ANNUAL REPORT

# Scaling Up Prevention, Care And Treatment To Combat The HIV/AIDS Pandemic In The Organisation of Eastern Caribbean States

**Report for the Period March 1st 2005 to August 31st 2006**

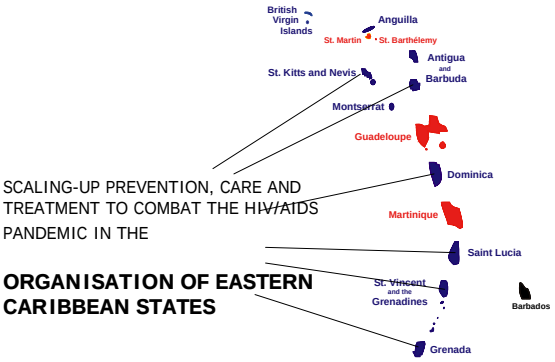
OECS

# SCALING UP PREVENTION, CARE AND TREATMENT TO COMBAT THE HIV/AIDS PANDEMIC IN THE ORGANISATION OF EASTERN CARIBBEAN STATES

Global Fund for HIV/AIDS, Tuberculosis and malaria
Grant Number MAE-305-G01-H

## Report for the Period March 1st 2005 to August 31st 2006

*The Report contained herein seeks to describe the implementation of the Plan described above for a period eighteen months from March 1st 2005 to August 31st 2006. Financial information will however be provided only for the period March 1st 2005 to February 28th 2006[1].*




## 1. BACKGROUND

The World Health Organization estimates the overall HIV/AIDS prevalence in the Caribbean to be the second highest in the world.

[1] The OECS Secretariat, as the Principal Recipient, has submitted a fifth quarter report covering the period March 1st to May 31st 2006. At the time of writing this report, the Local Fund Agent had not verified the data. Consequently, financial data is only provided for 12 months while programmatic data is provided for 18 months.

## The Project Design & Content

| | |
|---|---|
| **The Project Title** | ***Scaling up Prevention, Care and Treatment to combat the HIV/AIDS pandemic in the Organization of Eastern Caribbean States*** |
| **The Primary Target Populations (Beneficiaries)** | **Six (6) Member States of the OECS, namely, Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, Saint Lucia, and St. Vincent and the Grenadines** |
| **The Secondary Targets (Implementers)** | **a. Ministries of Health (and other line Ministries)**<br>**b. Local Non-Governmental agencies including FBOs and CBOs,**<br>**c. Regional Contractors e.g. UWI and CHRC** |
| **The Tertiary Targets (Fiduciary & Coordinating agencies)** | **a. The Regional Coordinating Mechanism**<br>**b. The Principal Recipient**<br>**c. The Ministries of Finance** |

The nine small island nations that compose the OECS sub-region (Anguilla, Antigua & Barbuda, the British Virgin Islands, Dominica, Grenada, Montserrat, St. Kitts & Nevis, St. Lucia and St. Vincent and the Grenadines), with a combined population of 609,000, have an estimated 5,000 persons living with HIV/AIDS (PLWHA). In small island nations, a HIV prevalence rate approaching one percent can rapidly affect the economic stability and overall health of the region. Thus the OECS has identified the fight against HIV/AIDS as critical to the sub-region's long-term economic growth and human development.

Recognizing the importance of a coordinated strategy to turn the tide on the pandemic, OECS Member States are implementing a plan to treat all persons living with HIV/AIDS and to prevent further infections. The primary objectives in this integrated prevention, care and treatment plan are to provide care and treatment to persons infected with HIV/AIDS to control the spread of HIV and mitigate the impact of AIDS on the human development of

the OECS through:

- The provision of universal access to care and treatment according to national protocols;
- Making VCT services available to the general population, with special emphasis on high-risk groups;
- Creating local capabilities to perform CD4 tests and clinically stage persons living with HIV/AIDS (PLWHAs);
- Procuring ARV medication at low cost;
- Removing barriers of stigma and discrimination through governmental and other actions;

- Strengthening surveillance programs;
- Strengthening contact tracing programs;
- Providing comprehensive HIV prevention services to educate infected and affected individuals, their families and the community;
- Broad-based and targeted HIV/AIDS awareness campaign to educate the public and promoting condom use; and
- Establishing monitoring and evaluation capabilities.

| | |
|---|---|
| **The Project 'Baseline' situation** | - In the total OECS population of 609,000 HIV Prevalence is "approaching one percent" in a mobile Caribbean region (with the second highest in world)<br>- Estimated total of 5,002 adults and 22 children are living with HIV/AIDS<br>- Estimated mortality rate from HIV/AIDS is 66%/5 yrs<br>- **Less than 5% of PLWHAs are in Treatment and Care Programs & about 1% are on ARV Therapy** |
| **The Project targets (within the next 5 years)** | - Decrease Mortality rate due to HIV/AIDS by 50 percent (for reported cases)<br>- Decrease Hospitalization from HIV/AIDS and related conditions by 50 percent (for reported cases)<br>- Offered comprehensive care and treatment (as per national protocols) to 100 percent of persons with HIV/AIDS who access the public health system<br>- Reduce transmission rate from HIV-infected mothers to their babies (from 25-30 percent) to <10 percent<br>- Increase the percentage of pregnant women receiving VCT services to 90-95 percent |

It is envisaged that by undertaking the activities identified above:

- Mortality rate due to HIV/AIDS will decrease by 50 percent (for reported cases)
- Hospitalization for HIV/AIDS and related conditions will decrease by 50 percent (for reported cases)
- One hundred per cent of persons with HIV/AIDS who access the public health system will be offered comprehensive care and treatment per national protocols
- The rate of transmission from HIV-infected mothers to their babies will be reduced from 25-30 percent currently to <10 percent.
- The percentage of pregnant women receiving VCT services will be increased to 90-95 percent.

## 2. INTRODUCTION

The Project financed by the Global Fund for HIV/AIDS Tuberculosis and Malaria (GFATM) seeks to develop a coordinated strategy among six countries (Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, Saint Lucia and St. Vincent and the Grenadines) in order to offer comprehensive care and treatment to all persons with HIV/AIDS who access the public health system. There are an estimated 5,100 people living with HIV/AIDS living in the six countries. The proposal aims to place 284 persons on antiretroviral (ARV) therapy during the first year and to reach over 1,700 over the 5 year proposal period.

As the Principal Recipient (PR) to the Grant, the OECS Secretariat, through the OECS HIV/AIDS Project Unit (HAPU) oversees the implementation of the project in accordance with the Grant Agreement. Project funds are intended, primarily, for co-financing the National AIDS Programs of the participating countries. To date, the OECS Secretariat has received USD 721,624 to cover the cost of activities during the first year of project implementation. An additional USD 510,586.00 has been approved, by the GFATM, for disbursement from the second year's budget. This phase of the project comes to an end on February 28th 2007. The Regional Coordinating Mechanism (RCM) for the Project, in collaboration with the the OECS is presently engaged in preparing a proposal for Phase II of the Project.

## 3. STATUS OF PROJECT IMPLEMENTATION

### 3.a Programmatic Performance

Regional Coordinating Mechanism

The OECS Secretariat, through its HAPU started project implementation only as of November 2005[2] after the relationships between the RCM and the PR were clearrly defined and articualted by the GFATM. At this meeting it was established that the PR was responsible for all aspects of project implementation, including Training and Monitoring and Evaluation (M&E)[3]. It was also established that inasmuch as the PR is responsible for all

[2] Pursuant to instructions that were issued by the OECS Authority, at its 42nd meeting that was held in Anguilla in November 2005.

[3] The initial lack of clarity on the governance structure of the project was inherited from the days when ECCB had been identified as the PR. The arrangements, at that time, were for ECCB to be only responsible for the fiduciary function; the RCM was therefore to be responsible for the M&E and Training deliverables. When the PR function was transferred to the OECS Secretariat, it was clearly stipulated in the Grant Agreement that in addition to the fiduciary function, the PR would also be responsible for all other aspects of project implementation, including M&E and Training.

aspects of project implementation, the RCM is the owner of the proposal and therefore has a vested interest to ensure that the project is implemented in a timely and efficient manner.

**Table 1: Number pf Persons on ARV Treatment and Accessing Care**

| Countries | No. of HIV(+) persons | | | No. of persons on ARV treatment | No. of persons accessing care |
|---|---|---|---|---|---|
| | M | F | Cumulative Total | | |
| Antigua and Barbuda | | | 553 | 60 | 105 |
| Dominica | | | 306 | 24 | 32 |
| Grenada | | | 277 | 25 | 49 |
| St. Kitts and Nevis | | | 252 | 39 | 49 |
| Saint Lucia | | | 592 | 24 | 68 |
| St Vincent and the Grenadines | | | 858 | 94 | 171 |
| | | | | | |
| Total | | | 2,838 | 266 | 474 |

Source: OECS HAPU

In February 2006, the OECS Secretariat met with some of the officials from the OECS RCM. That Meeting:

- Noted that the OECS RCM is now a legally established entity with clearly articulated by-laws.
- Agreed that:
  - (i) The Chairman of the RCM will be rotated once every two years;
  - (ii) In addition to the Chairman, the country from which s/he comes will have a two-person representation on the RCM, one of these persons will be a PLWHA;

(iii) The RCM will also have two representatives from each of the Overseas Territories who are Members of the OECS; and one representative from CRN++4;

(iv) The RCM will function as the Project Steering Committee and as such will undertake the following:

- monitor the progress of implementation of the Project through consideration of the various reports submitted by HAPU;
- approve the annual work programme and budget for the Project;
- provide guidance to the PR, and more specifically, to HAPU, on matters of policy and related issues that may enhance the implementation of the Project;
- at each quarterly meeting, the RCM will receive for its consideration and determination, written progress reports with appropriate recommendations from the PR. It may also, from time to time, request the preparation of specific reports dealing with issues that relate to the management and implementation of the Project.

(v) The RCM and the PR will meet quarterly. These meetings must include the Chairperson of the RCM; an additional Member of the RCM; a member of the RCM Secretariat; and representatives form the PR;

(vi) The annual meeting of the RCM will be held before the annual meeting of the OECS Ministers of Health. The Chairman of the RCM will report to the OECS Ministers of Health during their annual meeting;

(vii) The PR and the RCM will submit a joint proposal to DFID for additional funding;

(viii) The PR will undertake to formulate an OECS Agenda for HIV/AIDS, elements of which may be used by the RCM to develop a proposal for Phase II of the Project.

## OECS Accelerated Implementation Plan (OAIP)[5]

4 This is a regional agency representing the interests of PLWHAs

This Plan was developed, with assistance provided by the GFATM, in December 2005 in order to accelerate project implementation and to ensure that all project outputs for Phase 1 are delivered, and at least ninety per cent (90%) of the targets are met. The OAIP was then used to formulate individual Technical Assistance Plans (TAPs) for the countries. Each TAP identifies a comprehensive range of technical assistance that each Member States would require in order to achieve the project targets, in particular, and to scale the prevention, treatment and care for HIV/AIDS, in general. The TAPs were presented to a meeting of development partners that was held in February 2006. The TAPs are available for review at HAPU. Be that as it may, it will be useful to identify, for purposes of this report, the range of needs that Member States have identified. These include:

- Improved programme management and coordination
- Improved information management systems
- Strengthened and improved VCT services
- Improved pMTCT services
- Upgraded and decentralized treatment and care services for PLWHAs
- In support of prevention, treatment and care services
- Strengthening pharmaceutical services, including supply management
- Strengthening of surveillance systems
- Strengthening nutrition services units
- Strengthening the health promotion units
- Mobilising political will and national resources

Donor Coordination

The OECS Secretariat and the OECS RCM met with development partners in February 2006. The meeting was presented with the Technical Assistance Plans that HAPU, in collaboration with the National AIDS Programme staff, had developed for each country. Pursuant to that Meeting:

- The UN Theme Group has identified specific areas of assistance, e.g. UNAIDS will assist countries to monitor indicator 9.16; while UNFPA will assist with Voluntary Counselling and Testing (VCT) and access to condoms;
- PAHO CPC and CAREC have identified interventions in laboratory services and VCT;

5 Available, under separate cover, from OECS HAPU.

6 Percent of target population reached through awareness campaigns

- DFID provided an additional USD134,000 to cover the shortfall in the price of the first batch of ARVS and will finance an OECS HIV/AIDS programme;
- DFID will continue to provide financial assistance for the operations of the OECS RCM;
- I-TECH has provided a training coordinator to assist HAPU in implementing its training programme;
- The Centres for Disease Control (CDC) financing three additional posts[7] in HAPU for a period of one year;
- USAID has provided funds for one staff position in Dominica for one year;
- USAID will provide funds for one staff position each, in Grenada and Antigua and Barbuda, for a period of one year, to assist with programme management;
- The Clinton Foundation provided short term volunteers, to Grenada, St. Vincent and the Grenadines, Saint Lucia, Dominica and Antigua Barbuda, to assist in the preparation of second semester report to the GFATM.

The Assistance provided by the Development Partners is tabulated below.

**Table 2 Summary of Technical Assistance Provided by Partners**

| Partners | Countries | Area of Technical Assistance | Completion Dates |
|---|---|---|---|
| CAREC | Montserrat | Seroprevalence studies; surveillance; training | Dec-06 |
| | BVI | | |
| | Anguilla | | |
| | OECS | CD4 Machine Procurement | Dec-06 |
| CDC | OECS | Rapid Tests; Laboratory Services | Dec-06 |
| CHAI | HAPU | TA support to unit | On going |
| | Saint Lucia | NAP - Program Support | Aug-06 |

7 Programme officer, M&E Quality Assurance Officer, and a secretary

| Partners | Countries | Area of Technical Assistance | Completion Dates |
|---|---|---|---|
| | Dominica | NAP - Program Support | Aug-06 |
| | Antigua | NAP - Program Support | Aug-06 |
| | Nevis | NAP - Program Support | June-July-06 |
| | Grenada | NAP - Program Support | Aug-06<br>March 06 |
| | St. Vincent and the Grenadines | Forecasting Tool | Jun-06 |
| CHART (Harvard) | OECS | pMTCT, Paediatric; PEP protocol development | Jun-06 |
| CHRC | | Monitoring & Evaluation | May-07 |
| DFID | | Bridge Financing for GFATM<br>Financing OECS HIV/AIDS Porgramme | Jun-06<br>TBD |
| ITECH | | Program Management Training Course; Training Coordinator<br>Phase II proposal preparation | N/A<br>Aug-06 |
| Lutheran Medical Center | St. Kitts & Nevis | Patient Information Systems; Hardware Provisions | Dec-06 |
| PAHO | OECS | Laboratory services; VCT services; ARV Treatment related services; Provision of "Warm Bodies" | N/A |
| UNAIDS | OECS | Monitoring & Evaluation and Validation | Dec-06 |
| UNDP | Antigua & Barbuda | Program Management | Dec-06 |
| | Grenada | Program Management | Dec-06 |
| UNFPA | OECS | Prevention Education - Youth | May-08 |
| UNFPA | | Condom Supplies | May-08 |
| USAID/CDC | OECS | Monitoring & Evaluation<br>Programme Management<br>Administration<br>Formulation of RBM Framework for OECS HIV/AIDS Programme | Sep -06<br><br><br>Jun-06 |
| | Antigua & Barbuda | Program Management | N/A |
| | Grenada | Program Management | N/A |

| Partners | Countries | Area of Technical Assistance | Completion Dates |
|---|---|---|---|
| | Dominica | NAP - Program Support | May-06 |

Source: OECS HAPU

Procurement and Supply Management Plan

The OECS Secretariat, through HAPU and PPS, in collaboration with the National Implementing Authorities (NIAs), i.e., the Ministries of Health (MoH), will ensure that (i) the appropriate quality products and (ii) the correct quantity at the right time at the lowest possible overall price, are procured in compliance with international laws and regulations, and used in a rational way.

The capacity at national levels (SRs[8] and NIAs) is being built to standardize treatment protocols, lab systems, VCT sites, and Central Medical Stores, (CMS). Additional capacity is being built in the area of forecasting for HAART, reagents, rapid tests, and information systems, (especially surveillance systems) so that the sub-region can continue to benefit from pooled procurement; this practice ensures the lowest possible prices are obtained and that the OECS countries will be able implement an 'island to island' replacement system in case of stock outs due to slow supplier turn around.

To gain approval on all procurement activities the PR requires an 'open' bid process, using principles of transparency and free competition and adherence to national and international standards, as well as the use of formats with clear rules for suppliers, and clear technical specifications. The PR has established an evaluation criteria for (i) technical aspects to ensure the supplier's ability to fulfill the contract; (ii) ensuring that contracts are awarded for quality products at prices that are in line with market prices or below market prices; and (iii) monitoring the delivery, use and location of the products procured, in order to ensure that intended results are achieved.

Similar to the procurement of goods, the procedures for procurement of services will be subject to the following principles:

- Quality of services provided
- Transparency and reliability in the processes
- Equal opportunities for all providers of services with ensured competitiveness
- Economy and efficiency
- Promoting the participation of regional contractors and manufacturers

[8] Sub recipient

The NIAs shall be responsible for the procurement of services, health products, health related products and equipment, and non health-related items utilized in the project. Once a budget is approved for hiring or contracting a service with an external agency, the NIA will procure the service according to the above principles. Whether hiring personnel for full-time positions, or seeking technical assistance and training services, NIAs will first seek persons on-island. If expertise is not on-island, the NIA will award contracts to regional and international experts in the field. These contracts shall be structured to build local capacity so that reliance on these outside experts decreases over time. For instance, in the area of training of healthcare workers, the initial years of a contract may include several regional workshops and small "train the trainer" sessions on-island.

The Pharmaceutical Procurement Services (PPS) will be responsible for procuring all HAART, OIs, and essential medicines for the care of HIV and AIDS related conditions.

The Information Technology Office of the Secretariat, in consultation with HAPU's Project Coordinator and IT support from our partners of the PR's HIV/AIDS Project Unit (HAPU), will be responsible for the procurement of such items as computers and software.

The NIA's shall be responsible of the procurement for health products, services, including awarding contracts, health related products and equipment and non health-related commodities utilized in the project. HAPU, and in particular, the finance officer in HAPU, will be responsible for reviewing and ensuring the proper standards for all contracts, services and items procured within the project by SRs or NIAs. Additionally HAPU, in specific the Project Coordinator, will procure the services and award contracts to international and regional agencies in the area of training and Monitoring and Evaluation.

## Anti-Retroviral Drugs

The procurement of anti-retroviral drugs (ARVs) is the sole responsibility of the OECS Pharmaceutical Procurement Services (PPS) which, for purposed of this Project undertakes the following functions:

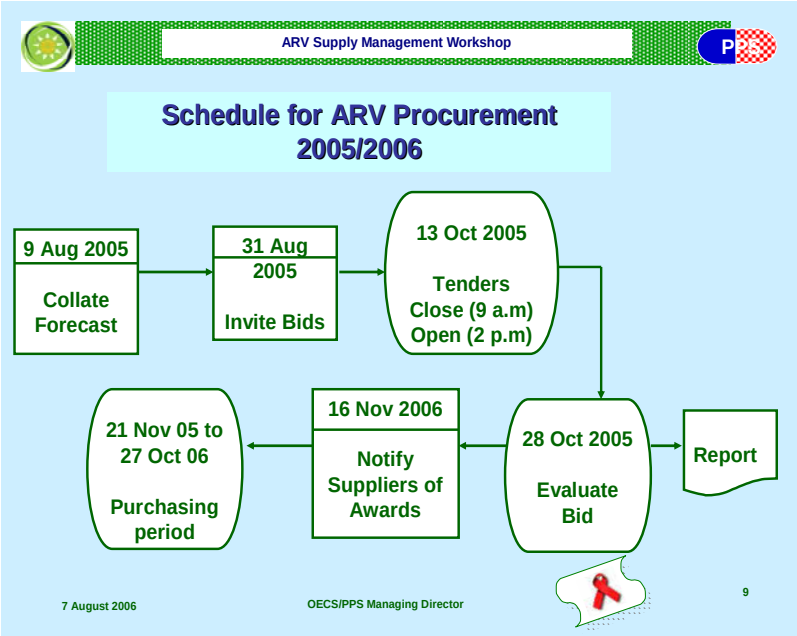
- Procure ARVs
- Forecast for ARVs
- Pharmacovigilance
- Track drug resistance
- Implementation of the procurement and supply management plan for drug commodities
- Monitor supplier performance, product quality, adherence to national treatment protocols.

The Procurement and Supply Management Plan provides guidelines for :

- Biannual inventory reports
- Prescription service levels
- Biannual stock-out reports
- Biannual expenditure reports
- Tendering selection and contracting of suppliers

The first batch of ARVs was ordered in December 2005. Fifteen Dosage forms were procured at a cost of USD 193,000.00 from 4 contracted suppliers[9]. These dosage forms catered to first and second line drugs; no order was placed for paediatric suspensions. However, the Clinton Foundation has committed to the OECS a one-time donation for pediatric suspension to treat 30 babies and young children for a one year period.

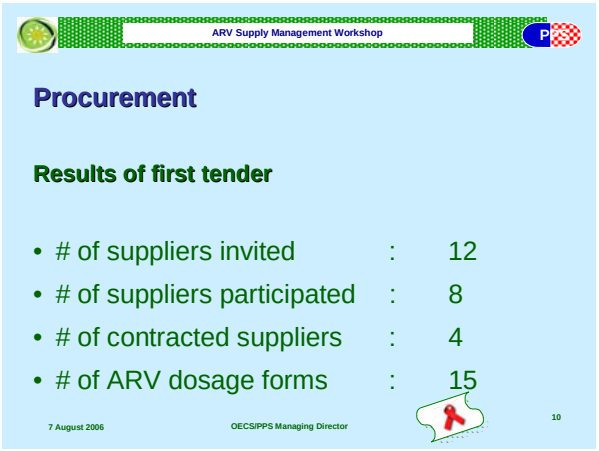
**Figure 1: Schedule for ARV PROCUREMENT**

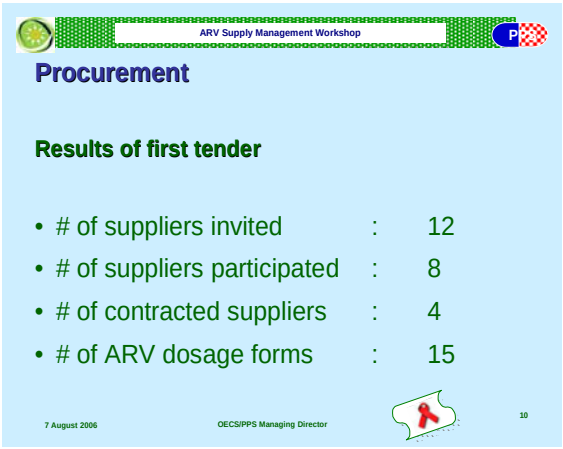



A description of the results of the first tender are provided in Figures 2 to 4.

**Figure 2: Results of the First Tender**

[9] Three of the suppliers are from India; the forth is from Barbados.


ARV Supply Management Workshop
Procurement
Results of first tender
• # of suppliers invited : 12
• # of suppliers participated : 8
• # of contracted suppliers : 4
• # of ARV dosage forms : 15
7 August 2006
OECS/PPS Managing Director
10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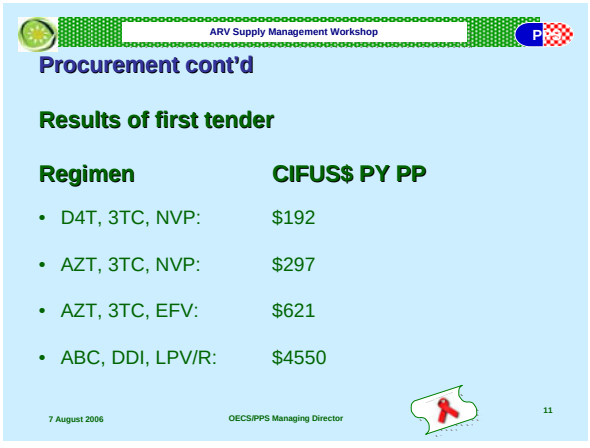

ARV Supply Management Workshop
Procurement cont'd
Results of first tender
Regimen CIFUS$ PY PP
• D4T, 3TC, NVP: $192
• AZT, 3TC, NVP: $297
• AZT, 3TC, EFV: $621
• ABC, DDI, LPV/R: $4550
7 August 2006
OECS/PPS Managing Director
11

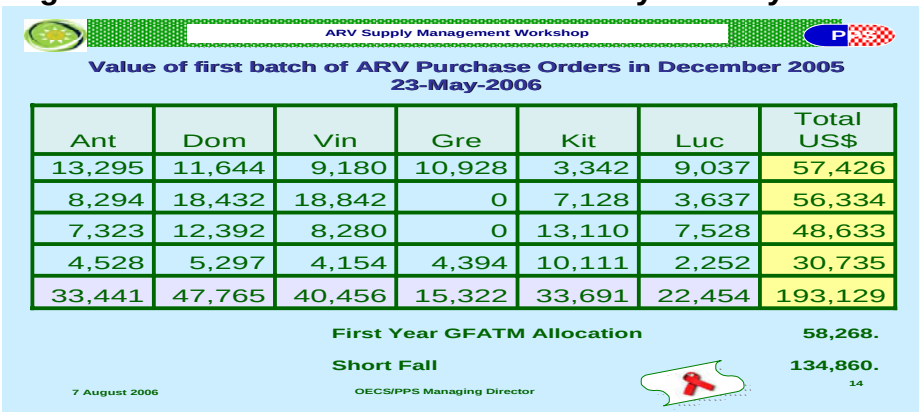
## Figure 3: List of Tendered ARVs by Country

| LIST OF TENDERED ARVS FOR OECS GLOBAL FUND 2005 - 2006 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| DRUG GENERIC NAME (strength, dosage form) | ANT | DOM | GRE | KIT | VIN | LUC | 1 Year total for all countries | Total Price US$ |
| | No. of Patients | | | | | | | |
| | 100 | 54 | 42 | 56 | 56 | 57 | | |
| Abacavir 300mg Tablet | 6,000 | 2,500 | | 4,000 | 7,000 | 400 | 19,900 | 21,890.00 |
| Didanosine 200 Tablet | | | 1,200 | | | | 1,200 | 0.00 |
| Didanosine 250 Tablet | | 3,100 | 1,200 | | | 1,700 | 6,000 | 8,950.00 |
| Didanosine 400mg Tablet | | | | | 2,000 | | 2,000 | |
| Efavirenz 600mg Tablet | 3,000 | 1,300 | | 2,000 | 2,000 | 20,000 | 28,300 | 25,470.00 |
| Indinavir 400 Tablet | 11,000 | 4,000 | | 8,000 | | 3,000 | 26,000 | 4,802.78 |
| Lamivudine 150mg Tablet | 13,000 | 6,000 | | 9,000 | 16,000 | 3,000 | 47,000 | 3,681.67 |
| Lamivudine 150mg/ Zidovudine 300mg Tablet | 72,000 | 39,000 | 30,000 | 40,000 | 40,000 | 41,000 | 262,000 | 60,347.33 |
| Lopinavir 133mg/ Ritonavir 33mg tablet | 11,000 | 12,000 | 7,000 | 11,000 | 15,400 | 10,000 | 66,400 | 33,015.56 |
| Nelfinavir 250 Tablet | | | 1,500 | | 51,300 | | 52,800 | 32,825.96 |
| Nevirapine 200mg Tablet | 72,000 | 39,000 | 20,000 | 40,000 | 40,000 | 3,000 | 214,000 | 20,865.00 |
| Stavudine 20mg Capsule | | 1,600 | | | | 2,000 | 3,600 | 120.00 |
| Stavudine 30mg Capsule | | | | 4,000 | 7,200 | 3,000 | 14,200 | 582.20 |
| Stavudine 40mg Capsule | 6,000 | | 2,000 | 4,000 | 3,000 | 3,000 | 18,000 | 741.00 |
| Tenofovir 300mg Tablet | | 3,100 | | | | 1,700 | 4,800 | 0.00 |
| Zidovudine 300 Tablet | 13,000 | 6,000 | 1,500 | | | 3,000 | 23,500 | 3,720.83 |
| | | | | | | | | 217,012 |
| | | | | | | | | EC$585,933 |

7 August 2006 OECS/PPS Managing Director



## Figure 4: Value of First Batch of ARVs by Country



The difficulties experienced with the suppliers included:

- Few suppliers
- Distant suppliers
- Poor supplier performance

The table below is a sample of the typical supplier leadtime.

**Table 3: Supplier Leadtime for Purchases destined for St. Vincent and the Grenadines**

| Supplier | Purchase Order Date | P.O. arrive | Leadtime (Days) |
|---|---|---|---|
| Cipla | 7/12/05 | 22/3/06 | 105 |
| Collins | 7/12/05 | 25/1/06 | 49 |
| Hetereo | 7/12/05 | 25/1/06 | 49 |
| Ranbaxy | 7/12/05 | 4/4/06 | 118 |

The OECS PPS has adapted a monitoring tool for the **Prescription Service Level for ARV which** is shown below.

| Rx # | # of Prescribed Drugs | # of Drugs Dispensed |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 30 | | |
| Total | X | Y |

Service level: Percentage of prescribed drugs that were actually dispensed for 30 prescriptions, X/Y x 100%.

The first forecast ARVs was PPS-driven and was based on morbidity and consumption methods. The factors that were used for calculating the order quantity included average monthly consumption (CA); lead-time (LT); safety stock (SS); minimum stock level (Smin); maximum stock level (Smax); stock position (SP) and the procurement period (PP). There were a number of difficulties experienced in the forecasting:

- Unreliable forecast data
- ADR
- Donations
- Evolving science

**Table 4: variances between Forecast and Purchased Quantities**

| Drug Generic Name and Description | OECS Forecast | OECS Purchases | % Difference |
|---|---|---|---|
| Abacavir 300mg Tab | 8,000 | 20,400 | 255 |
| Didanosine 200mg Tab | 1,000 | 14,640 | 1464 |
| Didanosine 250mg Tab | 1,700 | 8,820 | 519 |
| Didanosine 400mg Tab | 1,700 | 15,840 | 932 |
| Efavirenz 600mg Tab | 13,200 | 34,170 | 259 |
| Indinavir 400mg Cap | 15,100 | 23,400 | 155 |
| Lamivudine 150mg Tab | 38,300 | 28,020 | 73 |
| Lamivudine 150mg/Zidovudine 300mg Tab | 186,000 | 96,120 | 52 |
| Lopinavir 133mg/Ritonavir 33mg Tab | 41,000 | 45,360 | 111 |
| Nelfinavir 250mg Tab | 52,700 | 40,230 | 76 |
| Nevirapine 200mg Tab | 170,300 | 79,380 | 47 |
| Stavudine 20mg Cap | 600 | 5,520 | 920 |
| Stavudine 30mg Cap | 10,200 | 22,440 | 220 |
| Stavudine 40mg Cap | 11,200 | 34,320 | 306 |
| Zidovudine 300mg Tab | 16,700 | 35,280 | 211 |
| | | Average | 373 |

| Country | Source: Central Medical Stores | Source: Clinical Care Coordinators |
|---|---|---|
| Dominica | 35 | 24 |
| St. Vincent and the Grenadines | 62 | 94 |
| Saint Lucia | 34 | 24 |
| St. Kitts and Nevis | 54 | 39 |
| Grenada | 25 | 25 |
| Antigua and Barbuda | 53 | 60 |
| **Total** | **263** | **266** |

**Table 5: Number of Patients on ARVs, May 4th 2006**.

**Table 6: In-country Usage of ARVs**

| Country | Population | Persons on Treatment | Per capita ARV usage |
|---|---|---|---|
| ANT | 75,000 | 60 | 1,250 |
| DOM | 72,000 | 24 | 3,000 |
| GRE | 94,000 | 25 | 3,760 |
| KIT | 45,000 | 39 | 1,154 |
| LUC | 160,000 | 24 | 6,667 |
| VIN | 108,000 | 94 | 1,149 |
| TOTAL | 552,000 | 266 | 2830…Average |

There are 2 national treatments that OECS PPS has provided for:

| | |
|---|---|
| Zidovudine<br>Lamivudine<br>Nevirapine | Zidovudine<br>Lamivudine<br>Efavirenz |

The OECS PPS has identified a number of challenges in the procurement of the ARVs. These include, *inter alia*:

- Misdirected shipments
- Unreliable forecast data for ARVs
- Inadequate GFATM allocation for ARVs in the first year
- Inconsistent data[10] on patients receiving ARVs
- Small orders to multiple trans-shipment points
- Compliance with Global Fund Procurement Policy

Attainment of Targets

The OECS HAPU has formulated an Monitoring and Evaluation (M&E) Plan which serves to outline the process and objectives of the Principle Recipient's plan for monitoring and evaluating the pertinent HIV/AIDS activities within the Member States. This will ensure national programs programmes address the issue of collection, consolidation, and verification of country based information and on the bases of that allow for interpretation and further instructions to the country and to ensure that progress is made towards the reaching the intended targets and overall objectives.

| Indicator type | Frequency of M&E(OECS) | Frequency of M&E (National) |
|---|---|---|
| Input indicators | Continuously | Monthly/ Quarterly |
| Process indicators | Quarterly | Semi-annually |
| Output indicators | Quarterly | Semi-annually |
| Outcome indicators | Annually | Biennially |
| Impact indicators | Annually | Biennially |

**Table 7: Frequency of M&E by Indicator type, by Institutional Level and by Jurisdiction**

[10] There has been a variance in the numbers of patients provided by the Central Medical Stores and by the Clinical Care Coordinators.

## Table 8: M&E Framework

| Program / Service Delivery Area | | | Impacts of the Program | | | |
|---|---|---|---|---|---|---|
| IMPACT | INDICATORS | Baseline and date of baseline | Target and year of target | Partners involved in Measurement | Data Source | Frequency |
| | 1 Survival rates of PLWHA accessing treatment and care at 6, 12 and 18 months | | | *CCC* | Infectious Disease Clinic | Quarterly |
| | 2 Syphilis and Hep B prevalence among pregnant women | | | PMTCT | PMTCT report, Weekly laboratory report | Quarterly |
| | 3 Percentage of HIV infected infants born to HIV infected mothers | | | PMTCT | PMTCT report, Weekly laboratory report | Quarterly |
| | 4 Percentage of young people aged 15-24 that are HIV infected | | | CAREC | Special surveys of general population | Biennial |
| | 5 Percentage of young people 15-24 reporting condom use with a non regular sexual partner | | | NAPC | Population survey | Biennial |
| | 6 Percentage of young people who know at least one formal source of condom | | | NAPC | Population based survey | Biennial |
| | 7 HIV prevalence among pregnant women ages 15 - 24 | | | PMTCT | Sentinel Surveillance | Annual |
| | 8 Percentage of population aged 15 -45 receiving HIV test results in last 12 months | | | CCC | Program Reports | Annual |

| Program / Service Delivery Area | | | Impacts of the Program | | | |
|---|---|---|---|---|---|---|
| | **INDICATORS** | **Baseline and date of baseline** | **Target and year of target** | **Partners involved in Measurement** | **Data Source** | **Frequency** |
| 9 | Percentage of all pregnant women attending at least 1 ante natal clinic visit who received an HIV test result and post test counselling | | | PMTCT | Program Reports | Annual |
| 10 | Percentage of people with advanced HIV infection receiving ART | | | CCC | Program Reports | Annual |
| 11 | Percentage of Health Care facilities that protect against discrimination (eg. HIV test with informed consent) | | | NAPC | Health Facility Survey | Biennial |
| 12 | Amount of National funds spent by Governments on HIV/AIDS | | | NAPC/MOH | Program Records | Annual |

In order to build capacities for M&E, the M&E Officer in HAPU, in collaboration with CHRC, undertook the following activities:

- Assessment of country's ability to report accurately on each of the 15 indicators
- Recreate forms to collect data
- Conduct training in the use of excel for data entry
- Development of new forms for data collection, abstraction, compilation and reporting
- Conduct M&E workshop for National HIV/AIDS Coordinators and M&E Officers to review in detail, as well as developing operational definitions for all the indicators
- Assisted countries in the development of M&E frameworks
- Facilitated the setting up of data flow system for the collection of data and reporting
- Establishment of focal points and counterparts for M&E and Finance in each of the countries
- Assisted countries with the development of work plans

- Strengthen M&E Officers' capability to collect data on the indicators by providing guidelines for managing, monitoring and ensuring that information on indicators are reported to the national HIV/AIDS programme on time.
- Ensuring that quality control measures are adhered to for purposes of data verification.

A further elaboration of the capacity building activities by indicator type is provided in Table below.

**Table 9: Capacity Building by Indicator**

| ORIGINAL GFATM INDICATOR | Capacity Building Activities Undertaken by Indicator |
|---|---|
| 1.1 No. of PLWHA who access public health care systems and are provided with integrated care and treatment as per defined protocols. | • Determined the gaps/ volume of work to be undertaken by countries to achieve their targets<br>• Establishment at country level Clinical Care Coordinator (CCC) and team<br>• Provided training<br>• Establish operational definitions of indicator and M&E systems within the six countries<br>• Assessed systems for measurement for persons on ARV's<br>• Development and approval of protocols<br>• Development of tools to capture data |
| 1.2 No. of service delivery personnel trained in HIV/AIDS primary care. | • Provided training for health service delivery personnel in the areas of VCT, Lab, Nurses, Doctors<br>• Training in M&E and in Informatics<br>• Development of tools to capture data |
| 1.3 No. of PLWHA receiving anti-retroviral therapy. | • Development of data capture tools<br>• Training for Clinical Care Team |
| 2.1 No. of individuals participating in VCT programmes. | • Training for new VCT providers to enable the country to roll out more sites<br>• Operationalisation of definition to ensure uniformity in data collection<br>• Development of data capture tools |
| 2.2 No. and % of district health centers providing VCT services. | • Development of data capture tools<br>• Training of counselors in VCT<br>• Establishing the process for reporting on this indicator |

| ORIGINAL GFATM INDICATOR | Capacity Building Activities Undertaken by Indicator |
|---|---|
| 2.3 No. of national programmes incorporating contact tracing protocols into VCT services | • Assistance with protocol development<br>• Facilitate the sharing of protocols<br>• Development of data capture tools |
| **2.4** No. of countries with completed sero prevalence studies in two or more high risk populations (CSW, MSM, youth). | • Establishing the target population and clarification on methodology to be used |
| **3.1** No. of CD4 counts performed within the previous 12-month period. | • Development of data capture tools<br>• Training for CCC team |
| **4.1** Average cost of qualified first-line therapy per patient/year. | • PPS has satisfied the requirements for this indicator |
| **5.1** No. (and %) of persons under ARVs who are aware of recourse mechanisms available to them by the government to redress complaints of discrimination. | • Assist countries in developing a format to satisfy this indicator<br>• Development of data capture tools<br>• Establishing methodology to be used to ensure fulfillment of indicator |
| **6.1** Reported cases as a percent (and estimated number) of seroprevalance estimates. | • Data capture tools developed<br>• Operationalized definitions |
| **7.1** No. of countries with contact tracing protocols developed, implemented and evaluated for effectiveness. (Year 1 identifies the no. of countries with contact tracing protocols developed and implemented. Year 2 identifies the no. of | • Assistance with protocol development<br>• Definitions operationalised to facilitate uniformity in data collection amongst the countries<br>• Data capture tools developed |

| ORIGINAL GFATM INDICATOR | Capacity Building Activities Undertaken by Indicator |
|---|---|
| countries with contact tracing protocols evaluated for effectiveness.) | |
| **8.1** No. of workshops to increase knowledge of PLWHAs in care about effective HIV prevention techniques. | • Clarification of definitions to ensure workshops held for PLWHA's<br>• Assisted with the identification of topics to be addressed at training |
| **9.1** Percent of target population reached through awareness campaigns. | • Refinement of the definition of what the target and target populations are.<br>• Identification of methodology to collect data<br>• Revision and strengthening of recording and reporting methods used |
| **9.2** No. and % of community health centers with condoms in stock. | • Data capture tools developed<br>• Strengthening of reporting mechanism and data collection |

The next two tables provide an update of the status of attainment of the indicators as of May 30th 2006 and identifies some of the activities that need to happen to accelerate the attainment of the targets.

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## Table 10 Status of Indicators as of May 30th 2006

| GFATM Quarter 5 Country Reports | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ORIGINAL GFATM INDICATOR | Total (regional) target for Q5 only | Total (regional) actual data for Q5 only | % of Q5 Achieved | Antigua | Dominica | Grenada | St Kitts | St. Lucia | St Vincent |
| | | | | Actual Q5 | Actual Q5 | Actual Q5 | Actual Q5 | Actual Q5 | Actual Q5 |
| OBJECTIVE 1 - PROVIDE UNIVERSAL ACCESS TO CARE AND TREATMENT ACCORDING TO NATIONAL PROTOCOLS | | | | | | | | | |
| 1.1 No. of PLWHA who access public health care systems and are provided with integrated care and treatment as per defined protocols. | 290 | 79 | 27 | 30 | 4 | 6 | 4 | 17 | 18 |
| 1.2 No. of service delivery personnel trained in HIV/AIDS primary care. | 39 | 214 | 549 | 37 | 83 | 15 | 0 | 0 | 79 |
| 1.3 No. of PLWHA receiving anti-retroviral therapy. | 142 | 77 | 54 | 24 | 1 | 2 | 25 | 15 | 10 |
| Objective 2 - MAKE VOLUNTARY COUNSELLING AND TESTING (VCT) SERVICES AVAILABLE TO THE GENERAL POPULATION WITH SPECIAL EMPHASIS ON HIGH RISK GROUPS | | | | | | | | | |
| 2.1 No. of individuals participating in VCT programmes. | 5,000 | 5,017 | 100 | 757 | 659 | 511 | 322 | 969 | 1,799 |
| 2.2 No. and % of district health centers providing VCT services. | 78 | 79 | 101 | 7 | 7 | 5 | 15 | 6 | 39 |
| 2.3 No. of national programmes incorporating contact tracing protocols into VCT services. | 2 | 3 Dev. | 150 | dev. | Dev. | Draft | 0 | Dev. | Draft |

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| GFATM Quarter 5 Country Reports | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ORIGINAL GFATM INDICATOR | Total (regional) target for Q5 only | Total (regional) actual data for Q5 only | % of Q5 Achieved | Antigua | Dominica | Grenada | St Kitts | St. Lucia | St Vincent |
| | | | | Actual Q5 | Actual Q5 | Actual Q5 | Actual Q5 | Actual Q5 | Actual Q5 |
| 2.4 No. of countries with completed seroprevalence studies in two or more high risk populations (CSW, MSM, youth). | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Objective 3 - CREATE LOCAL CAPACITY TO PERFORM CD4 AND CLINICALLY STAGE PLWHA | | | | | | | | | |
| 3.1 No. of CD4 counts performed within the previous 12-month period. | 579 | 171 | 30 | 1 | 16 | 48 | 5 | 5 | 96 |
| Objective 4 - PROCURE ARV MEDICATIONS AT A LOW COST | | | | | | | | | |
| 4.1 Average cost of qualified first-line therapy per patient/year. | $472 | $290.00 | $163.00 | $290.00 | $290.00 | $290.00 | $290.00 | $290.00 | $290.00 |
| Objective 5 - TO REMOVE THE BARRIERS OF STIGMA AND DISCRIMINATION THROUGH GOVERNMENT AND OTHER ORGANIZATIONAL ACTIONS | | | | | | | | | |
| 5.1 No. (and %) of persons under ARVs who are aware of recourse mechanisms available to them by the government to redress complaints of discrimination. | 83 | 49 | 59 | 0 | 0 | 5 | 0 | 6 | 38 |
| Objective 6 - Strengthen Surveillance Programs | | | | | | | | | |

| GFATM Quarter 5 Country Reports | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ORIGINAL GFATM INDICATOR | Total (regional) target for Q5 only | Total (regional) actual data for Q5 only | % of Q5 Achieved | Antigua | Dominica | Grenada | St Kitts | St. Lucia | St Vincent |
| | | | | Actual Q5 | Actual Q5 | Actual Q5 | Actual Q5 | Actual Q5 | Actual Q5 |
| 6.1 Reported cases as a percent (and estimated number) of seroprevalence estimates. | 300 | 122 | 41 | 14 | 5 | 16 | 0 | 72 | 15 |
| Objective 7 - Strengthen Contact Tracing Protocols | | | | | | | | | |
| 7.1 No. of countries with contact tracing protocols developed, implemented and evaluated for effectiveness. (Year 1 identifies the no. of countries with contact tracing protocols developed and implemented. | 6 | 3 Dev. | 50 | | Dev. | Draft | 0 | Dev. | Dev. |
| Objective 8 - To provide comprehensive HIV prevention services to educate infected and affected individuals and their family | | | | | | | | | |
| 8.1 No. of workshops to increase knowledge of PLWHAs in care about effective HIV prevention techniques. | 3 | 15 | 500 | 1 | 8 | 0 | 0 | 4 | 2 |
| Objective 9 - CONTINUE HIV/AIDS AWARENESS CAMPAIGNS TO EDUCATE THE PUBLIC AND TO PROMOTE CONDOM USE | | | | | | | | | |
| 9.1 Percent of target population reached through awareness campaigns. | | | | | | | | | |
| 9.2 No. and % of community health centers with condoms in stock. | 46 | 166 | 361 | 9 | 36 | 32 | 17 | 33 | 39 |

## Table 11: Scaling Up Activities to Attain Full Coverage of Targets

| Indicators | Comments : What needs to happen at Country level |
|---|---|
| **1.1 No of PLWHA who access public health care systems and are provided with integrated care and treatment as per defined protocols** | Scaling up of services; Know your status campaigns; Reducing stigma and discrimination and introduction of HAART. |
| **1.2 No. of service delivery personnel trained in HIV/AIDS primary care** | Specific training to address challenges; adherence counselling; DOTS; New approaches to training e.g. study tours. |
| **1.3 No. of PLWHA receiving anti-retroviral therapy** | Removal of barriers to accessing care; improvement in adherence rates; confidentiality of services; preparation of clients and information on the availability of treatment. |
| **2.1 No. of individuals participating in VCT programmes** | Explore use of new methodologies - mobile VCT, rapid tests, edutainment models to incorporate the full VCT service. Revision of how this data is collected. |
| **2.2 No. and % of district health centers providing VCT services** | Rolling out of VCT sites - gradual. This has implications for infrastructure, staffing, salaries, national budgets. |
| **2.3 No. of national programmes incorporating contact tracing protocols into VCT services** | Finalize draft protocols. Review/develop protocols. Use of STI contact tracing protocols |
| **2.4 No. of countries with completed seroprevalence studies in two or more high risk populations (CSW, MSM, youth)** | CAREC to conduct studies. Protocol has been developed and is being reviewed by the countries. Studies to commence September. |

| Indicators | Comments : What needs to happen at Country level |
|---|---|
| **3.1 No. of CD4 counts performed within the previous 12-month period** | Operationalisation and validation of CD4 machines to be given priority so as to reduce the prolonged feedback on tests results from CAREC |
| **4.1 Average cost of qualified first-line therapy per patient/year** | CHAI has been able to negotiate 1st line therapy at low cost |
| **5.1 No. and % of persons under ARVs who are aware of recourse mechanisms available to them by the government to redress complaints of discrimination** | Develop brochures to address this indicator. Review of brochures developed. Provision of documentation of what CCC's are doing in this regard. |
| **6.1 Reported cases as a percent of seroprevalence estimates** | Report on cases are ongoing as identified |
| **7.1 No. of countries with contact tracing protocols developed, implemented and evaluated for effectiveness** | Full implementation of protocols, since evaluation is to take place in quarter 8. Training in use of protocols needs to be done with all those who will be using the protocols. |
| **8.1 No. of workshops to increase knowledge of PLWHAs in care about effective HIV prevention techniques** | Ongoing empowerment of PLWHAs. Encourage PLWHAs to take the responsibility for their health. Need to address stigma and discrimination issues in collaboration with PLWHA organisations. |
| **9.1 Percent of target population reached through awareness campaigns** | Validation measures to address this indicator require urgent attention. A number of awareness activities are conducted but there is difficulty in measuring the impact and coverage. Requires a uniform way of measuring these activities. UNAIDS to assist with measuring this indicator |
| **9.2 No. and % of community health centers with condoms in stock** | Closer monitoring of this indicator is required. Need to utilise the data verification tools developed |

Indicator Measurement Tools

In collaboration with the Clinton Foundation, HAPU has drafted a tool for verifying the indicators. This document is intended to be a guide to the data documentation and subsequent verification process for the OECS GFATM Phase I indicators. The provision of indicator-by-indicator definitions, and required document submissions as well as the assessment criteria will be discussed. The document will inform National Programs on how to prepare for the data verification process by first, acting as documentation for the project's standards for reaching the target value, second, by acting as a source for defining objectives and indicators terminology, and thirdly, by providing supporting assessment information on each indicator.

UNAIDS has also provided assistance in formulating a measurement tool for indicator 9.1 This indicator was formulated as a composite measurement of outputs (products and services) relating to continuation and scale up of 'awareness campaigns' in six countries, under proposal Objective 9: "Continue HIV/AIDS Awareness Campaigns to educate the pubic and to promote condom use." Unfortunately, measuring the coverage of awareness campaigns implemented by multiple organisations among multiple target groups, across six countries, poses a challenge.

An important source of information on current IEC/BCC activities at the country level relating to indicators 5.1 and 9.1 for the OECS-GFTAM grant is the Clinton Foundation's IEC report produced in June 2006. The Foundation carried out an IEC assessment during October 2005 and April 2006 in four countries: Dominica, St Kitts and Nevis, St Lucia, Grenada and St Vincent, with the intention of providing technical assistance for strengthening national IEC/BCC strategies, and ensuring the inclusion of awareness campaigns on treatment literacy.

National Work Plans

During the pre-implementation Phase of the GFATM project, all target countries developed annual work plans for both year 1 and Year 2; St Kitts and Nevis, however, has a work plan for only Year 1. Given the low level of spending and the limitations of time, OECS HAPU embarked on a GFATM-approved plan to revise the work plans accordingly. The revised work plans, which are now aligned with the Grant Agreement, are available under separate cover from HAPU.

Training

The Harvard Medical School Division of AIDS, through CHART, was contracted to provide training and capacity building in support of the efforts to expand HIV care and treatment including ART in the OECS. These activities have focused on

- Needs Assessments in all 6 countries
- Protocol development (ongoing):
    - Treatment and care (adult and paediatrics): Dominica, St Vincent and Grenadines, Grenada
    - pMTCT: Dominica, St Vincent and Grenadines, Grenada, Antigua and Barbuda, St Lucia
    - Post exposure prophylaxis: Dominica, St Vincent and Grenadines, Grenada
    - Partner Notification, Counselling and Referral Services (previously known as Contact tracing): St Vincent and Grenadines
    - Opportunistic infection management: Dominica, St Vincent and Grenadines, Grenada
- Didactic training11:
    - HIV care including Antiretroviral therapy (adult and paediatric), pMTCT, PEP, adherence, Opportunistic infection prevention and treatment
- Preceptorship
    - Adult and paediatric HIV care: Dominica, St Vincent and Grenadines
    - HIV Nursing: Grenada, Dominica
- Skills building workshops
    - Multidisciplinary protocol development, HIV nursing, team based approach to care
    - Adherence (planned June 2006): St Vincent and Grenadines, Dominica
    - Stigma and discrimination (planned June 2006) : Dominica
- Facilitating sharing of lesson learned and resources between countries

11 Didactic training sessions include in-country providers who are given support in development and provision of lectures in their area of work as a part of the overall program in order to develop in-country capacity and engagement. As appropriate, audiences and participants invited include providers from multiple disciplines including physicians, nurses, pharmacists, social workers, counsellors and people living with HIV/AIDS

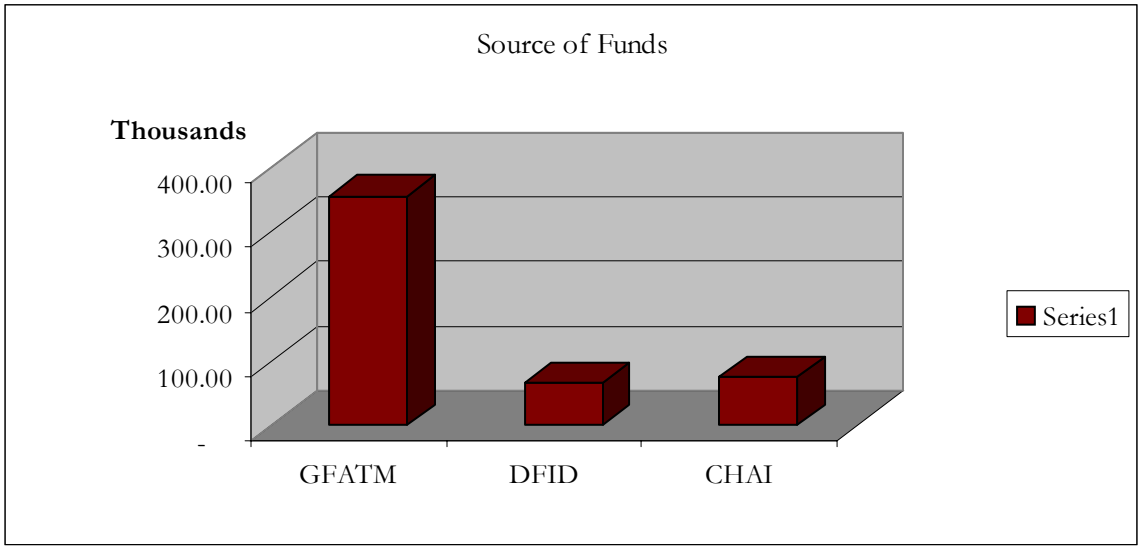
Communications Plan

The Clinton Foundation has drafted a Communications Plan for HAPU and has worked on communication strategies with National Programs.. The HAPU document provides a communications framework to improve the flow of information between the OECS HAPU and the Principal Recipient (PR), National Implementing Authorities (NIAs), Sub-Recipients (SRs), Sub-Sub-Recipients (SSRs), Regional Coordinating Mechanism (RCM), partners, and other relevant agencies. This system is being put in place in response to the need for better and more efficient sharing of information, and to improve the coordination of all players involved in the GFATM's implementation in the OECS.

### 3.b Financial Performance

As already mentioned previously, the financial information presented in this report covers only year 1, i.e. the period March 1st 2005 to February 28th 2006. For year 1, total actual expenditure was 63% of the Grant Budget. 45% was incurred by GFATM, while 8% and 10% was absorbed by DFID and CHAI respectively.

**Figure 5: Expenditure by Source of Funds**



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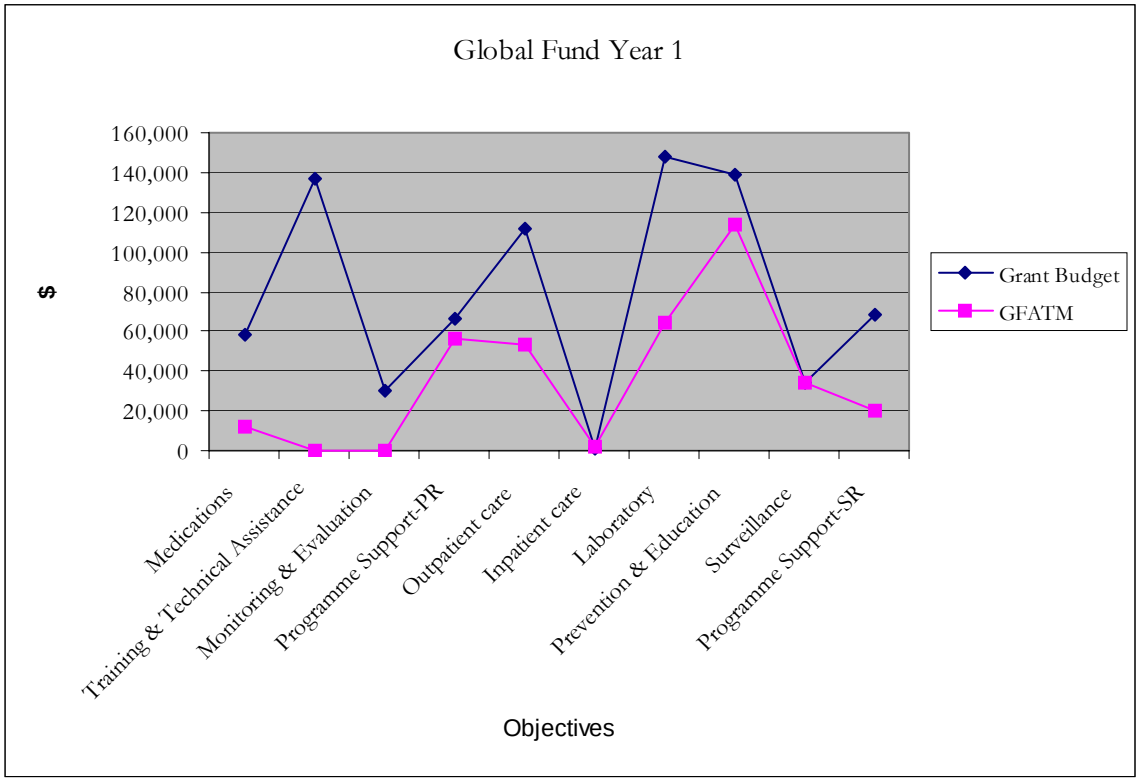
## Table 12: Expenditure by Grant Line Item

| | Grant Budget | Expenditure | Actual Expenditure by Fund | | |
|---|---|---|---|---|---|
| | | | GFATM | DFID | CHAI |
| Medications | $58,266 | $12,000 | $12,000 | $0 | $0 |
| Training & Technical Assistance | $136,422 | $6,039 | $0 | $0 | $0 |
| Monitoring & Evaluation | $29,751 | $11,349 | $0 | $0 | $0 |
| Programme Support-PR | $66,000 | $180,367 | $55,946 | $65,718 | $76,092 |
| Outpatient care | $111,836 | $52,994 | $52,994 | $0 | $0 |
| Inpatient care | $1,509 | $2,461 | $2,461 | $0 | $0 |
| Laboratory | $148,121 | $64,880 | $64,880 | $0 | $0 |
| Prevention & Education | $138,426 | $114,008 | $114,008 | $0 | $0 |
| Surveillance | $34,649 | $34,562 | $34,562 | $0 | $0 |
| Programme Support-SR | $68,644 | $20,142 | $20,142 | $0 | $0 |
| | **$793,624** | **$498,803** | **$356,993** | **$65,718** | **$76,092** |

## Table 13: Percentage Expenditure by Source of Funding

| | Expenditure | Actual Expenditure by Fund | | |
|---|---|---|---|---|
| | | GFATM | DFID | CHAI |
| **Expenditure versus Grant Budget** | 63% | 45% | 8% | 10% |
| **Fund versus Total Expenditure** | | 72% | 13% | 15% |

**Figure 6 Project Expenditure against Grant Allocations**




As mentioned previously, the national work plans and budgets are now all aligned with the Grant Agreement and are presently awaiting verification by the LFA. The total budget is now USD 97,802.12 more than the amount allocated in the Grant Agreement for Phase 1. This additional amount is being provided by the Clinton Foundation.

**Table 14: Alignment of Budgets with Grant Agreement**

| National Allocations | Year 1 | Year 2 | Total Budget | Variance |
|---|---|---|---|---|
| PR - OECS Secretariat: | 720,887.55 | 1,539,122.00 | 2,260,009.55 | 97,802.12 |
| Training & Technical Support | 136,422.00 | 337,310.00 | 473,732.00 | |
| Program Support - PR | 66,000.00 | 178,126.00 | 244,126.00 | |
| M&E | 29,751.00 | 79,047.00 | 108,798.00 | |
| | 232,173.00 | 594,483.00 | 826,656.00 | |
| Program Support - RCM & Sub-Recipients | 41,141.23 | - | 41,141.23 | |
| | 793,624.00 | 1,760,237.00 | 2,553,861.00 | |

## 4. THE PROPOSED OECS PROGRAMME FOR HIV/AIDS

There is now recognition in the OECS of the importance of expanding the GFATM financed intervention from a project to a **programme-based approach** for responding to the HIV/AIDS epidemic. The programme approach would seek to facilitate expansion of the scope and scale of activities, in particular:

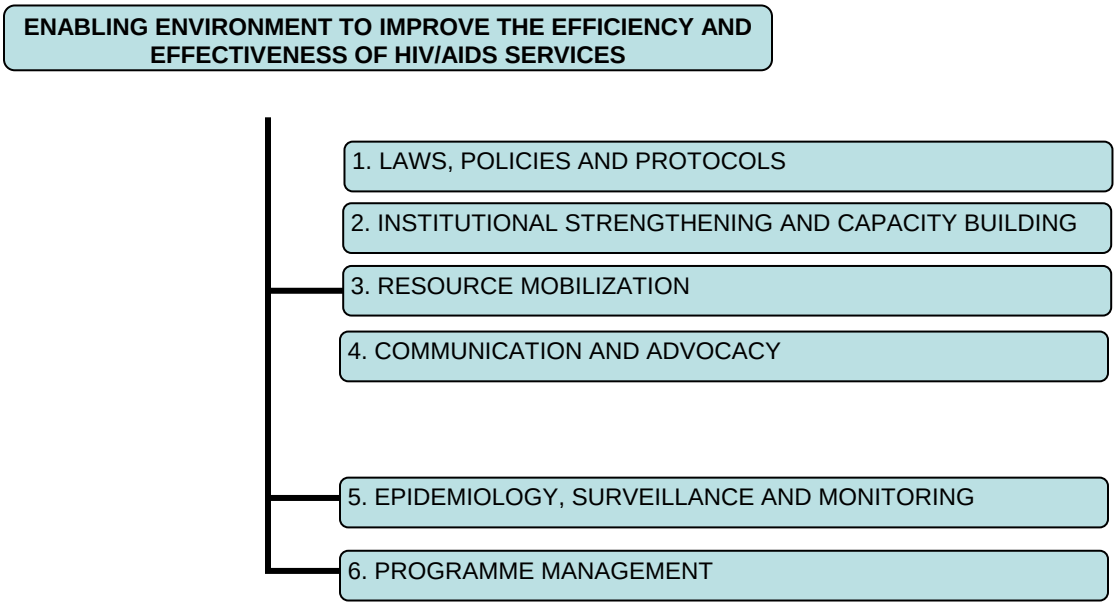
- Respond to the need to include in the sub-regional response all nine OECS Member States: Anguilla, Antigua and Barbuda, the British Virgin Islands, Dominica, Grenada, Montserrat, St. Kitts and Nevis, Saint Lucia, and St. Vincent and the Grenadines (three of which remain overseas territories of the United Kingdom, and hence ineligible for GFATM funding);
- Profit from complementarities of national HIV/AIDS programmes;
- Enhance the comparative advantage of strategic partnership, notably by reducing the transaction costs of doing business with multiple partners, especially given the small market size and close proximity of Member States;
- Address the various institutional, capacity and policy strengths, gaps and inadequacies; and
- Ensure harmonization and sustainability of implementation.

The overall goal of the programme would be to create an enabling environment to improve the effectiveness and efficiency of HIV/AIDS services in the OECS Member States. An enabling environment can be essentially defined as the existence of a set of conditions, influences, policies and practises that facilitate people and groups to take action and achieve their goals. The strategy of creating an enabling environment is a reflection of the recognition that national stakeholders are the principle agents in the fight against HIV/AIDS and the achievement of national and regional health and development goals.

On June 26-29, 2006, a four-day workshop was organised in Saint Lucia by the OECS Secretariat to guide the development of an effective and efficient OECS HIV/AIDS Programme. Participants included representatives of the OECS, national governments, international development agencies, civil society, research and training institutions, and the PLWHA community. Technical assistance was provided by MEASURE Evaluation, with financial support from the United States Agency for International Development (USAID).

The main outcome of the workshop was the drafting of a **results-based management (RBM) framework** to appropriately inform programme planning, implementation and management. The framework was elaborated over the course of various working sessions, including analyses of the programme challenges, objectives, partners and implementation strategies.

Drawing on the outcomes of the RBM framework workshop, six key areas of intervention for a strategic and integrated OECS HIV/AIDS Programme have been identified:




Between July 10 and 20, 2006, an initial series of missions was conducted in selected Member States by representatives from the OECS Secretariat and MEASURE Evaluation to support programme development and ensure the proposed framework appropriately addresses national strengths, needs and interests.

The objectives of the missions were to:

- Update and sensitise national stakeholders on the programme framework development;
- Generate ideas and ensure national ownership and relevance for the elements of the proposed programme framework;

- Identify synergies with existing HIV/AIDS plans and activities, including the proposal for the second phase of the OECS GFATM HIV/AIDS project; and
- Identify next steps for programme development and implementation.

A preliminary version of the RBM framework was circulated among relevant national resource persons prior to the arrival of the mission team for initial review and reflection. The expected outputs for the mission included a revised framework reflecting national interests and needs captured over the course of the mission. To this end, activities included briefing meetings with the National AIDS Programme Coordinator and Permanent Secretary of the Ministry of Health, as well as working sessions with key national stakeholders. Mission visits were initially organised in Antigua, the British Virgin Islands, Dominica and Saint Lucia.

The next steps for programme planning, development and implementation include:

- Continuation of the series of missions by the OECS Secretariat, in collaboration with MEASURE Evaluation, to update and sensitise countries to the programme development process, notably to cover in a timely manner the five Member States not yet visited (Anguilla, Grenada, Montserrat, St. Kitts and Nevis, and St. Vincent and the Grenadines).
- Undertaking of national-level consultations, under the direction of the NAPC or other focal point, towards: (i) identification of country needs from an OECS HIV/AIDS Programme as well as country strengths and potential partners; (ii) production of a harmonized set of national recommendations for the refinement and finalisation of the RBM framework; and (iii) production of a harmonized set of recommendations for next steps in programme development and implementation, including institutional arrangements and the establishment of a programme work plan and initial budget.
- Review and consolidation of the received country recommendations by the OECS Secretariat into a revised RBM framework for the OECS HIV/AIDS Programme.
- Formulation of an OECS Strategy and Action Plan, based on the RBM Framework.

## 5. CONCLUSION

### 5.1 Challenges

Although there are only sixteen months of project implementation to report on, a number of challenges have been encountered and warrant mention as experiences for future multi-island projects and small island States.

**Figure 7: Baseline Challenges**

1. Capacity and capacity building mechanisms at country level were limited prior to project implementation (in areas of technology, Monitoring and evaluation and project management)
2. Inadequate manpower especially in Clinical care management was exaggerated by:
   a) Stigma and discrimination which inhibited personnel from serving the clinical care needs of PLWHAs
   b) Low retention rates of health care providers which has:
      - Necessitated ongoing training
      - Increased our dependence on external institutions (most times at high costs) and
      - Foster closer working relationships with regional institutions
3. Public and Private sector collaboration was in need of improvement as information sharing between the sectors was very limited
4. The related Treatment and Care services was and remains centralized thus restricting access and use was further limited by breaches in confidentiality

a. The project was initially to have been implemented by the Eastern Caribbean Central Bank (ECCB). At the time of submission of the Proposal, the ECCB was to undertake only fiduciary responsibilities while the RCM was to have implemented the project. When project was transferred to the OECS Secretariat, as the PR, no one remembered to review and amend the Proposal. Consequently there was a delay of five months before project implementation went into full gear. This was further compounded by the delay in establishing HAPU which came into being in late June, although the Project had come into effect from March 1st.
b. The Project was designed on the assumption that capacities at both the national and regional levels were sufficient to undertake a project of this size and complexity. The assumption was also made that the national health systems were sufficiently developed and resourced to undertake the management, care and treatment of a communicable disease of the nature of HIV/AIDS.
c. The dynamics of the rules of procedure for multi-country projects has not been fully

understood by the GFATM. Much time has had to be spent in aligning national work plans with the Grant Agreement, in aligning work plan elements with budget allocation and in developing common validation and verification methods.

d. There were initial problems with the timeliness of Local Fund Agency (LFA). This, fortunately, has now been rectified although there is still scope for improving the length of time between submission of a semester report and of the validification exercise.
e. A multi-island framework shifts the transaction costs to the PR which is responsible for ensuring that there is convergence in project implementation by all parties in the framework and within the time frames identified in the Grant Agreement. This of course presupposes that all parties start from a common baseline of capacities and capabilities. This is not true in the case of this Grant Agreement. The unevenness in capabilities makes it more difficult to ensure that targets are met in a timely manner. Be that as it may, a multi-country framework also means that since the targets are cumulative, some countries can afford to lag behind while the more progressive countries pull them along.
f. Given the nature of the disease, there are very many partners who are involved in assisting the Member States. Much of HAPU's time is therefore taken up in creating modalities and mechanisms for consolidating resources from various sources and for ensuring that there are synergies between various projects and programmes.
g. Stigma and discrimination is causing many persons infected with the disease from sourcing care and treatment from the national public sector. Indeed, there are unconfirmed reports of patient seeking treatment in neighboring islands. In this case, the patient assumes that s/he will always be able to travel to continue to seek treatment outside of the national health system. In the event that this is not possible, then the patient's treatment regime is compromised.

Some other challenges are summarised in the figure below.

## Figure 8: PROJECT ISSUES

| Constraints | Challenges | Proposed Actions |
|---|---|---|
| • **People knowing their HIV status** | • Motivating people esp. youths, Addressing S&D and the attitude of health workers, and managing 'Partner notification', and the current system of HIV testing | • Intensification of BCC campaigns with focus on health workers and vulnerable groups, upgrading 'test' sites, and introduction of 'rapid' tests |
| • **Bringing PLWHA into Treatment and Care programs** | • Reducing S&D, assuring uninterrupted supplies of ARVs & reagents and maintaining confidential and ethical practices | • Establishment of national coded data bases, involvement of PLWHA in Adherence counselling |
| • **Spending donor funds** | • Adjusting bureaucracies to the TAC, increasing local 'absorptive' capacity | • Advocacy for simplification of procedures and improving validation of existing systems |

### 5.2 Lessons Learned

While it is still early to identify lessons learned, there are a few issues that warrant mention.

1. Adequate time must be allocated for capacity building, in country, prior to the start-up of project implementation. This must be preceded by a thorough evaluation of the national capacities to undertake project implementation and the attainment of the set targets within the pre-determined time frames.

2. Focal points should be established at country level for the coordination of all activities and be empowered for the smooth functioning of their respective country teams

3. Decentralization of services tends to reduce Stigma and Discrimination especially if the strategy is combined with a Public/private mix of patients accessing care.

4. For multi-country projects with common sources of ARV medications it is advisable to have:
   - Standardization of protocols, first line therapy, treatment failure management, etc
   - Sharing of experiences amongst countries in areas of protocol development, data collection, program implementation
   - Pool Purchasing of essential commodities such as drugs, reagents and equipment – save on cost

5. Information sharing at all levels of the public health system on HIV/AIDS issues is important for efficient implementation.

6. Ongoing training will lead to improved competencies in building their technical capabilities, plus basic courses in adherence and confidentiality; and should include all Health Care practitioners.

7. Increased publicity and advocacy has a multiplier effect. This will make it easier to penetrate work places to address issues of HIV in the workplace, and developing work place policies

8. Capability for in country testing exists (CD4), leads to better management and monitoring of patients.