interviewee interviews. This table lists CSOs whom the Pharos team interviewed in-person or remotely during March 2020. It may not be comprehensive of all CSOs active in the HIV and TB response in the region. Abbreviations: PHDP: Positive Health, Dignity, and Prevention; WAD: World AIDS Day.

Annex 12: The Caribbean HIV/AIDS Alliance

The Caribbean HIV/AIDS Alliance (CHAA) was a PEPFAR-sponsored project operating in the OECS from about 2010 to 2015. CHAA supported community action on AIDS through provision of sub-grants to community groups to implement HIV/AIDS prevention, care, and treatment projects. CHAA also assisted in areas such as HIV advocacy, training, and outreach via community-based educators. During its years of operation, CHAA was the largest regional non-profit, non-governmental organization in the Caribbean. CHAA's efforts focused on four key populations: MSM, SWs, TG people, and PLHIV.

The portfolio of CHAA consisted of five main elements: prevention; health services and PLHIV empowerment; care and support of people living with AIDS; peer support; and acceleration of the private sector response to HIV/AIDS. Specifically, CHAA built the capacity of these organizations, including through trainings in financial and technical reporting, M&E, and specific topics in HIV care such as combination prevention and retention of patients. CHAA also offered funds to support staff salaries.

Annex 13: Social Contracting Definition and Principles

Social contracting is defined in the *Social Contracting Diagnostic Tool* developed by Global Fund as the process by which government resources are used to fund entities that are not part of the government (referred to as civil society organizations) to deliver services. Social contracting mechanisms must include a legally binding agreement in which the government agrees to pay a CSO for services rendered and the CSO agrees to provide certain deliverables in exchange, either as services provided or health outcomes reached. SC is not the same as grants, subventions or in-kind support but instead it is a formal contracting arrangement. For example, the St. Lucia Child Development Center has received a building and subvention from the government to support the organization's work with children with disabilities.[146] While this is valuable support, it is not social contracting.

SC can be used as part of a broader sustainability strategy for the national HIV and TB response by promoting CSO financial sustainability and ensuring that CSO services for KPs are continued. Government funders can include Ministry of Health as well as other line ministries. In exploring this mechanism, it is important that contracted CSOs align staff compensation with typical domestic government salaries. Interviewees reported that some CSOs historically compensated their staff at higher rates than what government could afford because of generous grants received from USAID or other donors. Domestic governments will likely not be able to afford such compensation packages.

SC should be considered as a mechanism for engaging CSOs to reach key vulnerable populations in fulfillment of national strategic plans. CSOs may be able to reach certain KPs more efficiently and effectively than the government because of their connections and peer-to-peer relationships built within the KP communities. CSOs may also be positioned to assist KP members in addressing root causes of social determinants of health that fuel the HIV epidemic in the OECS, including by connecting members to government welfare programs, KP-friendly health providers, and educational opportunities.

Principles of Social Contracting

The overarching principles of protection, confidentiality, consent, and human rights should be applicable throughout the design of the country approach to engaging non-government players in achieving a government mandate to provide HIV and TB care to all its citizens. The strategy is guided by the following broad principles:

1. Political Leadership and Commitment: Strong political leadership and commitment at all levels is essential for a sustained and effective social contracting mechanism for the HIV response.
2. Good Governance, Transparency and Accountability: An effective mechanism to mobilize and manage human, financial, and organizational resources in the Ministry of Health in an effective, transparent and accountable manner is necessary. This multi-sectoral mechanism should be anchored in the MoH and the MoH NAPC can serve as the secretariat.
3. Program Management Structure: In order to successfully implement SC, there is need for a formal, standardized mechanism for applications. All proposals should include project monitoring, evaluation, and learning plans. The NAPC could offer guidance and/or trainings on submitting applications.

[146] In-country interview.

Annex 14: Implementation Strategies Templates

Antigua & Barbuda

Area	Mitigation Action	Lead Agent	Supporting Agents	Implementation Steps	Timeline				Cost estimate
					1st half 2021	2nd half 2021	1st half 2022	2nd half 2022	
Financing	Use national funds to finance HIV commodities as part of Global Fund transition								
	Consider cost-sharing between national governments and the Global Fund as soon as possible for laboratory equipment								
	Pay for lab and other commodities, demonstrating the importance of these investments and how they have helped the OECS to build a resilient system for testing for Covid-19								
	Identify ways to increase efficiency and cost-effectiveness of laboratory services, setting specific targets for savings								
	Investigate new sources of financing such as private philanthropies and the private sector. Explore donor mapping exercises								
	Explore the implementation of Debt to Health swaps where lenders forgive country debts, and in return, governments commit the freed debt repayment resources to KP programming.								
	Develop volunteer and internship agreements with public and global health programs in the region and around the world to serve as an interim solution for a lack of skilled labor.								
	Explore whether some HIV and TB programming, including for KPs, could be designed and administered at the regional level								
KPs and CSOs	Develop steering committees to design a national social contracting policy, prepare plans, sensitize stakeholders, and secure budgets								
	Use Global Fund grant resources to analyze and improve legal frameworks and regulations for social contracting								
	Disseminate best practices to the six countries drawing on experiences from nearby countries with successful social contracting								
	Phase in government contracting of CSOs (using national budgets)								
	Task the National AIDS Program and CSOs with making a proposal for Social Contracting to senior officials in health, finance, and Prime Minister's Office								
	Allocate budgets for Social Contracting as part of agreed cofinancing								
	Country governments must determine which HIV and TB services they will outsource to CSOs under the Social Contracts, and estimate the unit and total								

	costs so these can be included in performance-based agreements between government and CSOs.								
	Secure the needed domestic funding to implement the SC pilot, including MoH management and monitoring and payments to the CSOs for the services they deliver in HIV and TB.								
	Based on pilot results in the first year, governments to phase in contracting of CSOs (via dedicated budget line), expand the MoH budget for this purpose and reduce the matching funds from the Global Fund.								

Dominica

Area	Mitigation Action	Lead Agent	Supporting Agents	Implementation Steps	Timeline				Cost estimate
					1st half 2021	2nd half 2021	1st half 2022	2nd half 2022	
Health systems	Assign and formalize roles for CSOs in adherence counseling, patient follow-up, and VCT in public facilities								
	Establish a partnership among the HTEP, National AIDS Programs, and health professional schools in the OECS to develop and implement HIV and TB sensitization and care training for new healthcare workers								
	Develop a standardized HIV and TB in-service training program to meet the specific needs of each OECS nation								
	Increase domestic funding for MoH outreach and TB testing in migrant communities, and employ community animators who speak the first language of the clients								
	Implement pre-migration TB screening								
	Seek financial and technical support from PAHO/WHO to design a specialized TB surveillance and treatment program focused on migrant populations								
Financing	Use national funds to finance HIV commodities as part of Global Fund transition								
	Consider cost-sharing between national governments and the Global Fund as soon as possible for laboratory equipment								
	Pay for lab and other commodities, demonstrating the importance of these investments and how they have helped the OECS to build a resilient system for testing for Covid-19								
	Identify ways to increase efficiency and cost-effectiveness of laboratory services, setting specific targets for savings								
	Investigate new sources of financing such as private philanthropies and the private sector. Explore donor mapping exercises								
	Explore the implementation of Debt to Health swaps where lenders forgive country debts, and in return, governments commit the freed debt repayment resources to KP programming.								
	Develop volunteer and internship agreements with public and global health programs in the region and around the world to serve as an interim solution for a lack of skilled labor.								
	Explore whether some HIV and TB programming, including for KPs, could be designed and administered at the regional level								
	Conduct annual HIV and TB budget and expenditure monitoring, drawing on a range of sources including national health accounts, program-based budgeting,								

	records of national purchases of HIV and TB medical supplies through OECS pooled procurement, annual or quarterly time-surveys of health-workers, and hospital records of PLHIV hospitalized and outpatient care.								
	Systematically record national spending on HIV and TB medical supplies through OECS pooled procurement								
	Expenditure on health professionals can be estimated through annual or quarterly “time-surveys” in which a sample of providers is asked to report the hours per week estimated to devote to HIV and/or SRH promotion and prevention programs, treatment and care.								
	Hospitals to record of the number of PLHIV that are hospitalized or seek outpatient care for these infections. Once the number of persons is recorded, an estimate of total costs can be constructed using a simple calculation of average cost of hospital stay or consultation.								

Grenada

Area	Mitigation Action	Lead Agent	Supporting Agents	Implementation Steps	Timeline				Cost estimate
					1st half 2021	2nd half 2021	1st half 2022	2nd half 2022	
Health systems	Deploy Global Fund resources as planned to resolve the interoperability challenges between existing country health databases and the eCBS. Consider using discretionary eCBS funds to purchase laptops for testing sites where needed.								
	Develop an education and communication plan to bring private practitioners on board to participate fully in the eCBS. Policies could require private practitioners to upload HIV and TB data to the eCBS.								
	Explore the possibility of a region-wide patient coding system								
	Investigate alternative methodologies to estimate population sizes of KPs and national/regional HIV and TB burdens								
	Develop plans to improve HIV cascade, focusing on the bottlenecks that are impeding progress on each of the three 90-90-90 indicators								
	Recruit, retain, and train more HIV staff including CSO members, especially those specializing in case finding (see Risk A.1)								
	Train community health aids to respect patient confidentiality								
	Implement standardized health professional training in HIV and TB care, including sensitization to gender and sexual diversity and issues of confidentiality								
	Pilot a formal social contracting arrangement for peers/CSO members to conduct counseling and monitoring, especially for new patients and non-adherent patients to ensure they remain on ARVs and virally suppressed (thereby boosting the second and third 90s)								
	Encourage patients who are currently lost to follow up to return to treatment through special incentives and connect them with a peer counselor as described above.								
	Pilot pay-for-performance program to incentivize public hospitals, clinics, and CSOs to expand testing and linkage to care.								
Financing	Investigate new sources of financing such as private philanthropies and the private sector. Explore donor mapping exercises								
	Explore the implementation of Debt to Health swaps where lenders forgive country debts, and in return, governments commit the freed debt repayment resources to KP programming.								
	Develop volunteer and internship agreements with public and global health programs in the region and around the world to serve as an interim solution for a lack of skilled labor.								

	Explore whether some HIV and TB programming, including for KPs, could be designed and administered at the regional level								
KPs and CSOs	Form an umbrella CSO to promote strategic partnership among existing CSOs								
	Allocate a combination of Global Fund grant financing and national budgets to support CSOs with capacity building in management, financing, and administration, and with office space								
	Strengthen a pan-OECS network of CSOs.								
	Task the National AIDS Program and CSOs with making a proposal for Social Contracting to senior officials in health, finance, and Prime Minister's Office								
	Allocate budgets for Social Contracting as part of agreed cofinancing								
	Country governments must determine which HIV and TB services they will outsource to CSOs under the Social Contracts, and estimate the unit and total costs so these can be included in performance-based agreements between government and CSOs.								
	Secure the needed domestic funding to implement the SC pilot, including MoH management and monitoring and payments to the CSOs for the services they deliver in HIV and TB.								
	Based on pilot results in the first year, governments to phase in contracting of CSOs (via dedicated budget line), expand the MoH budget for this purpose and reduce the matching funds from the Global Fund.								

St. Kitts & Nevis

Area	Mitigation Action	Lead Agent	Supporting Agents	Implementation Steps	Timeline				Cost estimate
					1st half 2021	2nd half 2021	1st half 2022	2nd half 2022	
Health systems	Assign and formalize roles for CSOs in adherence counseling, patient follow-up, and VCT in public facilities								
	Establish a partnership among the HTEP, National AIDS Programs, and health professional schools in the OECS to develop and implement HIV and TB sensitization and care training for new healthcare workers								
	Develop a standardized HIV and TB in-service training program to meet the specific needs of each OECS nation								
Financing	Use national funds to finance HIV commodities as part of Global Fund transition								
	Consider cost-sharing between national governments and the Global Fund as soon as possible for laboratory equipment								
	Pay for lab and other commodities, demonstrating the importance of these investments and how they have helped the OECS to build a resilient system for testing for Covid-19								
	Identify ways to increase efficiency and cost-effectiveness of laboratory services, setting specific targets for savings								
	including national health accounts, program-based budgeting, records of national purchases of HIV and TB medical supplies through OECS pooled procurement, annual or quarterly time-surveys of health-workers, and hospital records of PLHIV hospitalized and outpatient care.								
	Systematically record national spending on HIV and TB medical supplies through OECS pooled procurement								
	Expenditure on health professionals can be estimated through annual or quarterly “time-surveys” in which a sample of providers is asked to report the hours per week estimated to devote to HIV and/or SRH promotion and prevention programs, treatment and care.								
	Hospitals to record of the number of PLHIV that are hospitalized or seek outpatient care for these infections. Once the number of persons is recorded, an estimate of total costs can be constructed using a simple calculation of average cost of hospital stay or consultation.								
Governance	Establish dedicated budget lines for HIV and TB. Eliminate the practice of lumping HIV funds with other health line items								
	Update the NSPs with the assistance of PAHO, UNAIDS, and/or PANCAP. Engage all stakeholder to promote widespread and bipartisan support of the HIV and TB								

	response. Use the NSPs to demonstrate the benefits and ROI of smart investments in HIV and TB.								
	Examine pros and cons of realigning HIV and TB programs with other priority areas, including NCDs and climate change and health, to raise their political visibility and sustainability								
	Share documents and best practices on national strategic planning across countries.								

St. Lucia

Area	Mitigation Action	Lead Agent	Supporting Agents	Implementation Steps	Timeline				Cost estimate
					1st half 2021	2nd half 2021	1st half 2022	2nd half 2022	
Health systems	Deploy Global Fund resources as planned to resolve the interoperability challenges between existing country health databases and the eCBS. Consider using discretionary eCBS funds to purchase laptops for testing sites where needed.								
	Develop an education and communication plan to bring private practitioners on board to participate fully in the eCBS. Policies could require private practitioners to upload HIV and TB data to the eCBS.								
	Explore the possibility of a region-wide patient coding system								
	Investigate alternative methodologies to estimate population sizes of KPs and national/regional HIV and TB burdens								
Financing	Use national funds to finance HIV commodities as part of Global Fund transition								
	Consider cost-sharing between national governments and the Global Fund as soon as possible for laboratory equipment								
	Pay for lab and other commodities, demonstrating the importance of these investments and how they have helped the OECS to build a resilient system for testing for Covid-19								
	Identify ways to increase efficiency and cost-effectiveness of laboratory services, setting specific targets for savings								
	Sustain ongoing advocacy for including HIV and TB in UHC packages.								
	Communities of PLHIV and CSOs to position themselves as important voices in the national dialogue on NHI. Consider the use of Global Fund grants to promote discussions within the community, create an advocacy group, and develop a position paper.								
	Ensure HIV and TB testing, counseling, and treatment are free at point of care for all residents regardless of ability to pay, including non-nationals.								
	Non-national residents should be eligible to opt into NHI, for example by paying the average cost of the package adjusted for age and gender.								
	Explore earmarked levies on tobacco, alcohol, or luxury goods to finance HIV and TB components of NHI packages.								
	Conduct annual HIV and TB budget and expenditure monitoring, drawing on a range of sources including national health accounts, program-based budgeting, records of national purchases of HIV and TB medical supplies through OECS pooled								

	procurement, annual or quarterly time-surveys of health-workers, and hospital records of PLHIV hospitalized and outpatient care.								
	Systematically record national spending on HIV and TB medical supplies through OECS pooled procurement								
	Expenditure on health professionals can be estimated through annual or quarterly "time-surveys" in which a sample of providers is asked to report the hours per week estimated to devote to HIV and/or SRH promotion and prevention programs, treatment and care.								
	Hospitals to record of the number of PLHIV that are hospitalized or seek outpatient care for these infections. Once the number of persons is recorded, an estimate of total costs can be constructed using a simple calculation of average cost of hospital stay or consultation.								
	Once social contracting is initiated, contracts should specify spending by program area, e.g., counseling and education, testing, stigma and discrimination reduction								
KPs and CSOs	Develop steering committees to design a national social contracting policy, prepare plans, sensitize stakeholders, and secure budgets								
	Use Global Fund grant resources to analyze and improve legal frameworks and regulations for social contracting								
	Disseminate best practices to the six countries drawing on experiences from nearby countries with successful social contracting								
	Phase in government contracting of CSOs (using national budgets)								
	Task the National AIDS Program and CSOs with making a proposal for Social Contracting to senior officials in health, finance, and Prime Minister's Office								
	Allocate budgets for Social Contracting as part of agreed cofinancing								
	Country governments must determine which HIV and TB services they will outsource to CSOs under the Social Contracts, and estimate the unit and total costs so these can be included in performance-based agreements between government and CSOs.								
	Secure the needed domestic funding to implement the SC pilot, including MoH management and monitoring and payments to the CSOs for the services they deliver in HIV and TB.								
	Based on pilot results in the first year, governments to phase in contracting of CSOs (via dedicated budget line), expand the MoH budget for this purpose and reduce the matching funds from the Global Fund.								

St. Vincent & the Grenadines

Area	Mitigation Action	Lead Agent	Supporting Agents	Implementation Steps	Timeline				Cost estimate
					1st half 2021	2nd half 2021	1st half 2022	2nd half 2022	
Health systems	Assign and formalize roles for CSOs in adherence counseling, patient follow-up, and VCT in public facilities								
	Establish a partnership among the HTEP, National AIDS Programs, and health professional schools in the OECS to develop and implement HIV and TB sensitization and care training for new healthcare workers								
	Develop a standardized HIV and TB in-service training program to meet the specific needs of each OECS nation								
	Develop plans to improve HIV cascade, focusing on the bottlenecks that are impeding progress on each of the three 90-90-90 indicators								
	Recruit, retain, and train more HIV staff including CSO members, especially those specializing in case finding (see Risk A.1)								
	Train community health aids to respect patient confidentiality								
	Implement standardized health professional training in HIV and TB care, including sensitization to gender and sexual diversity and issues of confidentiality								
	Pilot a formal social contracting arrangement for peers/CSO members to conduct counseling and monitoring, especially for new patients and non-adherent patients to ensure they remain on ARVs and virally suppressed (thereby boosting the second and third 90s)								
	Encourage patients who are currently lost to follow up to return to treatment through special incentives and connect them with a peer counselor as described above.								
	Pilot pay-for-performance program to incentivize public hospitals, clinics, and CSOs to expand testing and linkage to care.								
Governance	Investigate national sources of funding for HTEP activities								
	Explore the idea of converting the RCM to a regional NGO. ECADE is an example of a successful regional NGO								