PEPFAR TRANSITIONS:
LESSONS LEARNED THROUGH THE EXPERIENCE OF PAST DONOR TRANSITIONS AND APPLICATIONS FOR THE EASTERN CARIBBEAN

December 2014

This document was produced for review by the United States Agency for International Development. It was prepared by Abigail Vogus and Kylie Graff for the Health Finance and Governance (HFG) project and the Strengthening Health Outcomes through the Private Sector (SHOPS) project.

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Cooperative Agreements: SHOPS: GPO-A-00-09-00007-00 and HFG: AID-OAA-A-12-00080

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Recommended Citation: Vogus, Abigail and Kylie Graff. December 1, 2014. *PEPFAR Transitions: Lessons Learned through the Experience of Past Donor Transitions and Applications for the Eastern Caribbean.* Bethesda, MD: Health Finance and Governance and Strengthening Health Outcomes through the Private Sector Projects, Abt Associates Inc.

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SHOPS Project In collaboration with: Banyan Global • Jhpiego • Marie Stopes International • Monitor Group • O'Hanlon Health Consulting

HFG Project in collaboration with: Broad Branch Associates | Development Alternatives Inc. (DAI) | Futures Institute | Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D) | RTI International | Training Resources Group, Inc. (TRG)

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ACRONYMS

ART	Anti-retroviral therapy
ARV	Anti-retroviral
CHAA	Caribbean HIV/AIDS Alliance
CNCD	Chronic non-communicable disease
CSIS	Center for Strategic and International Studies
CSO	Civil Society Organizations
CSW	Commercial sex workers
DHS	Demographic and health surveys
FP	Family planning
IMF	International Monetary Fund
LAC	Latin America and the Caribbean
M&E	Monitoring and evaluation
MARP	Most at-risk population
MSM	Men who have sex with men
NGO	Non-governmental organization
OECS	Organization of Eastern Caribbean States
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PPS	Pharmaceutical procurement system
SHOPS	Strengthening Health Outcomes through the Private Sector Project
TA	Technical assistance
USAID	United States Agency for International Development
USG	United States government

ACKNOWLEDGMENTS

This initial literature review was funded by Abt Associates, Inc.'s HIV Technical Working Group. Further support for manuscript preparation was provided by the United States' Agency for International Development through the Health Financing and Governance Project (Cooperative Agreement Number GPO-A-00-09-00007-00) and the Strengthening Health Outcomes through the Private Sector Project (Cooperative Agreement Number - GPO-A-00-09-00007).

1 INTRODUCTION

The President's Emergency Plan for AIDS Relief (PEPFAR) has helped introduce life-saving treatment to 6.7 million people living with HIV (PLHIV) worldwide.[1] PEPFAR I (2003–2008) was an emergency response to a growing epidemic.[2] The PEPFAR reauthorization (2009–2013) acknowledged that expanded access to treatment and scale-up of prevention achieved under PEPFAR I merited a shift to a more targeted, sustainable response for greater country ownership (PEPFAR 2). This shift was highlighted in PEPFAR's 2012 Blue Print for Creating an AIDS-Free Generation, which lays the groundwork for an AIDS-free generation through a sense of shared responsibility and investing in the principle of country ownership.[2] A notion of shared responsibility was further laid out in PEPFAR's FY2014 Sustainability Planning Guidance Document: Advancing Country Ownership in PEPFAR III ("Sustainability Planning Guidance"), which outlines PEPFAR's approach to achieving high-impact national HIV responses that maintain service levels and quality under the ownership of "government, civil society, the private sector, and other stakeholders in the partner country."[3] The United States government (USG) and partner countries and/or regions are now tasked with using this guidance to develop individually tailored implementation plans outlining the future direction of PEPFAR-partner country relations.

In 2013, USAID/Barbados and the Eastern Caribbean requested the authors' assistance to help frame the transition of PEPFAR programming to country ownership in the Caribbean by conducting a literature review. Specifically, they were tasked with gathering and analyzing findings from other donor transitions, including graduation from USAID's family planning (FP) programs in Latin America and the Caribbean (LAC) and current PEPFAR transitions, to identify key themes and lessons learned that might be applied in the Caribbean. PEPFAR has since developed the Sustainability Planning Guidance noted above. This article complements that guidance by identifying themes and lessons learned to successfully plan, develop, and implement transition strategies that can translate across all PEPFAR countries. Specific emphasis is placed on taking these lessons learned and applying them to the Caribbean context in preparation for the shift from the PEPFAR-Caribbean Regional Partnership Framework ("Partnership Framework") (2010–2014) toward programs with greater country ownership and sustainability.

2 BACKGROUND

Comprised of a series of small island nations and mainland countries, the Caribbean has the second highest regional HIV prevalence rate in the world behind Sub-Saharan Africa. Adult HIV prevalence among Partnership Framework countries, namely Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago, is approximately one percent. The epidemic is primarily concentrated among most at-risk populations (MARPs), including commercial sex workers (CSW), men who have sex with men (MSM) and prisoners.[4] A low regional average masks much higher estimated prevalence rates among these MARPs. Research shows that seroprevalence rates among CSWs are 9 percent in Jamaica and 21 percent in Suriname.[3] Unprotected sex between men accounts for at least 10 percent of HIV-positive individuals in the Caribbean and is as high as 30 percent in Jamaica.[5]

The Caribbean's geopolitical, economic, and cultural context leads to unique challenges for consideration when planning sustainable, country-owned responses. Though predominantly middle-income countries, many significantly rely on PEPFAR funding for HIV programming. For example, recent national health accounts exercises in Dominica and St. Kitts and Nevis indicate that international donors provide 27 and 47 percent of HIV funding, respectively.[6,7] Chronic non-communicable diseases (CNCDs) account for almost 50 percent of disability-adjusted life years lost and up to eight percent of gross domestic product in some Caribbean countries.[8] National human and financial resources are oftentimes directed toward CNCDs, their largest concern, or emerging health threats such as chikungunya and Ebola, while donors have paid much attention and funding on HIV programs. Meanwhile, financial assistance from the USG to the LAC region declined 13 percent between fiscal years 2008 and 2012.[9] The USG has communicated to governments in the region that USG funding for HIV in the countries with lower prevalence and disease burden will drop further in the near future (letter from Larry Palmer, US Ambassador to the Eastern Caribbean and the Organization of Eastern Caribbean States, 13 Aug 2014).

Culturally, small population sizes with largely conservative religious influences reduce confidentiality and cultivate widespread stigma and discrimination. This is exacerbated by conservative public policies that outlaw transactional sex and criminalize homosexuality. The result is largely isolated MARP groups unwilling or unable to access essential HIV prevention, care, and support services. Small population bases also limit the number of qualified health workers available to implement HIV interventions. Unlike in Sub-Saharan Africa, the non-governmental organization (NGO) sector is small, fragmented, and oftentimes lacking the capacity to supplement public sector resources and reach target populations.

3 METHODS

A rapid review of both peer-reviewed and gray literature was conducted with expansive search terms to reflect the shifting language and changing contexts around donor transitions to country ownership. For example, USAID's transition away from funding large FP programs in LAC is typically referred to as graduation. While graduation was used in early discussions around PEPFAR transitions, there has been a steady movement in the dialogue toward country ownership and country-owned responses. Combinations of these terms were used to ensure a more comprehensive literature review. Searches also focused on the relationship between declining donor funding and program sustainability. Table 1 highlights the various combinations of words searched to identify potential articles and documents.

These search parameters returned thousands of documents. The authors then reviewed the resulting abstracts to determine whether they informed three key questions:

TABLE 1: KEY SEARCH WORDS AND PHRASES

Key search words and phrases
What does or could transition to country ownership mean within the PEPFAR context?
What are the key steps in the transition to country ownership?
When does a transition to country ownership become "successful?"

The initial review was conducted in January 2013 and updated in May 2014 to prepare for this publication. Ultimately, this literature review includes lessons drawn from 36 documents identified as directly relevant to the review's objectives.

3.1 LIMITATIONS

The need for broad search terms to capture changing language around transition to country ownership produced a volume of results that made an exhaustive literature search impossible. The review also relies upon the existence of available literature that conforms to the questions noted above. The majority of available literature was project reports and case studies.

4 RESULTS

4.1 DEFINING TRANSITION – IN PRACTICE AND THEORY

A major challenge in conducting this review was navigating the changing vernacular and perceptions of transition to country ownership among stakeholders. Oftentimes “graduation,” “transition,” “country ownership,” “sustainability planning,” and “donor withdrawal” were used interchangeably. Findings from the literature and anecdotal evidence from regional program implementation revealed a lack of clarity among stakeholders as to what transition to country ownership means in practical terms. This was exacerbated by a lack of strategic planning, which perpetuated skepticism that transition was equivalent to donor withdrawal.

The literature confirms that understanding the transition’s complexities is a common struggle. Hirschhorn et al conducted a literature review to identify best practices for sustaining HIV programs at-scale.[10] She notes that the term ‘scale’ has evolved from more narrow definitions of size, such as the number of sites in a program, to broader notions that include a shift to local ownership.[10] Esser suggests that a multiplicity of definitions exist for ‘ownership’ in the development community.[11] He contends that country ownership has moved away from the traditional notion of transferring power from donor to recipient country government to an expanded, de-politicized definition that includes civil society and other non-state actors.[11] In evaluating the beginnings of South Africa’s PEPFAR transition, Kavanaugh notes that transition planning remains ill-defined, especially for prevention programs, and that civil society organizations fear that that transition equates to PEPFAR withdrawal amidst USG budget cuts.[12]

Findings suggest that a unified message across government agencies and an initial framework to outline the process is vital for improving communication among stakeholders and building capacity to successfully manage the transition. PEPFAR’s Sustainability Planning Guidance is a critical step in clarifying the proposed process of achieving sustainable, country-owned programs. For the Caribbean, the challenge now becomes translating this guidance into an actionable long-term strategy that fosters country-owned HIV responses within its unique regional context.

4.2 KEY STEPS IN TRANSITIONING TO COUNTRY OWNERSHIP

Through a review of the existing literature, six key steps were identified in planning an effective transition to country ownership: 1) develop a roadmap; 2) communicate the plan through high-level diplomacy; 3) invest in stakeholder participation; 4) support mid-term evaluations; 5) provide technical assistance (TA) throughout the process; and 6) provide long-term monitoring and evaluation (M&E) support. This section outlines each of those key steps and specific factors for consideration when planning the Caribbean transition.

4.2.1 DEVELOP A ROADMAP

Concise roadmaps are necessary to clearly communicate transition goals and processes. A clear strategy did not exist in the early stages of graduation from FP programming in the 1990s; a review of those early graduations revealed that formal strategies were essential to successful transitions and resulted in a systematic process being put in place by 2004.[13] In South Africa, the Center for Strategic and International Studies (CSIS) found that the lack of a written plan and clear communication for PEPFAR's transition created substantial resentment and frustration among South African officials.[14,15] For example, South Africa's Partnership Framework made it clear that funding would decrease over time but it did not specify the pace of the reductions.[15] The plan also focused primarily on the transition of care and treatment but did not discuss what the transition would mean for prevention activities. This resulted in largely underfunded prevention programs and a lack of sufficient focus on high-impact interventions and strategies that were historically funded by donors.[15] Africa's experience highlights the need for clear guidance on *all* HIV program areas. This is a critical lesson for Caribbean road map development, as prevention programs are widely support by international donors.

Ideally, there should be two roadmaps. One should be within PEPFAR to outline the basic process for transition planning, such as the Sustainability Planning Guidance. The second should be country and/or region-specific and negotiated with stakeholders in-country. Country/region-specific roadmaps should lay out the shared responsibilities between USG agencies and local governments, donors, and other stakeholders, including intended funding levels.[16] This plan should clearly outline expectations, objectives, activities, timelines, and human and financial resource commitments among all stakeholders while indicating the seriousness of donor withdrawal. A mutually agreed upon roadmap of this nature would promote transparency between donor and recipient countries while minimizing misconceptions.

4.2.2 COMMUNICATE TRANSITION STRATEGIES THROUGH HIGH-LEVEL DIPLOMACY

Early reports from the FP graduation process found that many countries experienced mixed messaging from donors about funding timelines. This contributed to unwise resource utilization because of misunderstanding over how long funding would be provided.[13] Consistent messaging through high-level diplomacy helps alleviate these issues and strengthen country engagement by encouraging active stakeholder participation while stressing the seriousness of proposed donor withdrawals.[13,17,18] This level of engagement will be even more important with PEPFAR transitions in the Caribbean, given the multi-agency, multi-country nature of the response. High-level officials, such as Ambassadors, Mission Directors, Prime Ministers, and Ministers of Health, should be engaged early and often to relay consist messaging and reduce the risk of conflicting messages on critical factors like timelines and funding commitments. Engaging high-level ministers and diplomats also helps ensure political support for the plan and future programming.

4.2.3 INVEST IN STAKEHOLDER PARTICIPATION

Stakeholder participation is a vital component of any successful transition planning process.[13, 18–20] A variety of stakeholders should be involved, including high-level diplomats, ministry officials, civil society organizations, other donors, and private sector representatives. Involvement of country stakeholders increases the likelihood that counterparts at all levels buy into the plan, understand its intentions, and accept stakeholder responsibilities.[13] Country

counterparts need to own the process of mobilizing new resources and shaping the next phase of PEPFAR – partner country relations.

Intensive stakeholder participation will require a longer timeframe for transition. According to Slob and Jerve, no less than two years is required to sufficiently involve the full set of key stakeholders in the transition planning process.[18] In Mexico, FP graduation was originally planned as a five-year process. Two additional years were ultimately added to transition full ownership of FP programs.[19] In South Africa, health practitioners have already cautioned that while country ownership is essential to long-term sustainability, too rapid of a transition can undercut access to services.[21,22] South Africa's experience to date has shown that the speed of PEPFAR's withdrawal of human resources and funding has seriously disrupted treatment to an estimated 50,000 to 200,000 PLHIV.[15] In the Caribbean, the process is being jointly undertaken by twelve countries with different epidemics and varying technical and funding capacities. Adequate time is required for each country to sufficiently lead, manage, and fund their national response without adversely affecting current service provision levels.

4.2.4 SUPPORT MID-TERM EVALUATIONS AND ALLOW FLEXIBILITY

Mid-term assessments provide an opportunity to validate initial assumptions underlying transition plans and respond to emerging challenges. Early reviews of FP graduations found that the most successful transition plans are flexible to accommodate changing needs and contexts, oftentimes identified via mid-term assessments.[13, 18, 19] A critical failure identified in South Africa's transition is the lack of a system to track patients who may be lost to follow-up as services shift from NGO partners to government clinics.[15] The lack of tracking system means that the exact size, scope, and location of the problem is largely unknown, making it virtually impossible to make mid-course corrections. In Brazil, the FP transition incorporated a mid-term assessment which validated the strategy and recommended additional management components for two states.[13] In Mexico, a midterm assessment led to an extension of the phase-out timeframe.[13]

4.2.5 PROVIDE TECHNICAL SUPPORT TO IMPLEMENT THE PLAN

Many countries require additional support and capacity building to fully manage and integrate PEPFAR- funded activities into their national health plans. PEPFAR should commit to the provision of capacity building to strengthen overall HIV program management and build this assistance into any transition plan. Many countries may lack the technical expertise or funds to undertake necessary initial assessments needed to make decisions on funding priorities, resource mobilization and tracking, and improving efficiency that will be necessary for sustaining programming.

4.2.6 PROVIDE M&E SUPPORT

A sustainable program is one in which a country can maintain or improve priority health outcomes. The outcomes can be compromised by new health challenges, unexpected instability, or overestimation of in-country capacity after donor withdrawal. Not all countries have the financial resources and technical expertise to measure these outcomes. Surveys such as Demographic and Health Surveys (DHS) are usually sponsored by donors. Supporting ongoing M&E will be especially important in the Caribbean where seroprevalence data is currently nearly nonexistent. In order for USG to assist the country in continuously monitoring its progress, help measure USG's own success in transitioning, and contribute to global health research agendas, on-going funding for research and health outcomes measurement should be incorporated into

the transition roadmap.[17,19] Such support will also reinforce the ongoing partnership between USG and the partner country after direct program assistance is withdrawn.[13,20]

4.3 DETERMINANTS OF READINESS FOR SUCCESSFUL TRANSITION TO COUNTRY OWNERSHIP

PEPFAR's Sustainability Planning Guidance identifies four key dimensions for successful country ownership: political ownership and stewardship; institutional and community ownership; capabilities; and mutual accountability, including financing. This section expands on that guidance by describing nine key areas, as identified by existing literature, which should be evaluated when determining readiness for transition to country ownership. These principles are then applied to the Caribbean to assess readiness and potential barriers to success that may require additional support. Examples focus on countries in the Organization of Eastern Caribbean States (OECS) (Antigua and Barbuda, Dominica, Grenada, St. Kitts and Nevis, St. Lucia, and St. Vincent and the Grenadines).

4.3.1 LEADERSHIP AND MANAGEMENT CAPACITY

Country ownership of the national HIV response requires identifying advocates who will promote the cause.[16,23,24] Government decision makers must identify HIV programming as an essential part of health services and advocate for national funding using accurate and compelling analytics.

In the Caribbean, competing health priorities, stigma and discrimination, and relatively small affected populations make it especially difficult to gain the attention of decision makers. While most leaders recognize that care and treatment for HIV is important, it is politically challenging to invest significant resources, financial and otherwise, into their HIV response without first advancing CNCD programs. Successful transitions will need to identify champions for the process.

Successful implementation of transition plans will also require management capacity. Most research on sustainability and country ownership has highlighted the need for increased management capacity. Where PEPFAR has provided more direct provision of services, local partners may need further training in key areas like health planning, M&E, procurement, performance management, and financial management.[16–18, 23, 25] This will be a key area for PEPFAR's transition in the Caribbean. A series of health systems and private sector assessments in the OECS found that overall management capacity in the region is limited and few officials have planning or health financing backgrounds.[26–31]

4.3.2 POLITICAL AND ECONOMIC FACTORS

Political and economic factors have consequences for health outcomes and programming. In Mexico, for example, decentralization changed resource allocation needs during the transition plan, but the plan was not flexible enough to accommodate this change.[13, 19] Health reforms in Indonesia, which included decentralization, also affected the success of the FP graduation.[20] Political and economic analyses should be undertaken during roadmap development to identify internal and external threats to the transition plan. In the Caribbean, some destabilizing factors include heavy debt burden and dependence on the tourism industry in a time of global austerity.

4.3.3 POLICY ENVIRONMENT

Policies and laws are important in outlining a country's vision and communicating and regulating the role that local actors can play. Having appropriate policies in place to protect vulnerable populations, regulate the health sector, and provide guidance on the vision for HIV services are key indicators of the readiness of a country for transition. A critical lesson learned from FP graduation programs is that policies are needed to protect the rights of individuals to access essential services.[13] Cromer et al note that national policies like price controls, free distribution campaigns, and advertising restrictions create barriers for private sector involvement in service delivery. It is also important to examine and strengthen the inclusiveness and data-driven character of the policymaking process.[23]

In the Caribbean, key policy areas to examine during transition are national strategic plans for health (inclusive of HIV), guidance and regulation for private sector (for-profit and not-for-profit) providers of HIV services, and policies that protect the rights of vulnerable populations. Many Caribbean islands have allowed their strategic plans to lapse and have difficulty resourcing a thorough planning process. Many also lack policies to protect PLHIV and MARPs.[33] For example, sodomy laws are still enforced throughout much of the region and adolescents often lack the right to access services without parental permission. These types of policies limit access to services and create barriers for providers working with these communities. Because of these types of social and political barriers, many support organizations for MARPs will require on-going external support.[21] Without proper policies in place before transition, the result could be backsliding in the gains made under PEPFAR.

4.3.4 ALTERNATIVE FUNDING SOURCES

Governments must identify ways to replace donor funding.[20, 24, 33] This is difficult with even the strongest of government commitments because they must balance competing priorities.[13, 17] Economic instability and increasing healthcare costs often drive health budgets below desired levels. The private sector should be actively engaged to complement public services in a way that promotes efficient and cost-effective service delivery.[16]

Most Caribbean countries are undergoing health reforms to identify funding sources for soaring healthcare costs. Not all have determined what these reforms will look like or conducted the research needed to make informed decisions. Several countries are considering national health insurance schemes and wish to design essential packages of services under those schemes. Identifying and implementing strategies that leverage private sector resources, both human and financial, will be a critical component of any sustainability strategy. Examples of such arrangements include contracting private providers with specialty services and/or equipment not readily available in the public sector and formalizing arrangements with providers and local corporations to provide confidential, stigma-free counseling and testing services.

4.3.5 INTEGRATION OF HIV PROGRAMS

Bossert asserts that the sustainability of donor-funded programs relies on effective integration of programs into existing administrative structures.[33] The evolution of PEPFAR and other large HIV donors has seen a shift away from siloed HIV programs to integrated service delivery models. Incorporating HIV into general MOH structures facilitates the integration of HIV services into primary care, resulting in improved management of and access to these services. In the Caribbean, most HIV programs have been integrated at least nominally within MOH structures. In practice, however, as evidenced by HIV-only clinic days in some countries, HIV services are often still separate from other primary care services in a manner that perpetuates stigma.

Caribbean islands need assistance to fully integrate programs in a way that supports HIV services and protects the users of those services.

4.3.6 INSTITUTIONALIZE PROCESSES

To encourage sustainability, any process integral a program needs to be institutionalized and standardized.[24, 25, 34] Bradach notes that sustainable programs often require that systems, structures, and processes are standardized and articulated for others to successfully implement.[34] Standardization may require the development of standard treatment protocols, guidelines for service delivery, clear job descriptions, checklists for services provisions and monitoring, standardized indicator sets, or other job support tools. Standardizing and simplifying procedures also assist in overcoming human resource constraints.[24] Bennett et al. are evaluating a PEPFAR-funded program in India where management shifted from NGOs to the Government of India.[25] Two key areas of evaluation are how well programs have been integrated into existing organizational systems and practices and the extent to which institutional standards guide program management. The evaluation framework assumes institutionalization and standardization create processes to ensure program quality in activities that will be transitioned from the NGO to the government.

Health systems and private sector assessments conducted in six OECS countries revealed that HIV programs are often more likely to have standardized procedures than other health areas. This is especially true for M&E or anti-retroviral therapy (ART) provision, driven by donor requirements and funding. Further support may be needed to develop and increase the use of standard treatment protocols and regulate private facilities, including labs that provide testing for HIV. A Caribbean transition plan could provide further support to integrate and streamline the standards, guidelines, and M&E structures from HIV programs into the overall practice of the MOHs.

4.3.7 SUPPLY CHAIN MANAGEMENT

Pharmaceuticals and other commodities are an important part of ensuring access to testing and treatment. This is an area in which international donors, especially USG and the Global Fund, have made substantial investments. A key component of sustainable supply chain management involves building the capacity of in-country stakeholders to take responsibility for overseeing logistics and financing procurements.[13, 17, 20] For example, commodities were largely funded and managed by USAID prior to graduation from FP programs. Cromer et al note that early graduates from USAID FP funding had systems for procurement in place but experienced stockouts because they lacked experience procuring through different systems.[13]

The USG has consistently supported supply chain management efforts in the Caribbean, including support to establish the OECS Pharmaceutical Procurement System (PPS). Delayed payments have placed PPS under threat of collapse, which could lead to major challenges in procuring affordable anti-retrovirals (ARVs) when donor funds are no longer available. PPS has been working to improve forecasting and supply chain management, but local capacity is still weak. Central Medical Stores in each country often face stock outs of essential drugs, including ARVs, and testing reagents in part because there is low capacity for forecasting and monitoring of inventory. These challenges are intensified by a lack of cash flow within governments that prevent timely payments to manufacturers. Transition plans should consider building the capacity of PPS and local supply chain managers to improve and expand the current procurement system, including advocating to Ministries of Finance to ensure funding for essential medicines commodities currently procured and supplied by donors that will phase out

in the near future. Increasing pooled procurement of these commodities, especially reagents, could help attain cost savings and efficiency.

4.3.8 STAFFING AND TRAINING NEEDS

The capacity and retention of skilled workers is essential to ensuring a smooth transition from donor support.[16–18, 20, 23, 33] While PEPFAR often supports seconded staff within Ministries of Health, decreases in funding mean that countries must intensify their hiring, retention, and training of health professionals to fill these gaps. For example, PEPFAR supported nearly 150 positions in Botswana, mainly in planning and strategic information.[17] Decreases in PEPFAR funding meant that the government was faced with filling these positions alongside existing issues of major turnover and lack of key technical competencies in planning and management.[17] Botswana was further constrained by macroeconomic policies that created hiring freezes at the urging of the International Monetary Fund (IMF).

The Caribbean region has long suffered from brain drain, especially among nurses. Most Caribbean islands have health worker shortages and public health management positions are difficult to fill with experienced personnel. Rotational patterns often means that those who have been trained extensively in testing or other HIV services are rotated out of the facilities that host these services. Most countries in the region are currently working with the partners to develop human resources for health strategies and train health workers. However, there will inevitably be a lag in the time needed to fully develop new and train existing cadres of workers. While there are currently few seconded positions in the Caribbean, strategic secondments during the transition process could help fill these gaps and assist in identifying areas for capacity building.

4.3.9 CIVIL SOCIETY AND PRIVATE SECTOR ENGAGEMENT

In many countries, private sector providers and civil society organizations have played a large role in delivering services, monitoring quality of public services, and/or advocating on behalf of marginalized groups. For example, NGOs and the for-profit private sector played a large role in providing contraceptives. As a result, USAID focused its FP graduation plans on the development of sustainability and business plans for private sector providers to continue offering these services.[13, 20] In cases where civil society organizations (CSOs) or the private sector are delivering HIV services, transition will require these organizations either to develop their own sustainability plans[13] or align with government norms to function under government auspices.[25] In some countries, much work may need to be done to identify, establish, and/or formalize partnerships, networks, and roles between the government, private sector, and civil society.[23] Investments in NGOs will help increase the sense of urgency and community engagement around HIV.[17] When already an advocate, additional efforts should be made to ensure civil society has a place at the table for policy making, especially to represent the needs of marginalized populations.

The current and potential role of the private health sector in the Caribbean is vast. The NGO community plays an important role in reaching the most marginalized populations and addressing stigma and discrimination. However, many Caribbean NGOs are either volunteer-based or heavily reliant on donor funding. For example, in some islands the Caribbean HIV/AIDS Alliance (CHAA) provide important HIV prevention services for MARPs but it was more than 95 percent reliant on PEPFAR funding.[35] Without funding diversification strategies and appropriate sustainability plans, these groups may cease to exist. In some islands, NGOs are playing only a minimal role in advocacy efforts and will require support in providing services and expanding reach if this will be an expected role in a country-owned program.

Private health care providers also possess a breadth and depth of experience in providing HIV care and treatment services throughout the region. Oftentimes overlooked, the private sector is poised to play a larger role in filling gaps in HIV programming. Recent mapping exercises of private sector resources for health in four Caribbean countries conducted by the Strengthening Health Outcomes *through* the Private Sector (SHOPS) project found that the private health sector was much larger than originally understood and many private providers had training in HIV counseling, testing, and/or treatment but were not utilizing their skills due to lack of patient demand. [36-38] Activities geared toward greater private sector engagement, ranging from fostering sustainable partnerships and policy dialogue to increasing access to training will be crucial to sustaining health outcomes.

5 CONCLUSION

This review has attempted to identify successes and lessons learned from past and current transition processes to provide insights for PEPFAR's goal of transitioning from emergency response and program scale-up to sustainable, country-led programming. It has highlighted that the transition process requires changes in not only how USG engages in the planning and implementation programs but also a clear assessment and understanding of the capacity of a country to take on the management of the program.

In terms of process, evidence suggests that the first step in any successful transition to country ownership is mutually agreeing upon the goal and the steps required. This agreement would then be articulated in a defined, detailed yet flexible roadmap, developed and disseminated via an inclusive, participatory approach to ensure stakeholder buy-in and ownership of the process. In the Caribbean, this means active participation from public sector representatives like Ministries of Health and Finance and National AIDS Programs and key private sector stakeholders, including private providers, corporate entities, and key members of the NGO and CSO communities across all twelve Partnership Framework countries.

Assessing readiness for such transition is challenging and must account for unique contextual factors across all facets of the health system. For the Caribbean, readiness will require strengthening health systems, further engaging the private sector, and building the capacity of NGOs to take on essential program functions. On-going support, including targeted capacity building TA and long-term M&E, will be vital to ensuring that the countries of the Caribbean are able to take a leading role in their HIV responses while maintaining or improving upon the gains made under PEPFAR.

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