

Approved



Central America Region Country Operational Plan FY 2014

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.



Operating Unit Overview

OU Executive Summary

I. REGIONAL CONTEXT

a. Epidemiology of HIV Epidemic

The Central America region is characterized by a concentrated HIV/AIDS epidemic with low prevalence among the general population, but high prevalence among certain subgroups such as men who have sex with men (MSM); transgender women (male to female); male and female sex workers (SW); clients of sex workers; and certain ethnic groups such as the Garífuna.

According to the 2013 UNAIDS Global Report, HIV prevalence in adults is highest in Belize (1.4%), followed by Panama (0.7%), Guatemala (0.7%), El Salvador (0.6%), Honduras (0.5%), Costa Rica (0.3%), and Nicaragua (0.3%). These relatively low national percentages mask the concentrated epidemic among key populations (KP). Belize, a country which geographically, politically, and culturally straddles both Central America and the Caribbean, is an exception with a prevalence rate above 1%, but still has an epidemic driven by KPs.

Data continue to demonstrate that transgender women, MSM and female sex workers (FSWs) are the populations with the highest HIV prevalence rates in the region. Results from the most recent USG-supported behavioral surveillance surveys (BSS+) and other epidemiological surveys for Panama and Costa Rica show the prevalence for MSM is as high as 18.7% in Panama (2012), 13.9% in Belize (2012), 11.7% in Honduras (2012), 10.9% in Costa Rica (2009), 10.8% in El Salvador (2008), 8.9% for Guatemala (2013) and 7.5% in Nicaragua (2010). Transgender women were included separately in most of these studies since it is a relatively small but very high-risk group. Their HIV prevalence rates were as high as 37.6% in Panama, 31.9% in Honduras, 27.8% in Nicaragua, 25.8% in El Salvador and 23.8% in Guatemala. In the same studies, the HIV prevalence among FSWs was reported as high as 15.3% in Honduras, 5.7% in El Salvador, 2.4% in Nicaragua, 1.1% in Guatemala, 0.9% in Belize, 0.7% in Panama, and 0.01% in Costa Rica. The 2013 BSS+ Honduras survey showed the HIV prevalence for the Garífuna ethnic population was 4.5% among men and 4.3% among women in urban areas. In 2009, the USG supported BSS+ with the Belize Defense Force showed a prevalence rate of 1.14% among military personnel, while in the Honduran military, prevalence was less than 1% in 2013. The data available suggests that intravenous drug use is not a major factor in HIV transmission in the region.

b. Status of Regional and National Responses

Host country governments continue to show strong national and regional leadership in response to the



epidemic, and provide the majority of the resources in support of national HIV/AIDS programs. With some countries receiving additional grant support from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), government efforts have focused on providing anti-retroviral treatment (ART), care for people living with HIV (PLHIV), programs to prevent mother-to-child transmission (PMTCT), and Behavior Change Communication (BCC) for the general population and high-risk groups. Nevertheless, HIV activities supported by host governments continue to have notably limited coverage of KP, and stigma and discrimination directed toward these populations continue to represent major barriers to effectively address the epidemic across the region. As noted in the UNAIDS Investment Framework report for Guatemala, the largest funding gap in the continuum of response is prevention for KPs and this holds true for the entire region. For example, the Guatemala National Strategic Plan called for 9% of the budget to be spent on KP prevention and the Investment Framework suggested 32% as a more appropriate figure, but the actual expenditure on KP prevention was only 1%.

c. How does the USG fit into the national and regional response?

Under the auspices of the five-year Regional Partnership Framework (PF) signed by all seven Central American countries in March 2010, the USG supports host country governments to more effectively and efficiently lead the national and regional responses to the epidemic through strategic technical assistance and close coordination with all key stakeholders in the region from the GFATM and UN organizations to civil society, and increasing involvement with the private sector. A focus on KPs is the strongest cross-cutting theme of the PF and the USG team plays an essential role in keeping these populations at the forefront of the national and regional responses through community, policy, and technical level dialogues.

d. Donors and the Private Sector Contribution

Central America has a limited number of donors in HIV and the pool continues to grow smaller. In Nicaragua, over the last three years several donors who have traditionally worked in HIV/AIDS have ended their support. After the German government announced its reduction in HIV funding for the region in order to channel its support through the GFATM, the USG remains the largest bilateral HIV donor, and the only other major donor along with the GFATM. In Nicaragua, the GFATM is the principal donor for treatment programs. Honduras currently has a twenty-four month GFATM grant for \$8 million, and the focus of the grant budget allocation has shifted substantially towards key populations and certain municipalities based on the epidemiological data. The USG collaborates closely with GFATM and is an active member of the Regional Coordinating Mechanism (RCM) as well as the GFATM Country Coordinating Mechanisms (CCM) in the three countries with USG staff. Although all countries in the region are now eligible for funding under the new financing model, overall GFATM funding for the region is expected to decrease for the 2014-2016 round of funding.



Other donors that support the national response are a number of UN agencies: UNAIDS (policy development and civil society strengthening), PAHO (surveillance activities, Treatment 2.0, and TB/HIV co-infection), UNFPA (HIV prevention, condom policy and capacity development for advocacy), and UNICEF (PMTCT). The USG works in close coordination with the regional PAHO office to implement technical activities that strengthen the HIV and TB/HIV response and ensure international guidelines and recommendations are followed. The USG also coordinates with UNAIDS, WHO and UNFPA in providing technical assistance to countries developing or strengthening M&E systems to inform strategic planning and decision making (i.e., collection of UNGASS indicators and of HIV epidemic estimation and projections), and training activities in M&E with a focus in financial monitoring to build the capacity of stakeholders to implement the Investment Framework.

The USG has been working with the private sector to develop HIV workplace policies and there are now 75 large and medium enterprises with HIV policies in place, and more than 300,000 workers covered by these policies. This support has enabled these businesses to develop prevention activities that address stigma and discrimination and expand access to voluntary counseling and testing.

e. Contextual Factors

The most pervasive challenge affecting development work in all sectors is the continually deteriorating security situation in the region. In the most recent UN Office on Drug and Crime's Global Study on Homicide, four Central American countries were included among the top ten countries with the world's highest homicide rates, with Honduras and El Salvador in the number one and two spots, respectively. With violent crime consistently present in urban areas where KPs are concentrated, community outreach workers take enormous risks to deliver needed HIV services. While the violence in many countries touches all corners of the population, KP communities have been especially targeted and leaders from these communities have been killed or have left the region, making empowerment of these groups an even more complex effort. Despite these security challenges, important work continues to move forward buoyed by the courage of local leaders.

The latest State of the Region Report (2011) highlights the fact that the socioeconomic context varies across the region. Costa Rica and Panama have experienced growth in their Gross Domestic Product (GDP) as well as other economic and social indicators. Despite improvements, the rest of Central America has significantly higher poverty levels and higher rates of infant mortality and malnutrition in children less than five. While KPs are excluded from official statistics as no entities track access to health, education, employment and other basic services for transgender women, female sex workers and gay men, anecdotal evidence from fieldwork experience demonstrates the economic and social difficulties and inequities for these groups in the region.



Gender based violence (GBV) is increasing in the region and reaching crisis proportions in Honduras and Guatemala. GBV, including sexual abuse and assault, not only affects women and adolescent girls, but also gay men and transgender women. Transgender women are especially affected and reported high levels of physical and sexual abuse in the BSS+, including 67% of transgender women in Nicaragua reporting some kind of abuse in the last 12 months.

f. Pipeline Considerations

The USG team carefully conducted a portfolio review and considered pipeline information alongside technical priorities for each implementing mechanism to establish the funding levels for all partners in the FY 2014 ROP. In cases where pipeline was available to cover future activities, planned funding amounts were reduced accordingly. This was systematically done when setting funding levels for FY 2014 ROP Management & Operations costs. The USG team offset all M&O requests with available pipeline, and therefore the increase this year is less than 1%, even though the team is requesting 4.25 new LES positions.

As a regular part of the program's strategic planning, the USG continues to engage and take into account activities of the GFATM, PAHO, UNAIDS, and of national governments to ensure no duplication of efforts or resources.

II. PEPFAR FOCUS IN FY 2014 ROP

a. Top Priorities in FY 2014 ROP

In the FY 2014 ROP, the USG team will continue to be guided by the vision of the Regional PF and Global Health Initiative (GHI) principles with a clear commitment to country ownership and sustainability. The USG will redouble the PF focus on KPs (as defined by PEPFAR, UNAIDS & WHO), and on providing targeted technical assistance to strengthen the quality of the Continuum of Prevention, Care and Treatment for KPs with a special focus on strengthening the linkages to care and treatment.

While the KP focus for the region is not new, for the FY 2014 ROP the USG team can benefit from the results of the Prevention Reach Model, which estimated the reach into KPs in each country as a tool to better understand the gaps in current investments in the region. The USG team has critically analyzed evidence coming from USG supported studies to further investigate what sub-populations are driving the epidemic. The recent country level BSS+ studies show an extraordinarily high prevalence among transgender women and, while considered MSM for epidemiological purposes, their context and gender identity require specifically tailored interventions and services. The USG is providing technical leadership for the region in supporting these kinds of customized evidence-based activities. Through targeted programming, USG resources will have an increased impact on these populations over the next year.



Ongoing activities with MSM and FSW will also continue. In accordance with GHI principles, gender is a continuing crosscutting theme in our work with all these populations, and a priority this year includes focusing on GBV in relation to KP, especially transgender women, MSM, and FSW populations, who are highly vulnerable to extreme violence in this region due to ingrained cultural stigma and discrimination related to gender norms and identities.

Positive Health, Dignity and Prevention (PHDP) will continue to be a strategic priority for the USG and in the FY 2014 ROP, the USG will continue to strengthen efforts for MSM, transgender women, and SW that are PLHIV. Prevalence of high-risk sexual behavior is reduced substantially after people learn about their HIV status. Improving identification of HIV-positive individuals and offering treatment early to PLHIV will reduce the risk of transmission and reduce morbidity and mortality experienced by PLHIV. In the FY 2014 ROP, the USG, in collaboration with the regional network of PLHIV, will assist all seven countries in the region in the development of a regional and national PHDP strategy. In FY 2015, the USG will provide trainings on the minimum package of prevention services as defined in each country's national PHDP plan.

In addition to filling needed gaps in direct service delivery for KP, the USG will continue to engage with governments at all levels and explore creative ways to foster dialogue and collaboration between national and regional leaders and the most affected and marginalized KPs. USG efforts to build the technical, management, and leadership capacity of local civil society groups representing KPs improve their ability to respond to community needs as well as their effectiveness in advocacy and coordination with the government, including entering into contractual and financing relationships with governments to carry out activities. The USG will continue to facilitate dialogue and strategic planning with national and regional decision-makers that focus on the epidemiology and other strategic information and the need for increased host country government commitment to KPs in national HIV budgets.

The USG efforts to support priorities identified in the PF will continue with the FY 2014 ROP as PEPFAR activities work to strengthen health systems related to the continuum of prevention, care and treatment for KPs through capacity building in laboratory, supply chain management, quality improvement, and improving generation, access to and use of strategic information (SI). The USG will build on previous assistance in the policy arena to ensure HIV related policies now in place are actually implemented. Efforts will continue in the FY 2014 ROP on key PEPFAR priority areas such as comprehensive prevention programming for KP (including access to post-exposure prophylaxis (PEP) in cases of sexual violence), HIV counseling and testing, TB/HIV co-infection, and the integration of capacity building into every activity.

Greater efforts will be made to support the Regional Sustainability Strategy developed by the Council of



Ministers of Health from Central America (COMISCA), with the purpose of helping countries implement more cost effective programs and reduce spending on HIV medicines and other supplies through joint purchasing, and of facilitating greater ownership of the regional and national responses.

b. Changes from FY 2013 ROP

While the USG portfolio does not have any significant changes from the FY 2013 ROP, the USG team is focusing more on long-term sustainability with an emphasis on programs for KPs. Another change from the FY 2013 ROP is funding of the DoD program, which due to significant pipeline, was not funded in the FY 2013 ROP.

c. FY 2014 ROP Funding Letter

1. Prevention Reach Model and Technical Assistance Impact

With the Prevention Reach Model exercise, the USG was able to better understand the gaps in current prevention investments in the region, and as a result plans a renewed focus on reaching KPs. The Prevention Reach Model also revealed the need for better population size estimates for KPs, which the USG will work on together with other stakeholders. In the FY 2014 ROP, the USG will update the model with current information from UNAIDS and GFATM and will ensure that all system strengthening technical assistance has a focus on KPs with an emphasis on the quality and linkages of the Continuum of Prevention, Care and Treatment for the populations driving the region's epidemic. Another finding of the Prevention Reach Model was the need to harmonize the systems to count individuals reached through prevention activities used by MOHs, the GFATM, the USG and others. As a result, GFATM has adopted the USG developed unique identifier code (UIC) for its projects in Central America.

2. Support for an Investment Approach

The USG will continue to strongly support UNAIDS efforts in all countries through its Investment Framework exercise. In an environment of decreasing donor funds and host country MOHs financially strapped, this analysis to ensure resources are being allocated strategically for maximum impact is especially essential for the region. The USG will continue to provide significant technical assistance for the development and analysis of the National AIDS Spending Assessments, which has provided the data for the strategic stakeholder discussion around the Investment Framework.

Furthermore, with support from the USG, RCM members have participated in an analysis of current expenditures, resource needs in countries' strategic plans, and recommendations for fund allocation in accordance with the Investment Framework. In turn, they developed a set of priority actions to respond to the modes of transmission models, which determined that more than 50% of the total new infections in the Central American countries will come from MSM and transgender women.



3. Plan for Staffing/M&O

As described in the M&O narrative, the USG team went through an intensive review of its M&O costs. As a regional program with seven countries where USG team members are often directly providing technical assistance, the level of effort required is high as USG team members continue to engage with key stakeholders to facilitate the dialogue on a sustainable response for the region focused on KPs. At the same time, the USG is also mindful of keeping the M&O costs as lean and as efficient as possible, and the FY 2014 ROP M&O plan reflects this cost benefit approach.

4. DOD and Pipeline Considerations in ROP Planning

While DoD was zero-funded in FY 2013 ROP due to its pipeline, the FY 2014 ROP does include a request for DoD, which has carefully taken into account FY 2013 spending. The request also takes into account the need to fund DoD's Belize program, as it was previously funded by the Caribbean ROP, and also fund Honduras since DoD previously received those funds through the F/OP. Overall, the pipeline for each agency and each IM was carefully considered and factored into the FY 2014 ROP proposed funding amounts.

d. Interagency Approach

The USG interagency team approached the strategic planning process for the ROP from many different angles. The recently formed interagency Technical Advisory Group considered technical priorities and the new interagency M&O team reviewed pipeline in detail. With the interagency portfolio review, these two lenses of analysis were combined as each IM was evaluated based on alignment with technical priorities, pipeline, burn-rate, and cost-effectiveness. The final FY 2014 ROP budget reflects a careful consideration of how to best use limited resources for maximum impact.

III. PROGRESS & FUTURE

a. PF/PFIP MONITORING

With this being the final year of PF implementation, FY 2014 represents a pivotal year for the region to consider progress on PF goals and look to our host countries and regional counterparts towards the future of a sustained and effective response. Activities included in the FY 2014 ROP aim to continue to fulfill the USG commitments outlined in the PF, which include support for national and regional responses to achieve the following four goals:

- 1) To increase healthy behaviors among KP to reduce HIV transmission
- 2) To build the capacity of countries to more effectively reach KP by delivering sustainable high quality HIV/AIDS services.
- 3) To build the capacity of countries to monitor and use strategic information that enhances understanding the epidemic.



4) To improve the policy environment for reaching the ultimate goal of Universal Access to HIV/AIDS services for KPs.

In 2013, an independent consultant team undertook a qualitative evaluation of PF progress based on in-depth interviews and surveys with a diverse group of regional stakeholders from each country. The evaluation findings were discussed and validated in stakeholder meetings in each country and the results of those discussions have fed directly into FY 2014 ROP planning so that the final year of PF implementation and beyond works to address the gaps that still exist. A primary recommendation was the need to continue to address the long-term sustainability issue for services geared toward KPs that are highly dependent on USG and other donor funding, but lack government support, and this remains a key priority of USG technical assistance and leadership going forward.

b. Country Ownership

With the majority of the USG investments in the region supporting technical assistance, country ownership has always been at the heart of the regional program. The USG provides support to programs that have always been 'owned' by countries or the region, whether USG partners are working to improve the quality of HIV related services at a public hospital or building the capacity of a KP oriented NGO. In the FY 2014 ROP, the USG team plans to continue efforts to build country ownership and articulate what this means especially in terms of country ownership of a KP focused response. The USG has played a key role in supporting the development of regional and national strategic plans (NSP) that better reflect the reality of the region's concentrated epidemic.

The RCM has developed a regional sustainability strategy and an action plan with clearly defined phases to reduce dependency on external resources and sustainably increase care and treatment coverage. This strategy addresses the following areas: i) policies and human rights, ii) prevention (with focus on KP), iii) comprehensive care, and iv) funding. With the endorsement of COMISCA, this regional strategy was approved at the XL Meeting of the Central America Integration System (SICA in Spanish) presided over by all the region's Presidents, ensuring high level support for a sustainable response to HIV and AIDS priorities in the region.

All USG activities are reviewed, validated and often developed jointly with host country government and civil society counterparts at different levels, and all activities must clearly align with the NSP in each country. At the country level, discussions are held with the GFATM and other donors to ensure there is no duplication. In preparation for the FY 2014 ROP, the USG held a series of meetings in each country to assess the progress and challenges as found in the PF evaluation. With seven countries, the region has seven different models of country ownership and a regional sense of ownership.



Political Ownership

On the one hand, governments and regional entities show clear political leadership in articulating priorities and plans represented by comprehensive NSPs developed with multi-sectorial stakeholders convened and led by government representatives. In all countries, the vast majority of stakeholders respect the government's stewardship capacity and they are open and transparent regarding the details of their HIV related activities. Real government oversight of other stakeholder activities is more limited and varies greatly between countries. Since the signing of the PF, national plans now have a more explicit focus on KPs.

The USG provides key technical assistance to national and regional bodies in support of developing national and regional visions. The USG plays a pivotal role in fostering the relationship between government and civil society in many countries and ensuring that KPs remain at the center of high-level dialogue. With the GFATM and UNAIDS sharing the same priorities, and with data from USG supported epidemiological studies continuing to show high prevalence rates among KPs, governments are receptive to this support. However, it often falls to donor funding to cover the parts of the national plan that address KPs and in countries like Costa Rica with extremely limited donor funding and no active GFATM grants, KP focused programming is discussed by all but only supported by the relatively small amount of PEPFAR funding. USG programs are also engaging private sector companies in areas such as HIV workplace policies and bringing them into the fold of stakeholders.

Institutional Ownership

The majority of financing comes from host country governments, and local public institutions manage this funding and thus are responsible for all aspects of program implementation. In countries like Guatemala, El Salvador, Nicaragua and Honduras, government institutions are principal recipients of GFATM grants and in all cases, governments and civil society participate and lead the CCM responsible for oversight of GFATM funded activities. While local civil society groups work to set their own agendas, they are often highly dependent on donor funding and priorities, which means they do not have complete decision-making authority for all stages of their program development.

The USG works to build the capacity of local institutions and provides direct financial support to COMISCA for work on shared priorities, such as technical assistance to develop their Regional Sustainability Strategy. In an innovative arrangement in Honduras, the USG funds the Ministry of Health to use its own mechanism to fund local KP civil society organizations. This puts resource management in the hands of local organizations and also establishes a precedent for the government to provide grants to these NGOs.

Capabilities



The technical and management capacity of local entities vary greatly between countries, technical areas and sectors. Overall human resource capacity is relatively strong throughout the region (with the exception of Belize), but specific technical and management expertise is lacking. High turnover, especially in public institutions, remains a challenge as individual capacity might be strengthened but institutional capacity is stagnant.

The USG continues to work to build the capacity of the public health sector, from community health workers to policy makers and including military health systems. As governments are already managing the majority of their national response, the USG provides specific and strategic technical assistance to address identified gaps in areas such as monitoring and evaluation and surveillance, as well as improving capacity for higher quality of HIV care and services, including pre-service and in-service training. The USG is also increasing efforts to build the management and administrative capacity of small community organizations that represent and work with KPs to facilitate their ability to qualify for external funding.

Accountability

Formal structures such as National AIDS Commissions and CCMs are functioning better in some countries than others, but all these bodies provide platforms for dialogue between government and civil society, which is a key step to accountability. In all countries, the USG supports the functioning of these structures with technical assistance for implementation of strategies and workplans. There continues to be spaces at the table for civil society groups but true accountability is hard to ensure. Around certain issues, such as ARV stock-outs, civil society advocacy groups and their supporters have been successful in holding the government accountable by exerting public pressure and using the media. Challenges remain around issues specific to KPs who are socially marginalized and not considered politically important constituencies.

c. Trajectory in FY 2015 and Beyond

The on-going challenge for PEPFAR in the region is how to facilitate and ensure that a government-led national response in each country maintains a clear KP focus as appropriate to their concentrated epidemic. In FY 2015, the USG team does not foresee a major change in programming, but does take a long-term view on the process of using the scientific evidence to demonstrate the need for national budgets to include programming for KPs. With the eventual expected decrease in GFATM funding in the region, the USG will continue to play a crucial role in providing targeted assistance for KP programming and filling the gaps along the continuum of prevention, care and treatment for KPs.

IV. PROGRAM OVERVIEW

1) Prevention



Based on the PEPFAR Combination Prevention Guidance, USG activities implemented across the region in key high prevalence hot spots include educational, biomedical and structural interventions, focused on MSM, FSW, and transgender women, with a minimum prevention package uniquely tailored to each group. The use of the UIC allows accurate monitoring of the number of people reached by NGOs and now will be used by GFATM projects in some countries. New for the FY 2014 ROP, the UIC will also be used to track HIV positive individuals as they enter into care and treatment services to help strengthen those linkages. As part of the targeted assistance model, local organizations and MOHs are leading the implementation of the activities, and USG partners are providing technical assistance to assure high quality. The USG is supporting efforts to reduce stigma and discrimination for KPs and increase access to counseling and testing through mobile units. The anticipated challenges in the FY 2014 ROP are expanding the principles of Combination Prevention, improving alliances with GFATM implementers, and monitoring the quality of the interventions. Through additional resources from the Key Population Challenge Fund (KPCF), the number of local organizations implementing prevention services will increase in the region as well as increased activities addressing stigma and discrimination in various countries to improve the enabling environment across the region. Alliances with local networks of PLHIV will be a key factor in improving the coverage of services to this population, in particular at the community level, and other venues outside of the clinical setting.

The Sexually-Transmitted Infection Sentinel Surveillance and Control Strategy (VICITS in Spanish) is an HIV prevention strategy for KPs combining improved STI diagnosis and treatment, condom distribution, targeted behavior change counseling, ARV referral, and a second-generation surveillance information system. These clinical sites are selected by host country governments based on epidemiological trends and KP needs. The VICITS information system provides countries with the capacity to monitor behavioral and HIV and STI prevalence trends among KPs, which is critical for long-term sustainability and evidence-based decision making. VICITS activities in the FY 2014 ROP will focus on expanding the number of KP reached by increasing services to MSM, transgender women, FSW, and PLHIV. In addition, the USG will continue to provide TA to integrate VICITS data into the MOH data structure, allowing MOH officials to merge these data with other national HIV databases to monitor HIV epidemic trends among KPs seen at clinical facilities, and identify the number of KPs linked to care and treatment over time. In Honduras, the USG will expand innovative strategies for MSM who do not access services through a multi-level HIV prevention intervention.

Peace Corps Volunteers (PCVs) are working to nurture and sustain strong community relationships. These relationships facilitate the link between community services and health facility services, bridging the divide between social and clinical PEPFAR services. These relationships promote country ownership, along with community ownership and sustainability and are key to the PEPFAR Blueprint. PCVs are in rural areas and are able to reach inaccessible and hidden KPs that elude many PEPFAR programs.



PCVs will focus on addressing stigma and discrimination towards KPs, and on GBV.

The USG team recognizes the military population as a priority population and activities will continue in five countries of the region: Belize, Guatemala, El Salvador, Honduras and Nicaragua. The USG will work to build the technical and managerial capacity of the military medical corps in strategic planning, development, and monitoring of HIV programming activities, including support for standardizing data collection methods that feed into national program monitoring and health information systems. The USG will work with military medical corps in identifying personnel for delivery of a tailored combination prevention package and technical assistance in training and supportive supervision of HCT activities to include active referral to a range of health delivery and support services. In addition, USG will provide technical assistance to ensure that all HIV+ individuals are actively referred and linked to HIV care and treatment services, including to CD4 testing.

2) Health System Strengthening

During FY 2013, the USG supported 90 hospitals in six countries to improve the quality of the Continuum of Prevention, Care and Treatment services for PLHIV and other key populations, taking into consideration that most PLHIV are MSM, FSW, and transgender women. In all countries there was an improvement in the quality of services in comparison to the previous year and all countries now have a quality improvement institutionalization strategy to ensure sustainability. At the local level, the USG supports 27 community networks promoting adherence and self-care for PLHIV, and primary and secondary prevention activities with other KPs. Training in stigma and discrimination and gender issues is a key part of strengthening these networks as is the development of advocacy skills to demand better and qualified services at the local level. In Nicaragua, protocols, norms and pedagogical materials were developed to ensure comprehensive HIV pre-service training for all medical professions, and an intensive training program was implemented to strengthen all public health sector facilities. In Honduras, technical assistance focused on supporting the MOH in the implementation of a comprehensive national HIV strategy, including prevention, promotion, treatment, and care and support services at different levels of the health care system. In the FY 2014 ROP, the USG is planning to expand these activities to more hospitals and community networks with a renewed focus on KP engagement and strengthening linkages between services for KP. In Honduras, technical assistance focuses on building sustained organizational capacity within the MOH and civil society to partner via decentralized contracts to provide HIV testing services to KP.

The USG will continue supporting initiatives to strengthen national supply chains with an emphasis on HIV programs in Guatemala, El Salvador, Panama, Honduras, and as part of the Regional Sustainability Strategy, which includes a component on regional negotiation for commodity pricing such as ARVs. The technical assistance provided to governments contributes to improved storage conditions, distribution



systems, information systems, quantification processes, systems design, and procurement, especially of ARVs, test kits and other HIV commodities.

Building capacity for laboratories remains a priority for the USG and includes working with National Laboratories to promote their leadership role in their respective countries. In the FY 2014 ROP, the USG will continue to: 1) support SE-COMISCA with the establishment of a regional lab network for HIV, STI, fungal infections, and TB; 2) support implementation of a short HIV diagnosis algorithm and dried tube sample-based proficiency testing program to allow rapid expansion of HIV testing and improve the quality and accuracy of testing; 3) develop laboratory strategic plans; 4) strengthen laboratory capacity for detection of fungal co-infection among PLHIV; and 5) support countries with the implementation of testing for ARV resistance for patients in treatment failure to improve clinical monitoring of PLHIV. The USG has implemented the Strengthening Laboratory Management towards Accreditation (SLMTA) program as a practical approach to improve laboratory quality and management systems in a sustainable way. Laboratory personnel from military hospitals in the region will also be included for participation in regional trainings or in specific follow up SLMTA activities. The USG will work to provide assistance for training, technology transfer and exchange within the region. By strengthening laboratory activities, countries will improve the quality of HIV diagnosis and data collection, analysis, and use of programmatic and strategic information to better understand trends and contributing behaviors, especially behaviors of KPs, to inform evidence-based decisions according to epidemic needs.

3) Strategic Information

The USG will continue supporting the improvement of data collection, analysis and use of strategic information, and sustainable regular reporting processes with National AIDS Spending Assessments, National Response Reports, and Stigma and Discrimination Monitoring, among others. Local dissemination of information will continue to be a key factor to improve evidence-based decisions. The USG will support improvements in the collection, analysis, and dissemination of data related to: HIV surveillance, size populations estimations, expenditures related to HIV and AIDS, implementation of National Plans and policies, access to condoms among KPs, political environment for a sustained response in HIV, performance improvement in hospitals, prevalence of condom use and reduction of concurrent sexual partners among KPs and their determinants. There will be an emphasis on conducting cost effectiveness analyses in order to address the expected reduced funding in the region.

4) Policy Environment

Policy activities will continue to focus on improving the HIV policy environment and have three specific objectives: 1) improved implementation of national and regional HIV and AIDS policies, (2) improved use of national resources in the HIV response, and (3) improved engagement of the private sector in the HIV response.



In the FY 2014 ROP, the USG will focus on increasing the proportion of government funding that is allocated to support proven interventions aimed at KPs. With regional and national coordinating bodies, the USG will facilitate development of targets and indicators to monitor changes in resource allocation. The targets and indicators will be designed to achieve a better balance between basic programs, enabling structural interventions to support planning, budgeting, and procurement offices in health and non-health sectors, including civil society.

The USG is working to improve the policy environment around sexual violence and GBV, especially in those countries where transgender women suffer sexual assault and health services do not even contemplate PEP as part of their primary care. Protocols have been updated, and for the next year the focus will be on the implementation of these protocols.

Activities to improve the participation of the private sector in the HIV response will continue in the FY 2014 ROP. Activities will include a regional entrepreneur's forum, business meetings on HIV in each country including creating champions, and the continued development of a regional platform to support the expansion of the number of medium and large enterprises developing HIV workplace policies with a focus on addressing stigma and discrimination towards KPs.

5. TB/HIV

The USG will continue to strengthen the response to TB and TB/HIV by providing: 1) Improvement of TB/HIV care by intensifying TB case finding among PLHIV; 2) improving access of HIV testing among TB patients; 3) conducting TB infection control assessments in HIV clinics; 4) improving linkages to care across TB and HIV clinics; 5) strengthening of laboratories in the region by providing trainings to MOH staff on diagnosis of TB and fungal opportunistic infections; and 6) strengthening of health information systems and surveillance departments within all Ministries of Health including surveillance of fungal OIs among PLHIV.

V. Program Integration and other considerations

a. GHI Strategy

With GHI, the USG is committed to partnering with countries to work towards sustainable country- owned global health and to enable countries to establish and execute an ongoing evidence cycle for their health priorities. While only Guatemala and Honduras have formal GHI strategies, all PEPFAR Central America programs work to build sustainability through the strengthening of prevention, care and treatment services focused on KPs. As part of these efforts, there is a particular emphasis on increasing quality and availability of comprehensive HIV/AIDS services for KPs. The USG builds capacity in HIV and AIDS



monitoring in line with the GHI principle of helping to promote learning and accountability between all stakeholders in the regional HIV response.

b. Engagement with Partners

The USG works closely with the GFATM to ensure a coordinated response and as the primary sources of external funding in the region, both the USG and the GFATM want to ensure that resources are being used strategically and focused on the gaps for KP prevention, care and treatment. There has been very close coordination with the GFATM especially with the collaboration on the Prevention Reach Model and the use of the UIC launched by the USG and adopted by many countries (Guatemala, El Salvador, Nicaragua and Panama) in the region to follow individuals being reached by prevention activities, as well as the TB electronic information system module and work to improve supply chain management in countries like Honduras and Guatemala. The USG will continue to work closely with UNAIDS, especially in supporting the Investment Framework, and overall, the USG will continue to coordinate with all donors to optimize resources and avoid duplication in technical areas.

c. Central Initiatives

1) Gender Challenge Fund resources continue to support ongoing work related to GBV in Guatemala, with a special focus on sexual violence, exploitation and the trafficking in persons of FSW, MSM, and transgender women. A GBV working group led by the government, USG and partners works with service providers and KP groups to expand knowledge of and access to quality services for survivors of GBV. Legal frameworks and medical protocols are being updated to reflect KP needs. For example, men are now being included in the protocols for GBV for the first time. The program is working with KP civil society groups to create an awareness of resources for GBV and cases of trafficking and sexual exploitation, and to develop linkages to these newly KP friendly services.

2) With Key Population Challenge Funds, the USG will continue to analyze the barriers to accessing services for KPs and will pilot new approaches to assure that HIV positive KP engage with and stay in quality care and treatment services that are free from stigma and discrimination. The USG will implement activities to increase prevention coverage for KPs in Honduras and Nicaragua, increase coverage of the social movement against stigma and discrimination in the region, and improve the linkages to care and treatment services for HIV-infected MSM and transgender women in Guatemala.

3) During the implementation of the FY 2014 ROP, the USG team will use Key Population Implementation Science funds to improve understanding of the use of HIV care and treatment services and adherence to treatment among MSM and transgender women living with HIV in Guatemala City to inform the design of effective interventions along the Continuum of Prevention, Care and Treatment services. Results from this three-year study will provide evidence of the effectiveness of strategies to improve retention in care and

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adherence to treatment, as well as the “treatment as prevention” paradigm. These findings can also be used to advocate for health policies in Guatemala and the Central American region more broadly, promoting well-being and ongoing prevention among MSM and transgender women living with HIV.