



Request for Proposal

To the

Pan American Health Organization (PAHO)

For the provision of services in relation to

Caribbean Epidemiology Centre (CAREC)

on the implementation of the

CAREC Strategic Plan

for the

**Prevention and Control of the
HIV/AIDS Epidemic in the Caribbean:**

2001-2005

December 2001

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List of Abbreviations

| | |
|---------|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| CAREC | Caribbean Epidemiology Centre |
| CARICOM | Caribbean Community and Common Market |
| CARe | Community Action Resource |
| CATIN | Caribbean AIDS Telecommunication and Information Network |
| CBOs | Community based organisation(s) |
| CCH-II | Caribbean Cooperation in Health -II |
| CDC | Centers for Disease Control and Prevention |
| CIDA | Canadian International Development Agency |
| CMCs | CAREC Member Countries (Anguilla, Antigua & Barbuda, Aruba, Bahamas, Barbados, Belize, Bermuda, British Virgin Islands, Cayman Islands, Dominica, Grenada, Guyana, Jamaica, Montserrat, Netherlands Antilles, St. Kitts & Nevis, St. Lucia, St. Vincent & the Grenadines, Suriname, Trinidad & Tobago, Turks & Caicos Islands) |
| CRN+ | Caribbean Regional Network of People Living with HIV/AIDS |
| FSW(s) | Female Sex Worker(s) |
| HCWs | Health Care Workers |
| HIV | Human Immunodeficiency Virus |
| IEC | Information, Education and Communication |
| MCH | Mother and Child Health |
| MSM | Men who have sex with men |
| MTCT | Mother-to-Child Transmission |
| NAPs | National AIDS Programme |
| NGO(s) | Non-governmental Organisation(s) |
| PAHO | Pan American Health Organization |
| PLWHA | People living with HIV/AIDS |
| PMTCT | Prevention of Mother-to-Child Transmission |
| SLAPA | St. Lucia AIDS Prevention Association |
| SPSTI | Special Programme for Sexually Transmitted Infections |
| STIs | Sexually Transmitted Infections |
| TTHAA | Trinidad and Tobago HIV/AIDS Alliance |
| UKCOTS | United Kingdom Caribbean Overseas Territories |
| UNAIDS | United Nations Joint Programme on AIDS |
| UWI | University of the West Indies |
| VCT | Voluntary Counselling and Training |
| WHO | World Health Organization |

Introduction

The Pan American Health Organization (PAHO) is seeking a Consultant to collaborate with the Caribbean Epidemiology Centre (CAREC) on the implementation of the CAREC Strategic Plan for the Prevention and Control of the HIV/AIDS Epidemic in the Caribbean: 2001-2005. The Consultant should have access to a sufficiently large pool of expertise in various disciplines to function as a partner and “broker” to help meet the technical support needs for the implementation of the activities outlined in the CAREC Strategic Plan.

The contract for services awarded on the basis of this request for proposal (RFP) will be funded through the contribution of the Canadian International Development Agency (CIDA) to PAHO to support CAREC in the implementation of its strategic plan for the Prevention and Control of the HIV Epidemic in the Caribbean region, 2001-2005. The sum of one million, two hundred thousand Canadian dollars (\$1.2 million CDN) shall be used for the recruitment of Canadian Technical Assistance Labour to support the implementation of the strategic plan. The Consultant, in the context of this RFP means an individual, corporation, partnership, consortium, joint venture or other type of association. Among other things, the Consultant, including *each* member of the consortium, joint venture for other type of association, must comply with the Canadian Eligibility Requirements as specified in the Canadian International Development Agency General Conditions (RFP) – CIDA 102, which include among other things:

- If the Consultant is an individual, he/she must be a Canadian citizen or a Canadian landed immigrant; or
- If the Consultant is a profit organisation, it must be a legal entity and have a place of business in Canada; or
- If the Consultant is a non-profit organisation, it must be a legal entity established in Canada.

Where the proposal is submitted by a consortium, joint venture or other type of association, EACH member must comply with either requirement (i), (ii) or (iii).

The balance of this Request for Proposal (RFP) contains information on the background of this project, the scope of work, period of performance, items the proposal should include, evaluation criteria, contact persons and deadlines.

Background on CAREC

CAREC is a centre of the Pan American Health Organization and serves twenty-one (21) CAREC Member Countries (CMCs). CAREC provides public health consulting, information, laboratory reference and epidemiology services to its CMCs. CAREC's Special Programme on Sexually Transmitted Infections (SPSTI) focuses on the prevention and control of sexually transmitted infections and has its main focus, the prevention and control of HIV/AIDS. SPSTI has a multidisciplinary programme that it has been implementing for the past sixteen years.

Programme Description

The CAREC Strategic Plan identifies strategies and actions through which the Special Programme on Sexually Transmitted Infections (SPSTI) can anticipate and respond in technical co-operation with CAREC Member Countries (CMCs) to the HIV/AIDS epidemic in the Caribbean within the next five years (2001-2005). Key achievements, challenges, gaps, lessons learnt, and opportunities are identified, and CAREC's roles and responsibilities in relation to the Caribbean Cooperation in Health Phase II (CCH-II) and the Regional HIV/AIDS Strategic Plan are detailed. A total budget of a minimum of US\$13,120,871 is required to support the implementation of this regional initiative and make it a success in terms of HIV/AIDS/STI prevention and control.

The Goal, Purpose and the Expected Results of the Strategic Plan are as follows:

Goal

To reduce the spread of HIV/AIDS/STI as well as minimise the impact on individuals and communities in CMCs.

Purpose

The capacity of CMCs strengthened to manage and provide sustainable programmes for the prevention and control of HIV/AIDS/STI and care of persons living with HIV/AIDS.

Expected Results

Expected Result #1

Health information, surveillance systems and research capabilities strengthened to generate reliable data on HIV/AIDS/STI to allow for decision-making, planning, implementation and evaluation.

Expected Result #2

Capacity of decision-makers strengthened to use the expanded response approach for policy formulation, planning, implementation and evaluation of HIV/AIDS programmes that will build alliances and mobilise communities.

Expected Result #3

Capacity of CMCs to deliver efficient and effective HIV/AIDS/STI services in clinical and diagnostic management as well as care and psychosocial support increased (e.g. MTCT, VCT, PLWHA, NGOs, special interest groups and youth friendly services).

Expected Result #4

Capacity of CMCs to develop, implement and evaluate behavioural and communication interventions targeting priority vulnerable populations (e.g. Young people, PLWHA, MSM, women including female sex workers) strengthened.

Expected Results #5

CAREC-SPSTI's capacity to manage the expanded response by providing timely, scientifically sound expertise using the highest standards, the latest available technologies and internally coordinated managerial systems for programme planning, delivery and monitoring and evaluation strengthened.

Scope of Work

The Consultant shall provide technical services for the following:

- Identify Canadian expertise to support specific project activities;
- Assist CAREC as appropriate in the development and implementation of skill building activities in the Caribbean;
- Organise Canadian on-site training programmes as required;
- Identify and distribute appropriate material resources to CAREC;
- Prepare reports to PAHO/CAREC as required by PAHO/CAREC;
- Assist in the preparation of workplans as required.

Project Duration

The Consultant will be required for the period of the Contribution Agreement between CIDA and PAHO for the implementation of CAREC Strategic Plan for the Prevention and Control of the HIV/AIDS Epidemic in the Caribbean, 2001-2005. The Contribution Agreement covers the period May 1, 2001 to September 30, 2006.

Standards of Performance

The services performed by the Consultant pursuant to the requirements of the contract shall conform to the highest professional standards. Further, any information and/or documents obtained from or provided by PAHO for the purpose of the contract must be used exclusively for the activities agreed upon.

Summary of Roles and Responsibilities of Project Parties

PAHO

PAHO will be responsible for providing technical, administrative and operational services to the project. The performance of services under the Contract will be subject to the technical direction of the PAHO Project Officer, Dr. Stephen Corber.

CAREC

CAREC will be responsible for the following:

- The implementation of the Strategic Plan;
- The provision of the relevant reports for the Strategic Plan to donors and stakeholders;
- Coordination and organisation of Annual Partners' Meeting and Joint Assessment Missions;
- Liaising with the Canadian Consultant for the preparation of workplans and the implementation of activities for which Canadian technical expertise have been identified.

Canadian Consultant

The Canadian Consultant will be responsible for collaborating with CAREC on the development of the annual workplans and the selection and securing the provision of Canadian technical expertise where appropriate. The Canadian Consultant will be expected to participate in programme planning and review meetings including the Annual Partners' Meeting and key regional meetings for example, the meetings of the National AIDS Programme Coordinators, the National Epidemiologists and Laboratory Directors, etc. The Canadian Consultant will provide the relevant reports, technical and financial, in the agreed format in a timely manner.

Consultant Objectives, Organisation and Qualification

Objectives

- The general objectives of contracting a Consultant for the implementation of this project are:
- To collaborate with CAREC to identify areas where Canadian technical assistance can add value;
- To identify relevant Canadian Technical Expertise to assist in the achievement of the results of the Strategic plan in the various programme areas;
- To coordinate this technical expertise in collaboration with CAREC;
- To assist CAREC in the establishment of appropriate linkages with Canadian technical organisations.

Consultant Expertise and Organisation

The Consultant should propose a technical team with expertise in the priority areas of assistance which include but are not limited to the following:

- New diagnostic technologies for HIV/AIDS/STI.
- Design, implementation and evaluation of preventive and supportive counselling services including voluntary counselling and testing.
- Design and implementation of targeted behavioural interventions including safer sex practices.
- Communication training and development of communication strategies including social marketing.
- Public health programme management and evaluation.
- NGO and CBO development on HIV/AIDS issues in developing countries.

Project Coordination

The Consultant's team will be led by a Project Coordinator based in Canada, who shall be responsible for all Consultant activities in relation to this project. The Project Coordinator will be responsible for collaborating with CAREC to identify opportunities for and the selection, contracting, if necessary, and monitoring of appropriate Canadian technical expertise so as to achieve the results of the project. The Project Coordinator will be responsible for managing the funds and preparing relevant reports.

The Project Coordinator should have the following characteristics: experience in project management; experience in managing complex public health projects with an emphasis on stakeholder involvement and consultative approaches; experience in coordinating multi-disciplinary activities; experience in contracting, financial control and reporting; knowledge of stakeholders in regional and international health environment; experience in working in developing countries and especially in the Caribbean region or in multi-island settings; strong academic and professional qualifications.

Technical Team / Other Personnel

The Consultant should identify no more than five technical members of the team.

The skills of the technical team should include, but are not limited to the following:

- General qualifications for each team member: strong academic and professional qualifications; experience in participating in large multi-disciplinary projects in developing countries and especially in the Caribbean; demonstrated skills in collaborating with stakeholders and NGOs.
- Specific qualifications for each team member (must have specialisation in at least one of the following areas with some knowledge of other areas depending on role): Experience and professional qualifications in : New diagnostic technologies for HIV/AIDS; design, implementation and evaluation of preventive and supportive counselling services including voluntary counselling and testing; design, implementation and evaluation of targeted behavioural interventions; public health programme management and evaluation; communication training and development of communication strategies; non-government organisation and community based organisation development on HIV/AIDS issues.

The Consultant may wish to engage support level personnel to assist with project coordination. It is the responsibility of the Consultant to determine the number of support level personnel needed in order to fulfil the project requirements.

Proposal Preparation, Language and Number of Copies

The proposal will consist of a technical and a financial component. The technical and financial components are to be presented in separately bound documents and should be provided in two separately sealed envelopes with the name of the proposing Consultant and the contents clearly marked. The envelopes should be marked as follows: **PROPOSAL FOR PROVISION OF CANADIAN TECHNICAL ASSISTANCE – Technical Component** or **Financial Component**, as appropriate.

The working language for this project is English and proposal shall be presented in English.

The Consultant's proposal is to be presented in ten (10) copies.

Proposal Content Requirements

Technical Component

Proposals should include a description of the Consultant's approach, (including type and quantity of management oversight), relevant experience, resources, and qualifications of staff to be assigned to the project. Proposals also should demonstrate the Consultant's understanding of the relevant issues concerning HIV/AIDS and should address each of the specific areas outlined in the Evaluation Grid in Appendix B.

Reimbursable Expenses

The Consultant must provide a list of the estimated reimbursable expenses it will incur in the implementation of the project in Canada and in the Caribbean. The basis on which the expenses have been established must be consistent with the proposed methodology and the level of effort.

Reimbursable expenses must be included with the technical component of the proposal and is subject to negotiation with the selected Consultant.

Financial Component

Fees must be all-inclusive and reflect the level of effort. Fees are the rates (inclusive of all mark-ups) relating to professional, technical and administrative services to be provided, including those of the Consultant's personnel in Canada and overseas, its sub-consultants, outside consultants and local professionals. The all-inclusive rates (hourly, daily, monthly) shall include all the following cost elements: direct salary, fringe benefits, overhead/indirect costs and profit. The Consultant should distinguish all personnel/positions assigned to the Project under the categories Consultant's personnel, sub-consultants, outside consultants and local professionals. The conditions as stated in CIDA's General Conditions for RFP – CIDA 102 apply.

Proposal Evaluation and Selection Criteria

The Technical, Financial and Oral Presentation and Interview Components of the proposal will be assessed separately as follows:

| | |
|---|-------------------|
| Technical Component will be assessed out of a possible 800 points as follows: | |
| Experience of the Consultant | <i>200 points</i> |
| Methodology | <i>300 points</i> |
| Proposed Personnel | <i>300 points</i> |
| Financial Component | 200 points |
| Oral Presentation and Interview | 100 points |

Financial Component

The Financial Component must be submitted in a separate sealed envelope with the proposal, and is opened and evaluated only if a pass mark of 60% or more is achieved for the Technical Component.

The financial proposal with the lowest cost will be awarded the maximum number of points (200). The scores for all other financial proposals are calculated on a pro-rata basis.

The sum of the Technical Score and the Financial Score will be referred to as the Adjusted Technical Score.

Oral Presentation and Interview

CAREC/PAHO Evaluation Team may, at its discretion, invite the top three (3) finalist bidder(s) with the highest Adjusted Technical Score to participate in an oral presentation and interview to assess the Consultant's understanding of the proposed methodology and to assess personal suitability of the proposed team. The Oral Presentation and Interview will be judged out of 100 points.

The oral presentation is anticipated to last up to two (2) hours including the presentation followed by questions and Consultant's answers. To facilitate the bidders, oral presentation will be arranged for a convenient location in Canada. CAREC/PAHO anticipates that these oral presentations will take place approximately two (2) to four (4) weeks following the closing date of the proposals.

Selection of Consultant

The score from the Oral Presentation and Interview will be added to the Adjusted Technical Score. The proposal receiving the highest sum of the Adjusted Technical Score and Oral Presentation and Interview represents the best value to CAREC/PAHO.

CAREC/PAHO reserves the right to verify all information included by a Consultant in its proposal. In all cases, CAREC/PAHO reserves the right to cancel this RFP and request new proposals.

Submission of Proposals

The Proposals must be addressed to:

Dr. Bilali Camara
Caribbean Epidemiology Centre
16-18 Jamaica Boulevard,
Federation Park,
Port of Spain.
TRINIDAD
Telephone: 868-622-2153.

The envelope should be marked as follows: **PROPOSAL FOR PROVISION OF CANADIAN TECHNICAL ASSISTANCE**

Technical Questions

Technical questions may be addressed to Dr. Bilali Camara at the following email address: Camarabi@carec.paho.org, with a carbon copy to chowhyac@carec.paho.org or by fax to 868-622-9585 no less than five working days prior to the scheduled RFP closing date.

Deadlines

All proposals must be sent by courier and dated no later than 2:00 p.m. Eastern Time on February 15, 2002.

Appendix A

Summary of CAREC Strategic Plan with Logframe

HIV/AIDS has become a major developmental problem affecting every country, and the Caribbean countries in particular, where the epidemic is second in magnitude only to that in Sub-Saharan Africa. As the epidemic has spread throughout the Caribbean, the primary mode of sexual transmission has changed from predominantly a homosexual one to a mosaic of homo/bi and heterosexual epidemics. The epidemic is also shifting to younger populations, in particular, young females. The major feature of the epidemic is the growing numbers of persons living with HIV/AIDS (PLWHA) and families affected requiring care and support. The changing profile of the epidemic has already begun to impact dramatically, not only the health sector but also on the economic resources in the Region in terms of loss of human potential and productivity.

Factors Driving the Epidemic

The single most important environmental factor driving the epidemic is the impoverishment of large population groups in an overall context of economic downturn. Poverty in the region is pervasive and multi-dimensional. This includes various kinds of poverty: social, (e.g. lack of parental caring and family/community relationships); financial (low or non-existent incomes), and educational (ignorance, lack of information and skills). This poverty and poor socialisation for young people, in particular, are the root causes of major societal pathologies such as teenage pregnancies, drug abuse, and violence, the latter two also having negative repercussions on the mainstay of the region's economy, tourism.

Economic

- Poverty and grossly inequitable income distribution
- Unemployment
- Urbanisation creating "ghettos"
- Globalisation creating internal economic pressures
- Migration and tourism removing social control and providing incentives for risky behaviour

Social and Cultural

- Globalisation with cultural penetration distorting value systems including the fostering of materialism
- Dysfunctional gender relations including male insecurity resulting in anti-social behaviour
- Lack of general education and, specifically, sex education
- Marginalisation of young people
- Cultural and religious sexual taboos, contrasting with social norms that promote sex
- Discrimination and stigmatisation of PLWHA, MSM, and other vulnerable groups
- Reluctance to provide information, services and sex negotiation skills to young people

Behavioural

- Multiple sexual partners
- Low condom usage and reluctance to promote condom usage
- Low tolerance to MSM causing hiding and mixing of partners
- Sex work of various types: full-time (career), part-time (ranging from school girls through employed women to married women)
- Substance abuse leading to risky behaviours: crack, cocaine and alcohol

Biomedical and Access to care

- Presence of other STI
- Lack of access to health care for some populations
- Lack of standards of care, treatment and support procedures for PLWHA and STI
- Attitude of health care workers (HCW) towards PLWHA: judgmental, fear, reluctance to treat

Legal

- Illegal status of vulnerable groups e.g. mobile population, sex workers and MSM, driving them underground
- Lack of protection for PLWHA, especially in the workplace
- Lack of legislation addressing issues surrounding PLWHA including discrimination in the workplace; wilful transmission of HIV
- Lack of legislation to ensure minimum standards of care
- Limited access to family planning services without required parental knowledge and permission
- Restrictions on Health Care Workers providing certain sexual and reproductive health related services to young people without parental knowledge and permission.

Response Analysis-Achievements and Gaps/Challenges

Achievements

From the time the first AIDS case was described in Jamaica in 1982, CAREC has pioneered the regional response to the HIV epidemic. Since then, there have been numerous key achievements:

Behaviour

Ten core indicators for behaviour surveillance have been identified for monitoring at regional level. Recent years have shown that the knowledge among people in some Caribbean countries about AIDS has increased, from 80% in 1995, to between 81% and 90% at the end of 1998. Condom importation and condom sales have increased in some countries (e.g. Barbados from 719,460 in 1994 to 1,081,980 in 1997, and in Guyana from 217,260 in 1994 to 449,640 in 1997). Persons who always use a condom during last sexual act have increased from 22% in 1991 to 29% in 1997 in St Vincent and the Grenadines, one year after the AIDS Action Group (a new NGO established with the support of the Canadian International Development Agency - CIDA) started its programme. In 1998, among University students the knowledge about condom access was very high (90%) and 50% of them were using condoms consistently during sexual act.

Socio-Cultural and Community Involvement

NGO development, (e.g. the Caribbean Regional Network for People Living With HIV/AIDS (CRN+), Trinidad and Tobago HIV/AIDS Alliance (TTHAA) St Lucia AIDS Prevention Association (SLAPA), the Life Line, and the AIDS Action Group in St Vincent and the Grenadines), is resulting in broader community involvement, including that of People Living with HIV/AIDS, and other groups such as MSM and young people.

During 1997-1998, articles in the media related to HIV/AIDS improved significantly in quality and quantity in Trinidad and Tobago compared to 1994. Overall sensitisation of media professionals in various Caribbean countries, and forged alliances with their institutions, has also resulted in improved quality and quantity in HIV/AIDS-related articles and broadcasts at the regional level.

Better knowledge and skills development among vulnerable groups (People Living with HIV/AIDS, young people, MSM, Female Sex Workers (FSW), women) through pilot testing of eight innovative projects targeting vulnerable groups and their environment. These were successfully carried out in six countries and are ready for replication in the rest of the CMCs.

Epidemiology, Biomedical and Access to Care

Overall the trend of reported incidence of STI during 1998 and 1999 has slightly decreased, despite the fact that in some countries an increase in absolute number of reported STI cases was observed.

Skills have been improved among health care workers to treat sexually transmitted infections using the syndromic management approach. Follow-up evaluation in Grenada and Guyana two years after training has shown an improvement of knowledge, skills and performance among 67% of the trainees.

In terms of observance of universal precautions and desensitisation towards AIDS patients, the pilot project conducted in St Lucia was evaluated with results indicating 63% of the health care workers trained were using their skills without fear or negative attitudes when handling PLWHA.

HIV transmission through blood and blood products accounts for less than 0.4% of transmission in the region due to early and sustained efforts to ensure the quality of transfused blood.

Laboratory HIV diagnosis has improved, and quality assurance (QA) programmes adopted by many CMCs. Regional policy relative to quality improvement in health institutions has been adopted by national laboratories in 16 CMCs, resulting in QA programme-implementation being initiated in these CMCs. More than 500 technologists have been trained to participate in national QA programme-implementation activities. Because of the safety net provided by CAREC through referral, validation and troubleshooting services, 65 new HIV infections through blood transfusion were averted since 1997. Additionally, 16% of total samples submitted for HIV confirmatory testing (1,259 out of 8,027) were found negative and thus mis-diagnosis averted, with implications both for socio-personal and economic impact when taking into account the potential for increased medical costs for HAART or prophylactic treatment.

Legislation, Policy-Making and Planning

High-level advocacy for AIDS and increased national response and political will in the Region has resulted in increased national budgetary allocations to prevention and control of HIV/AIDS, and to put AIDS on the national and regional agenda as a priority public health and development issue in some countries.

Expanded national response has been engendered in Guyana, and a national strategic plan is being implemented with the support of the Government and other partners (CAREC, PAHO, CIDA, GTZ etc.). Barbados, St. Kitts and Nevis, Antigua and Barbuda, and Dominica have initiated the process of establishing an expanded national response. An inter-ministerial Government committee was established in Trinidad and Tobago to implement the annual national plan for HIV prevention and control.

National policy change regarding adoption and implementation of MTCT initiatives at country level in seven CMCs.

Resource mobilisation and establishment of a coordinated regional response to the HIV epidemic, and also a well integrated and multi-source funding for CAREC programmes aimed at prevention and control of HIV/AIDS, exist.

At least five countries have produced draft legal policy documents for HIV/AIDS and the workplace.

Gaps and Challenges

In spite of these achievements, many *gaps* and *challenges* remain to be addressed:

- **Political will** needs to be concretised into action, policies, legislation, services and resources. The political directorate have not yet appreciated the potential impact that HIV could have on the economy, national security and political stability nor have they appreciated that HIV/AIDS is an important entry point to deal with other developmental issues (teenage pregnancies, violence, drug abuse, unemployment in young people).
- **Comprehensive care and treatment** for persons living with HIV/AIDS remains a major gap in the regional response to the epidemic.
- **Discrimination and stigmatisation** have not been systematically tackled. A supportive environment is still not a reality. Societies remain distant from the HIV/AIDS epidemic and persons living with HIV/AIDS, and the level of social discrimination and rejection are high in the small Caribbean societies.
- **Parents, teachers and religious leaders** remain reluctant about some prevention measures (condom use and introduction of sex education into the curriculum of schools).
- **Sexual behaviour change** is a slow process, and once established, it must be sustained.
- **Inadequately equipped health services** for care and diagnostic capacity to support the clinical management and treatment of PLWHA.
- The growing issue of **support for orphans** has not been addressed.
- **Limited use of epidemiological and behavioural information** for policy formulation, programme planning including targeted interventions and allocation of resources.
- Lack of adequate and updated **policy and legislative framework** to protect individual and family rights of vulnerable populations (e.g. young people, MSM, PLWHA, Sex workers, women and incarcerated and mobile populations).
- **Restricted absorptive capacity of CMCs** and limited skilled personnel given the small population size.

CAREC faces the challenge of broadening its capacity to support / facilitate an expanded response through development of relevant alliances/partnerships and in-house expertise.

To sum up, the region is facing a generalised epidemic. There is a complex mosaic of interwoven factors driving the epidemic related to socio-economic environments, deep-rooted behaviours and cultural norms.

The CAREC response, in support of the CMCs, has been to strengthen public health capacity and to support the development of NAPs and to mobilise resources for care and treatment. Although noteworthy achievements have been registered, some gaps in the response, and challenges remain to be faced. In the meantime future scenarios show an epidemic evolving in magnitude (in terms of morbidity and mortality) and in overall socio-economic impact.

As research advances, the molecular dynamics of the virus, its variability, structural complexity and pathogenetic potential, as well as host immune reactions are better understood. Spectacular scientific breakthroughs have resulted in highly active anti-retroviral therapies (HAART) and vaccine trials. These two developments point the way to the future profile of the epidemic: preventable, treatable, chronic disease syndrome. A strategic approach with a long view is required to project the epidemic five, ten, twenty years from now, in order to envision and plan the CAREC's response. For this, it will be necessary to build on success, benefit from lessons learned and be boldly proactive.

Mission Statement

To reduce the spread and minimise the impact of HIV/AIDS/STI by enhancing the capacity of CMCs to mount an effective and sustained response.

Guiding Principles

The major Guiding Principle of this Strategic Plan is an integration of prevention, care and support of PLWHA and those affected by the epidemic in line with accepted best practices world-wide.

- **The Caribbean Charter for Health Promotion** as stipulated in the Caribbean Cooperation in Health, Phase 2 (CCH-II) document is the strategic framework that will be applied to SPSTI Health Promotion. In the Caribbean context, it is an approach that should strengthen the capacity of individuals and communities to control, improve and maintain physical, mental, social and spiritual well-being.
- **Capacity building in CMCs** and at CAREC: CAREC will provide technical assistance to CMCs wishing to carry out interventions. Emphasis will be placed on building skills of country personnel, while maintaining and improving CAREC's capacity to provide the necessary support at the sub-regional level.
- **Focus on the gender dimensions of the epidemic:** Traditional gender relationships and family patterns that render the population vulnerable to HIV have to be addressed. SPSTI will, in particular, promote gender sensitivity in prevention and control initiatives.
- **STI as a basic service:** SPSTI will promote adequate STI care and treatment as a basic health service, equal in importance to other services such as maternal and child health and immunisation.
- **Interventions against discrimination, stigmatisation and in promotion of human rights** are effective when strategically integrated into all stages of the response, policy, programme planning and implementation.
- **PLWHA are effective partners** to be incorporated in the decision making process.
- **Integration with other projects and programmes:** At CAREC, initiatives will be integrated with those supported by donors, and, as appropriate, with activities being implemented in other CAREC programmes. CMCs will also be engaged to integrate HIV/STI prevention, care and support with other programmes at the central level to ensure optimal use of resources, and at the peripheral levels to ensure closer collaboration and coordination.
- **Multi-sectoral approaches:** CAREC will adopt and will encourage CMCs to use multi-sectoral approaches and broad-based strategies in preventing and controlling the spread of HIV/AIDS including building alliances with public and private sector bodies, especially the media.
- **Pilot interventions:** Certain pilot interventions will be tested in two or three CMCs before being implemented in others. Countries will be chosen based on their state of "readiness".

Super-Goal

To improve the health status of the Caribbean people.

Goal

To reduce the spread of HIV/AIDS/STI as well as minimise the impact on individuals and communities in CMCs.

Purpose

The capacity of CMCs strengthened to manage and provide sustainable programmes for the prevention and control of HIV/AIDS/STI and care of persons living with HIV/AIDS.

Lessons Learnt and Anticipated Risks

Several lessons in preventing and mitigating the spread and impact of the epidemic in the Caribbean have emerged as a result of a review of experiences, challenges and progress gained through CAREC's technical cooperation with member countries:

- Acting early and effectively pays off both in terms of avoiding socio-economic impact and in cost saving. A major success is the Bahamas programme which adopted care and treatment for PLWHA as a priority and was able to reduce AIDS case by 50% and decrease HIV incidence significantly. Delay in policy-making and programme response resulted in rapid generalisation of the epidemic in several CMCs.
- Multi-source funded programmes work when integration is achieved through strict, periodic planning and coordination meetings to develop comprehensive plans for implementation in CMCs.
- Expanded national response could increase the absorptive capacity of CAREC member countries by involving other sectors and non-governmental organisations.
- Advocacy for AIDS works when adequate tools are developed to support the process, and when several related issues are presented and discussed together (economic and social impact, epidemiological and behavioural information), and solutions approached holistically.
- Targeted behavioural change is critical, requires ongoing education, and can be achieved working with peer groups.
- Targeted interventions focussing on vulnerable groups have proven to be an effective strategy.
- The utilisation of a positive youth development approach, based on sound information and focusing on strengths and development of protective skills, is essential and has the potential to have multiple benefits in other areas and thus represents a cost effective approach from a societal point of view.
- Sustainability is achievable through skills building, promotion and training in laboratory quality assurance, syndromic management of STI, HIV/AIDS/STI surveillance, information and communication, and implementation of comprehensive behavioural change programmes.
- Change in social norms is conducive to behaviour change (discussion about sexuality, sex education, condom use etc.).
- Empowering individuals and groups works, for example, as illustrated by CRN+ and CARE.
- Changes in health care policies are useful public health tools, for example, to strengthen syndromic management as a treatment approach for STIs and opportunistic infections related to AIDS.
- Flexibility is important for effective HIV treatment and preventive measures because understanding of the epidemic is constantly shifting in light of new scientific advances and experiences.

Strategic Approaches

This HIV/AIDS Strategic Plan has put the focus of CAREC's technical cooperation on sustainability through skill building process involving different national sectors. The different expected results, key activities and indicators are summarised below and presented in the logframe matrix attached.

HIV/AIDS/STI Surveillance

Since 1975, CAREC has collected and analysed communicable disease surveillance data from its member countries. AIDS surveillance begun in 1982 and by the end of 1989, all CAREC member countries had reported at least one AIDS case. In 1985, when the transfer of HIV antibody testing skills to member countries was initiated, quarterly reporting of AIDS cases to CAREC, using a standard PAHO form was introduced. AIDS case definition was introduced at that time, and in 1996 a new CAREC HIV/AIDS case definition was developed and introduced in member countries. HIV surveillance among specific groups was introduced, and many preliminary studies were conducted among FSWs, MSM, STI patients, farm workers, food handlers,

pregnant women, etc. In 1989 the HIV reporting was introduced, and countries are using the same quarterly reporting form for that purpose.

The Caribbean epidemic is generally well understood, including shift in AIDS epidemiological profile, estimates and incidence, and impact. But overall, there is a lack of agreed-on surveillance strategy and plan. Evaluations of existing surveillance systems have been carried out, but to date there has been limited follow-up and implementation of their recommendations. In addition, as care and support of PLWHA and their families assume greater importance, surveillance data needs are increasing for purposes of case management, coverage and quality of care of PLWHA and monitoring sexual behaviour. Understanding these limitations, under CAREC's leadership in September 1999, a regional meeting was held on visioning the future surveillance system in the Caribbean. The objectives of the new surveillance system are to promote and implement at national level, systems that will detect early HIV/AIDS/STI cases and monitor quality of care and behaviours. The new systems will be used for the overall evaluation of programmes through monitoring of change in HIV/STI seroprevalence surveys and research on sexual behaviour patterns, with focus on specific groups (PLWHA, Young People, MSM and Women).

The implementation of the new approaches already started in 2000 will continue during this new strategic plan.

Expected Result #1

Health information, surveillance systems and research capabilities strengthened to generate reliable data on HIV/AIDS/STI to allow for decision-making, planning, implementation and evaluation.

Planning, Programming and Policy Formulation

HIV/AIDS must be understood as a major developmental problem affecting a large cross section of the region's population, and posing a threat to the developmental goals of island states. The epidemic is driven by a set of complex and rapidly changing circumstances that requires countries to deepen their response by involving new players. This perspective of an expanded response builds on the multi-sectoral approach originally implemented in countries, pulling together government, non-governmental organisations, the private sector, and persons living with HIV/AIDS and their families.

The Strategic Planning Process promoted by UNAIDS has been endorsed by CAREC as a valid approach as it allows countries the flexibility of adapting the process to meet their own planning needs. CAREC has provided technical assistance to initiate the process in a number of our member countries, and this has to be sustained. The National AIDS Programme Coordinators meetings are being used as a platform for sharing of experience and information and promoting the CCH-II orientation.

The level of commitment varies from country to country as does the level of resources allocated to the national response. National budgetary allocations are being established as political will and awareness increase. However, with the impact of the structural adjustment process and the economic downturn in some countries, spending on health, particularly preventative health is declining.

As stated in the Caribbean Regional HIV/AIDS Strategic Plan, the Health Sector Reform process has not made any notable effort to date to shift resources to the primary health care sector or to integrate HIV/AIDS more systematically within primary care. HIV/AIDS in the health sector reform contexts of decentralisation and financing reform has been allowed to remain as a special case and still functions as a "vertical" programme. There is no policy framework in favour of integrating the response to the HIV/AIDS epidemic. Challenges that the new CAREC Strategic Plan will address are the strengthening of planning and programming at country level and development of skills for use of research data for policy formulation. That will be the best way to achieve coordination at national level, as well as integration of the HIV programmes into broader health and development programmes.

In terms of policy development for HIV/AIDS, this has varied throughout the region depending largely on the political status of countries. Territories that are still not independent tend to fall under the policies of the European or North American country to which they are still attached. It is felt that countries of the region having varying degrees of independence and a plurality of cultural and linguistic background have hindered the development of a truly Caribbean response to the epidemic. In addition much of the policy actually developed has remained poorly documented, unevenly acted upon and slow in formulation, in response to the rapidly evolving epidemic, and the legal, ethical and public health issues generated by the response – in particular the technological advances.

CARICOM has indeed undertaken initiatives, but these require assessment, updating and vigorous advocacy with policy makers. In 1994, a special meeting of medical and legal experts was convened, "to address special attention to the rights of individuals affected by HIV/AIDS, and groups and communities affected by the epidemic." This meeting not only identified the main ethical issues in HIV/AIDS for policy makers and practitioners, but it also provided a broad set of recommendations on legal issues for governments. These issues, which remain cogent today, included confidentiality, testing and screening, duty to warn, duty to treat, anti-discrimination legislation, regulation of private laboratories, wilful transmission of HIV, notification, informed consent, immigration and mandatory testing. During the next four years, CAREC will support the regional efforts in policy formulation by providing relevant, accurate and timely data.

Expected Result #2

Capacity of decision-makers strengthened to use the expanded response approach for policy formulation, planning, implementation and evaluation of HIV/AIDS programmes that will build alliances and mobilise communities.

Care and Support Services, Diagnosis and Applied Research

Care and support services for PLWHA and their families are recognised as the major gap in the regional response. Death rate among AIDS patients is high. Over the last nine years, the ratio AIDS cases and AIDS deaths was 1.5:1. AIDS is the leading cause of death among the 15-49 years old. Several factors are contributing to this high case fatality rate, including late diagnosis of HIV infection and related conditions, lack of skills and interest among physicians, and the absence of anti-retroviral therapies in the Caribbean.

But it is now recognised that, in the Caribbean, the health care system is not very different from the broader society in terms of rejection of people living with HIV/AIDS. In some instances, PLWHA have been evicted by their family, friends or landlords and burdened on the public system or hospices run by charitable organisations. PLWHA are reluctant to use health services, and very often, wait until late stage or terminal AIDS before they do so.

Clinical management of HIV disease has been revolutionised over the last four years. Access to HAART should be seen as one of the interventions that can make a difference:

- in the quality of life and survival of PLWHA,
- to increase their contact with the health care system by improving their health care seeking behaviour.
- to encourage the practice of safer sex and ultimately, to reduce new exposures and HIV spread to the rest of the population.
- In the absence of HAART, monitoring of PLWHA status should be done to institute prophylactic measures as recommended and to identify and treat early opportunistic infections.

Among recent effective strategic approaches is the integration of prevention with care and support programmes. It is shown that prevention indices, including behaviour change, improve significantly when adequate care is offered to patients and their families. As PLWHA survival increase, they seek and remain in contact with health practitioners and services and, often, become valuable allies in the response.

Through this strategic plan CAREC will play its role by advocating for better treatment at institutional and community level, and support the development of regional policies that protect PLWHA in institutions and communities.

This requires the development of a minimum package of care and support based on an integrated approach to prevention and care and support. This includes traditional prevention interventions based on a broader use of the existing multi-disciplinary Primary Health Care teams; promotion of condom use; voluntary counselling and testing; treatment of other STI; promotion of a continuum of care between levels of services; minimum drug regimens including those for opportunistic infections, laboratory diagnostic services, clinical management protocols. CAREC will build on existing regional framework and opportunities to promote individual rights (CRN+, CARICOM, UNAIDS, ILO, and other NGOs involved in the protection and promotion of individual rights).

Research and establishment of pilot studies as well as documentation of existing best practices in the Caribbean will point the way for the most cost effective protocols to guide the development of a minimum prevention, care and support package.

During the course of the HIV/AIDS epidemic, Caribbean laboratories have paid increased attention notably in training and development of quality assurance guidelines. Laboratories have been required to ensure that HIV was not transmitted through regional blood supplies by the provision of reliable HIV blood screening, also to support the diagnosis and management of those infected with HIV, and to provide support for the tracking of the epidemic by participating in national sero-surveys.

By 1989, all CMC national laboratories, with CAREC's assistance, had implemented HIV screening for all blood supplies and for screening clinical referrals. During this period, CAREC also strengthened its own capacity to provide a relevant HIV confirmatory reference facility for national laboratories. As the epidemic progressed, the serious personal implications of a positive result forced labs to focus not only on the availability of testing i.e. the quantity and types of tests offered, but also on the quality of testing.

In 1994, CAREC, in collaboration with national counter-parts, launched a regional initiative to strengthen the efficiency and quality of laboratory operations with a focus on rigorous evaluations, and the development of and compliance with acceptable operational standards. The initiative also promoted quality assurance training and implementation, the use of less costly but effective diagnostic technologies, external quality assessments and appropriate customer service.

As the programme places greater focus on the care of those infected, and on the prevention of HIV transmission from mother-to-child. CMCs have articulated their need for access to technologies or approaches which will allow for a faster turn-around of results to clients, and a more comprehensive and efficient management of HIV-infected persons. They have, therefore, articulated their need for both simpler, rapid tests for use at the point of client contact with the health system, and an expanded CAREC reference capability and service, providing both PCR and viral load reference testing, in addition to improved confirmatory services for opportunistic infections. Additionally, there is still much to be accomplished in the strengthening of QA programmes before the goal of 21 CMCs meeting and sustaining defined operational standards can be achieved, laboratory error minimised, and laboratory clients satisfied.

Future programme initiatives must, therefore, focus on the implementation of more sophisticated diagnostic technologies (PCR, viral load testing and testing for opportunistic infections at CAREC), and on the evaluation and identification of rapid simple reliable HIV/STI technologies appropriate for point of contact testing in countries. Greater focus must also be placed on building the collaborative team approach – epidemiology and laboratory - in the conduct of sero-surveys, etiologic and evaluative studies.

The development and enforcement of laboratory standards, the design of more effective training strategies as well as the involvement of a wider body of training institutions and the modification of current training curricula, will be key to improving and sustaining the QA gains made within the past five years. As a corollary, a more aggressive stance on the conduct of external assessment programmes for HIV and related STI must be adopted.

Expected Result #3

Capacity of CMCs to deliver efficient and effective HIV/AIDS/STI services in clinical and diagnostic management including care and psychosocial support increased (e.g. MTCT, VCT, PLWHA and youth friendly services).

Behavioral Change, Communication & Information, Applied Research

Personal behaviour is central to driving the HIV/AIDS epidemic. STIs, by definition, are transmitted by interpersonal relationships, which are influenced by broad social forces. Initiatives to prevent and control HIV/AIDS/STI need to be based on knowledge of behavioural patterns and an understanding of the factors affecting behaviour and the dynamics of behavioural change.

Knowledge is a cornerstone of any effective behaviour change strategy. Information, education and communication (IEC) interventions will seek to replace misconceptions with accurate knowledge and to nurture attitudes that are conducive to prevention and control of HIV/AIDS/STI. For example, they will seek to reduce the discrimination against people living with HIV/AIDS which discourages these people from seeking care and preventing transmission to others.

CAREC has been at the forefront of informing and educating the people of the region about HIV/AIDS since the late 1980s. In addition to its ongoing publications, CAREC will continue to collaborate with other regional organisations to mount region-wide campaigns for targeted groups, stakeholders and the public, and will move to utilising other modern information technology products including DVDs, and digital audio discs, to complement behavioural and other IEC interventions.

CAREC will continue activities to sensitise and build alliances with the media, not only for the dissemination of information, but also towards making them partners in advocating for policy and other changes, to facilitate a more enabling environment for people living with HIV/AIDS. In this context, CAREC will also continue to place emphasis on strengthening the capacity of CMCs to make more effective use of mass media and modern information technology for sustained development, production, exchange and dissemination of timely, accurate, high quality material to support their IEC efforts.

In this connection, the piloted Caribbean AIDS Telecommunication Information Network (CATIN), now operational in nine CMCs, will be expanded to embrace all CAREC member-countries. The network will also be upgraded from being an exclusively bibliographical database of HIV/AIDS documents and materials to a multi-media on-line facility. This will provide CAREC member countries with the option of utilising the fullest Internet capabilities including full text, audio and video for on-line exchange of information. This will be integral to further training to be provided to CMCs in the design and implementation of IEC interventions. Additionally, CAREC will continue to assist CMCs in IEC interventions with health care workers.

In order to inform decision-making for effective and efficient HIV/AIDS prevention, control and care strategies, behavioural surveillance systems are needed which monitor the extent of risk behaviours, the factors influencing behaviour and the dynamics of behaviour change. CAREC will strengthen behavioural surveillance systems in the Caribbean region, to enable the design of interventions which are sensitive to local realities and which have the greatest chance of success in modifying behaviour. CAREC will advocate for the inclusion of key indicators of behaviour in HIV/AIDS/STI reporting systems. It will strengthen the capacity of CMCs to conduct periodic behavioural surveys and qualitative research. It will advocate for the inclusion of an evaluative component in behavioural interventions, to enable the dissemination of lessons learned and thus improve the quality of interventions.

Strengthening communities is a key component of health promotion. Behavioural interventions are more effective if they are adapted to the specific socio-cultural characteristics and vulnerabilities of target populations and if communities actively participate in the process. CAREC will continue to strengthen the capacity of NGOs and CBOs to carry out behavioural interventions and surveillance. The focus will be on the needs of vulnerable groups, such as women of childbearing age, men who have sex with men, sex workers, people living with HIV/AIDS and young people.

Expected Result #4

Capacity of CMCs to develop, implement and evaluate behavioural and communication interventions targeting priority vulnerable populations (e.g. Young people, PLWHA, MSM, women including female sex workers) strengthened.

Programme Coordination

Over the years, CAREC-SPSTI has had to produce individual financial and technical reports to satisfy the varying reporting requirements of the many donor agencies constituting the unit's funding base. Since the PAHO reporting cycle, which operates from January to December, differs from those funding agencies, this multi reporting system has created a number of challenges for CAREC-SPSTI. In implementing its next Strategic Plan, CAREC, with the collaboration and active involvement of its partners, would like to streamline its reporting requirements by introducing a single format.

This new approach is intended:

- To enhance co-ordination in CAREC-SPSTI's financial and technical accountability to its partners.
- To improve efficiency in the delivery, monitoring and evaluation of expected results detailed in the Strategic Plan.
- To deepen mutual involvement between CAREC-SPSTI and relevant partners and regional institutions in the planning of activities in HIV/AIDS prevention and control in the Caribbean.

The mechanisms envisaged to achieve these include joint meetings between CAREC-SPSTI and its different partners, including the regional institutions, on a regular basis, as well as joint monitoring of CAREC-SPSTI's programmes.

In implementing the new approach, CAREC-SPSTI will also ensure that the proper analyses are carried out to define and make available the required human resources and overall support from other divisions of CAREC, including Administration, Laboratory, Epidemiology, as well as PAHO, to carry out the Strategic Plan,

Expected Results #5

CAREC-SPSTI's capacity to manage the expanded response and to provide timely scientifically sound expertise using the highest standards, the latest available technologies and internally coordinated managerial systems for programme planning, delivery and monitoring and evaluation strengthened.

Logframe

SPSTI Strategic Plan (2001-2005): The Logframe

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|---|--|---|---|
| Goal | | | |
| To reduce the spread of HIV/AIDS/STI as well as minimise the impact on individuals and communities in CMCs. | Reduction of the increase in the curve of HIV prevalence in Young people (e.g. Young pregnant women) 15-24 in at least 5 CMCs by end 2005. | HIV/AIDS Status and trends report in 2001 and 2005. Comparison of baseline data, mid-term and end of project data. Special study reports. | 1. The gains achieved under this plan will be sustained by other developmental programmes that will be implemented in the countries and by CAREC. |
| | At least 50% reduction of HIV transmission in children born to infected mothers who have received ARV in at least 5 CMCs by end 2005. | Trip reports and updates on implementation of MTCT programmes in CMCs. Surveillance forms submitted to CAREC annually. | |
| Purpose | | | |
| The capacity of CMCs strengthened to manage and provide sustainable programmes for the prevention and control of HIV/AIDS/STIs, and care of persons living with HIV/AIDS. | At least 50% increase in the resources allocated by government on HIV prevention and care programmes in at least 10 CMCs by the end of the project. | National Budget allocations, NAP budget. | 1. Activities implemented under this programme will assist in reducing the stigma and discrimination against people living with HIV/AIDS and assist in creating a supportive environment. |
| | In at least 7 CMCs by end of 2005, 40% improvement in the operations of National AIDS Programme in key functional areas relevant to CAREC according to evaluation criteria developed by the end of 2001. | Evaluation reports of NAPs. Baseline data and end of project data. | 2. Governments and other influentials, partners, stakeholders in the Region remain committed to the prevention and control of HIV/AIDS/STIs. |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|---|--|--|--|
| | | | 3. Activities implemented will complement other initiatives in the Region. |
| Expected Results | | | |
| 1. Health information, surveillance systems and research capabilities strengthened to generate reliable data on HIV/AIDS/STI to allow for decision-making, planning, implementation and evaluation. | 1.1.Semi-annual epidemiologic updates based on data generated by laboratories and epidemiology surveillance units produced, disseminated and utilised for health decision-making by all CMCs by end 2005 (CCH 2). 1.2 A minimum of two national research projects related to STI developed and executed in five CMCs by end 2005. | Semi-annual epidemiologic updates. Trip reports. Research protocols, final reports of studies. | 1. Minimum natural disasters (hurricanes etc) occurring in the Region. 2. Required resources (human & financial etc) will be committed to HIV/AIDS by the Governments, NGOs and private sector. 3. Governments are willing to implement the Paris Declaration that focuses on the rights of PLWHA. |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|---|---|--|---|
| <p>2. Capacity of decision-makers strengthened to use the expanded response approach for policy formulation, planning, implementation and evaluation of HIV/AIDS programmes that will build alliances and mobilise communities.</p> | <p>2.1 Multi sectorial mechanism (National AIDS committees including NGOs and persons living with AIDS) which reflects the expanded response required for the HIV/AIDS epidemic established in all CMCs by 2003. (CCH2).</p> <p>2.2 At least 12 CMCs implementing annual workplans that have been developed from their new national HIV/AIDS plans that include an expanded response to HIV/AIDS by end of 2004.</p> <p>2.3 At least 7 CMCs have a support group for PLWHA run by PLWHA by end of 2004.</p> | <p>Terms Of Reference of the NAP Committees. List of representatives.</p> <p>National Strategic Plans, Annual workplans, trip reports.</p> <p>CRN+ reports and evaluation reports.</p> | <p>4. Countries will attempt to improve access to medication for persons living with HIV/AIDS.</p> <p>5. Political Leadership and civil societies will demonstrate strong compassion towards people living with HIV/AIDS.</p> |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|--|---|---|-----------------------|
| <p>3. Capacity of CMCs to deliver efficient and effective HIV/AIDS/STI services in clinical and diagnostic management including care and psychosocial support increased (e.g. MTCT, VCT, PLWHA and youth friendly services).</p> | <p>3.1 50% of reported PLWHA receiving appropriate clinical management which includes supportive counselling in accordance with approved standards of case management in at least 13 CMCs by 2005.</p> <p>3.2 75% of patients with conventional STIs at selected health centres are appropriately diagnosed and treated according to CAREC guidelines in at least 13 CMCs by 2005.</p> <p>3.3 80% of pregnant women diagnosed with syphilis and 60% of their sexual partners adequately treated in at least 12 CMCs by 10/2005.</p> <p>3.4 At least 60% of National labs will meet 80% of the defined indicators as specified in the QA standards.</p> <p>3.5 At least 60% of National Blood Banks adhering to Regional Blood Bank Standards by 2005.</p> | <p>Quality of care surveys regarding HIV/AIDS/STI services.</p> <p>Quality of care surveys regarding HIV/AIDS/ STI services.</p> <p>Training reports.</p> <p>Clinic reports, reports of monitoring visits.</p> <p>Baseline information.</p> <p>In-country lab reports, trip reports, evaluation reports.</p> <p>Trip reports, in-country lab reports.</p> | |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|--|--|---|---|
| <p>4. Capacity of CMCs to develop, implement and evaluate behavioural and communication interventions targeting priority vulnerable populations (e.g. Youth, PLWHA, MSM, Women including Female Sex workers) strengthened.</p> | <p>4.1 At least 6 CMCs implementing behavioural change programmes that are evaluated using CAREC's behaviour surveillance indicators by 8/2005.</p> <p>4.2 At least 15 CMCs applying integrated social marketing and communication programmes by the 8/2005.</p> <p>4.3 At least 15 CMCs outputting special information programmes relevant to HIV/AIDS/STI prevention and control on national media by 8/2005.</p> <p>4.4 At least 15 CMCs storing, retrieving, exchanging and disseminating information using CATIN by 8/2005.</p> | <p>Evaluation reports of interventions conducted.</p> <p>Copies of the communication strategies developed.</p> <p>Copies of material produced.</p> <p>Copies of media material produced.</p> <p>List of bibliographies of each country.</p> | <p>6. Academic and training institutions (including UWI) collaborate in providing training.</p> |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|--|---|---------------------------------------|---|
| 5. CAREC-SPSTI's capacity to manage the expanded response and to provide timely scientifically sound expertise using the highest standards, the latest available technologies and internally coordinated managerial systems for programme planning, delivery and monitoring and evaluation strengthened. | 5.1 Technical and financial reports submitted to all SPSTI funding agencies two month after the end of each reporting period. | Financial reports, technical reports. | 7. Funding agencies are willing to use the single reporting format that is developed with their input and the MOU signed between them and CAREC is respected. |
| Activities | | | |
| <p>1.1. Promote the use of regional standards and guidelines among national professionals and key partner institutions involved in HIV/AIDS/STI surveillance.</p> <p>1.2. Conduct in country audits and training to strengthen systems to generate HIV/AIDS/STI information for interventions, policy formulation and planning utilising a multidisciplinary approach.</p> <p>1.3. Promote regular data collection and analysis to monitor HIV/AIDS/STI and associated risk-behaviours trends among targeted groups and effectively communicate results at local, national, and regional levels.</p> | | | |
| 1.4. Co-ordinate and support the conduct of surveillance, capacity building and research studies on special areas related to HIV/AIDS/STIs in partnership with national, regional and international agencies. | | | |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|---|-----------------------------------|-----------------------|-----------------------|
| <p>1.5. Facilitate collaboration and exchange of experience between CMCs to share information on the epidemiology and trends of HIV/AIDS/STI epidemics in the Caribbean.</p> <p>1.6. Support new surveillance HIV/AIDS initiatives such as the Physician Sentinel CAREC project.</p> | | | |
| <p>2.1 Conduct in-country sensitisation and training to build partnerships to increase political commitment for the implementation of National HIV/AIDS Plans.</p> <p>2.2 Train NAP personnel and other partners (including NGOs) in the use of management tools to build management capacity.</p> <p>2.3 Conduct socio-economic studies to support the regional advocacy activities of the SPSTI.</p> <p>2.4 Provide technical assistance for the development, monitoring and evaluation of national plans that promote an expanded response to AIDS epidemic.</p> <p>2.5 Continue to support the development of alliances with regional and international partners to promote an expanded response for HIV/AIDS that addresses legal, ethical, and human rights issues.</p> | | | |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|---|-----------------------------------|-----------------------|-----------------------|
| <p>2.6 Support HIV/AIDS activities of NGOs/CBOs wishing to participate in the response.</p> <p>2.7 Coordinate Regional Meeting of Caribbean National HIV/AIDS Programme Coordinators.</p> | | | |
| <p>3.1 Strengthen national testing systems to ensure reliable HIV/AIDS/STI diagnostic services and to support surveillance and applied research activities.</p> <p>3.2 Promote the use of the regional standards with regards to safety of transfused blood and lab operations.</p> <p>3.3 Strengthen inter country exchange with regards to lab quality assurance.</p> <p>3.4 Promote and strengthen skills of nationals for clinical management of HIV disease at institutional and community levels through the development and implementation of standards and guidelines.</p> <p>3.5 Strengthen STI syndromic management in CMCs.</p> <p>3.6 Promote the development of care and support systems for PLWHA including HAART and the necessary laboratory support (e.g. PCR, CD4, Viral load or their alternatives).</p> | | | |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|---|-----------------------------------|-----------------------|-----------------------|
| <p>3.7 Continue to provide technical support to regional efforts to reduce mother to child transmission.</p> <p>3.8 Conduct periodic audits on quality of care of PLWHA.</p> <p>3.9 Encourage health sector reform to promote strategies to reduce the inequity of access to care for vulnerable groups (PLWHA, Women including FSWs, Youth, MSM).</p> <p>3.10 Strengthen regional testing systems to supplement national testing systems</p> | | | |
| <p>3.11 Promote quality counselling services to ensure accessibility of these services which underpin prevention and care.</p> | | | |
| <p>4.1 Train partners in CMCs to design, implement and evaluate communication interventions to reach priority populations.</p> <p>4.2 Provide technical assistance to CMCs for the design, implementation and evaluation of communication strategies and materials targeting priority issues.</p> | | | |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|--|-----------------------------------|-----------------------|-----------------------|
| <p>4.3 Upgrade Caribbean AIDS Telecommunication Information Network (CATIN) to provide stakeholders in CMCs and CAREC with improved access to relevant, timely, and accurate HIV/AIDS/STI information.</p> <p>4.4 Increase partnerships between CAREC and CMCs with national and regional media institutions for information production and dissemination, community mobilisation and advocacy.</p> <p>4.5 Assist CMCs to develop skills to conduct applied research for behavioural change programmes and the use of behavioural data for planning and policy formulation.</p> <p>4.6 Assist CMCs in the conception, development, implementation and evaluation of behavioural change programmes with regards to HIV/AIDS/STI in collaboration with other partners e.g. social science institutions and NGOs.</p> | | | |

| Narrative Summary | Objectively Verifiable Indicators | Means of Verification | Important Assumptions |
|---|-----------------------------------|-----------------------|-----------------------|
| <p>5.1 Develop and implement a single and comprehensive reporting system (technical and financial).</p> <p>5.2 Ensure that human resource needs at CAREC-SPSTI are in place to meet the requirements of this evolving epidemic.</p> <p>5.3 Produce standardised technical and financial SPSTI reports that meet the needs of key stakeholders.</p> <p>5.4 Organise annual joint partners' co-ordination meetings to facilitate closer involvement with the review, planning and evaluation.</p> <p>5.5 Participate in regional co-ordination and technical meetings organised by PAHO/WHO, CARICOM, and other agencies.</p> <p>5.6 Coordinate midterm review and end of project evaluation with partners.</p> | | | |

Appendix B: Evaluation Grid

| Evaluation Criteria | Weighting | Score | Passing Mark |
|---|------------|-------|--------------|
| 3.2 Rated Technical Component Requirements | 800 | | 480 |
| 3.2.1 Experience of the Consultant | 200 | | |
| <p>3.2.1(i)</p> <p>If a single entity: Demonstrate capacity including sufficient in-house and associated resources to carry out the project.</p> <p>If a consortium, joint venture or any kind of association: State</p> <ul style="list-style-type: none"> • The value added to the consortium by each member. • The history of collaboration between each member. • The approximate percentage of the total proposed level of effort (based on person days or months) allocated to each member of the consortium for the implementation of the project. <p style="text-align: center;">(Maximum one page)</p> | | | |
| <p>3.2.1 (ii) Describe the Consultant's understanding of the key principles underlying the concept of capacity development in the context of public health. Describe briefly how the Consultant has applied these principles on other projects and what results were achieved at the end of the project.</p> <p>(Maximum one page)</p> | 50 | | |
| <p>3.2.1 (iii) Describe two (2) projects demonstrating significant experience in:</p> <ul style="list-style-type: none"> • Assembling a team of experts, outreach capacity and creating partnerships; • Working with and through Steering and Advisory Committees and other partners and selecting and contracting local experts and monitoring their performance; • Using logical framework management systems to manage and monitor project performance; • Experience in policy development/advocacy initiatives; • Experience in health promotion / behaviour change projects; • Experience in mobilising communities to address social or behavioural issues; • Experience in developing countries particularly in the Caribbean. <p>Maximum points will be given for relevant project experience in the Caribbean. The scores will be reduced for relevant project experience in other developing countries, and further reduced for Canadian experience.</p> <p>(Maximum of 6 pages: that is, 3 pages for each project.)</p> | 100 | | |
| a) Project A | | | |
| b) Project B | | | |

| Evaluation Criteria | Weighting | Score | Passing Mark |
|--|------------|-------|--------------|
| 3.2.2 Methodology | 300 | | |
| <p>The purpose of this section is to seek the most innovative, creative and responsive proposal. This section seeks to assess the Consultant's understanding and vision of what the project aims to achieve and how the Consultant intends to undertake the activities in the Terms of Reference to achieve the expected program results.</p> <p>SPSTI (CAREC) intends to hold a planning meeting annually with all its donors, partners and major stakeholders to review the activities of the previous year and to develop an annual integrated workplan. This will be followed with a joint mid-term review of the Programme will be undertaken.</p> <p>Based on the details in the RFP and the Summary of the Strategic Plan and Logframe (Appendix A) and guided by this Proposal Evaluation Grid, the Consultant shall respond to the following:</p> | | | |
| <p>3.2.2(i) Describe the strategy to be used to source technical assistance for the various programme components, the mechanisms for coordination and management of the process.</p> <p>Where applicable, the proposal shall clearly identify the type of arrangements, contractual or otherwise, that will be made to acquire these services if it is being undertaken by others (e.g sub-contracting).</p> <p>(Maximum 5 pages.)</p> | 150 | | |
| <p>(ii) Outline the key challenges and determinants of HIV infection in developing countries and recommend key strategies / approaches and critical assumptions that apply in implementing a project of this type.</p> <p>(Maximum 4 pages.)</p> | | | |
| 3.2.3 Personnel | 300 | | |
| 3.2.3.1 Project Coordinator | 100 | | |
| <p>Project Coordinator will be based at the Consultant's headquarters and should have the following characteristics:</p> <ul style="list-style-type: none"> • experience in project management; • experience in managing complex public health projects with an emphasis on stakeholder involvement and consultative approaches; • experience in coordinating multi-disciplinary activities; experience in contracting, financial control and reporting; • knowledge of stakeholders in regional and international health environment; experience in working in developing countries and especially in the Caribbean region or in multi-island settings; • strong academic and professional qualifications. <p>(Curriculum vitae of maximum 3 pages.)</p> | | | |

| Evaluation Criteria | Weighting | Score | Passing Mark |
|---|-----------|-------|--------------|
| <p><i>3.2.3.2 Proposed Technical Team</i></p> <p>The Consultant should outline the mechanism for accessing technical expertise and identify the individuals and/or organisations from which it will be drawn.</p> <p>The Consultant is encouraged to submit a biographical sketch of the above organisation and /or narrative overview of the available technical expertise.</p> <p>(Maximum of 2 pages per organisation and/or CVs.)</p> <p>The Consultant should ensure that they have experience with large multi-disciplinary projects in developing countries and especially in the Caribbean as well as demonstrated skills in collaborating with stakeholders and NGOs.</p> <p>Main areas of focus are:</p> <ul style="list-style-type: none"> • New diagnostic technologies for HIV/AIDS/STI; • Design, implementation and evaluation of preventive and supportive counselling services including voluntary counselling and testing; • Design, implementation and evaluation of targeted behavioural / health promotion interventions; • Public health programme management and evaluation; • Communication training and development of communication strategies; • Non-government organisation and community based organisation development on HIV/AIDS issues. <p>Maximum points will be allocated for experience in developing countries, specifically in the Caribbean region or multi-island settings.</p> | 200 | | |
| <i>Financial Component</i> | 200 | | |
| <i>Oral Presentation and Interview</i> | 100 | | |