FY 2016 Regional Operational Plan

Central America Region

Strategic Direction Summary

3 June 2016

PEPFAR

THE UNITED STATES AND CENTRAL AMERICA
IN PARTNERSHIP TO FIGHT HIV/AIDS

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Goal Statement

In order to reach the 90-90-90 goals, the PEPFAR Central America program strategy is centered on 1) focused direct impact activities at high burden sites; 2) above site activities to remove structural barriers to services for key populations; and 3) regional engagement for leveraging of lessons learned for policy advocacy and cross-country sharing. Guided by the PEPFAR 3.0 and UNAIDS Fast Track Strategies, the USG works together with national and regional stakeholders to implement this strategy for sustainable epidemic control in the region.

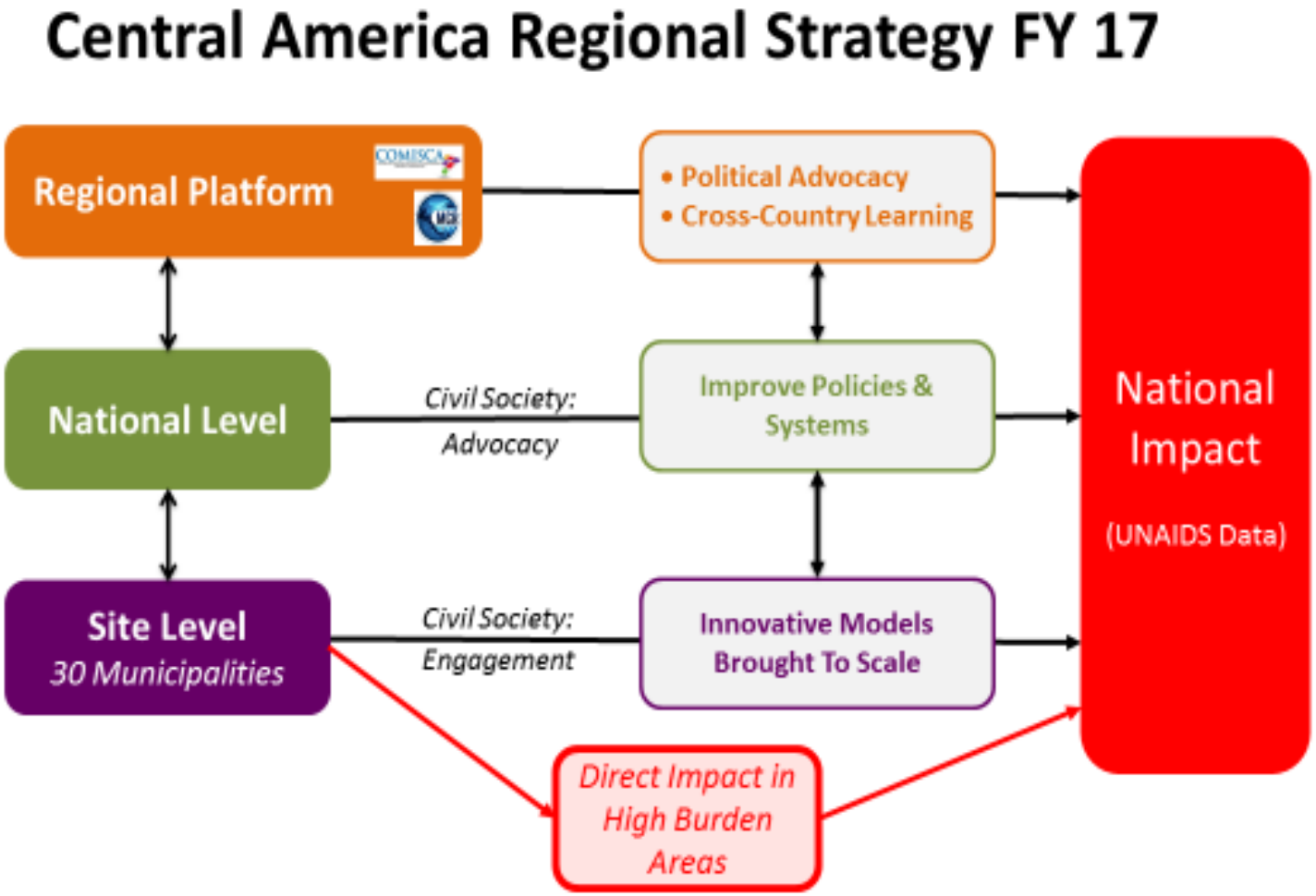
Impact at High Burden Sites - With an emphasis on working in the "right places" the USG is using the epidemiological data to strategically reduce our geographic footprint to only 30 high burden municipalities to aggressively target hotspots and to maximize impact. Proposed activities for FY 2017 will focus on the continuum of response for key and priority populations (KPs and PPs) at both KP friendly health facilities and in the community, including high yield testing strategies such as partner testing of newly identified HIV positive individuals and the utilization of peer networks. PEPFAR will provide strategic technical assistance (TA) for evidence-based interventions for the immediate implementation of Test &Start (T&S) and will increase efforts to find not only new HIV positive individuals among KPs and PPs, but also previously diagnosed PLHIV who are not currently on treatment and link them to community and facility treatment services.

Systems & Policies to Improve Access - At all levels, PEPFAR will promote the adoption of T&S, and continue to play an essential role in keeping KPs at the forefront of the national and regional responses, anchored in a human rights approach to ensure that those KPs and PPs living with HIV are able to access services free of stigma and discrimination. The five PEPFAR-supported countries have committed to the UNAIDS 90-90-90 goals and the regional team will continue to assist countries to be more cost-effective and to strategically invest their own resources towards the most effected and affected populations. The regional team will continue strategic and targeted support to system level activities in order to build up national capacities to reach 80% treatment coverage in high burden SNUs.

Leveraging the Regional Platform –As a regional program, PEPFAR Central America has the unique opportunity to amplify the lessons learned at the site and national levels and have them applied across the region through USG regional implementing partners and through strong regional counterparts including the Council of Ministries of Health from Central America (COMISCA- Spanish acronym) and the Regional Coordinating Mechanism. The USG leverages the regional platform for high-level policy advocacy and elevate the focus on KPs and now the transition to T&S.

Tailoring Support for Sustainable Epidemic Control- The regional team has grouped countries according to the type of support they require. High intensity countries (Honduras, Guatemala & Nicaragua) require substantial support to build technical capacity to increase impact across their KP cascade. Medium intensity countries (El Salvador & Panama) need support to maintain current impact and bridge specific gaps and TA to ensure the sustainability of their cascade.

Figure 1 - FY 2017 Regional Strategy



1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

The Central America Region where PEPFAR is focused is comprised of five countries (El Salvador, Guatemala, Honduras, Nicaragua and Panama) and has a population of 41 million. Per capita gross national income (GNI) in the region ranged from a high of $11,130 in Panama to a low of $1,870 in Nicaragua (the 2nd poorest country in the Western hemisphere), followed by Honduras ($2,270), Guatemala ($3,430) and El Salvador ($3,920) (World Bank, 2015). The population living in poverty reaches up to s 62.8% in Honduras. According to the World Bank 2015 income classification, one country(Panama) is considered "upper middle countries" and the other four (Guatemala, Honduras, El Salvador and Nicaragua) are still classified as "lower middle countries".

Table 1.1.1 Key Regional Demographic and Epidemiological Data: general and key population size and burden of disease

Country	**Population (a)**	**%**	**PLHIV (b)**	**%**	**Annual New HIV infections (b)**	**KP size (c)**	**%**
High Intensity							
Guatemala	15,468,000	34	49,000	37	2,900	130,724	30
Honduras	8,098,000	18	23,000	18	~1,000	73,729	17
Nicaragua	6,080,000	13	11,130	9	<1,000	80,278	18
Medium Intensity							
El Salvador	6,340,000	14	20,874	16	<1,000	71,932	16
Panama	3,864,000	9	16,565	13	<1,000	40,391	9

Source: (a) Official census estimates 2014, (b) and (c) UNAIDS 2014; MoH Reports in 2014

According to the latest UNAIDS report, as of 2014, an estimated 120,000 (114,200-183,700) people were living with HIV in the region (UNAIDS, 2014). During the ROP 16 development process, an analysis of new demographic, epidemiological and response data led to an updated geographic prioritization at country, departmental and municipal level (explained in detail in Section 3.0 below). Five countries have been prioritized (High Intensity & Medium Intensity) for PEPFAR support: Guatemala, Honduras, Nicaragua, El Salvador, and Panama, which account for 88% of the regional population, 91% of estimated key populations, and 90% of all estimated people living with HIV.

Table 1.1.2 Key Regional Epidemiological Data: HIV Prevalence (%)				
Country	**General Population**	**FSW**	**MSM**	**TGW**
High Intensity				
Guatemala	0.5	1.1-3.7	2.8-8.9	23.8
Honduras	0.4	3.5-15.6	6.9-11.7	31.9
Nicaragua	0.3	1.8-2.4	2.8-7.5	27.8
Medium Intensity				
El Salvador	0.5	2.5-5.7	8.8-10.8	25.8
Panama	0.6	0.7	18.7	37.6
Data reflect latest available country data reported as of 2015 but period of data collection may vary. For general population: UNAIDS 2014; Guatemala and Nicaragua: ECVC 2013, Honduras and Belize: ECVC 2012; El Salvador ECVC 2010; Panama and Costa Rica: HSH Survey 2009.				

The HIV epidemic in Central America is concentrated among key and priority populations, with a low prevalence of less than 1% among the general population. The highest prevalence in the general adult population age 15-49 was reported in Panama (0.6%), Guatemala and El Salvador (both 0.5%), Honduras (0.4%), and the lowest general population prevalence was in Nicaragua (both 0.3%).
Higher prevalence rates were reported among key populations: men who have sex with men (MSM), transgender women (TGW), and male and female sex workers (FSW) in some locations. By type of KP, TGW are the most affected, ranging from 23.8% in Guatemala to 37.6% in Panama; followed by MSM ranging from 2.8% in Nicaragua and Guatemala to 18.7% in Panama. The prevalence rate for FSW has been decreasing, ranging from 0.7% in Panama to 15.6% in Honduras. High prevalence rates (above the general population) have also been found among the Garifuna ethnic group in Honduras (>4%) and people infected with TB.

Table 1.1.3 Central American Region Cascade Summary							
Country	**PLHIV** 100 %	**Diagnosed**	**%**	**On ART**	**%**	**Viral Suppression**	%
Guatemala	47,800	28,537	60	16,965	60	8,747	52
Honduras	23,000	12,167	53	9,752	80	7,935	81
Nicaragua	11,130	7,760	70	2,502	32	1,295	52
El Salvador	20,874	14,403	69	6,471	45	4,592	71
Panama	16,565	13,583	82	8,283	61	5,301	64
TOTAL	**119,369**	**76,450**	**64**	**43,973**	**37**	**27,870**	**63**
Source: MoH Reports in 2014 Note these data are not KP specific.							

The major gaps in achieving HIV epidemic control in the region are a) HIV case finding (only 64% of estimated cases diagnosed), b) insufficient linkage of newly diagnosed and previously diagnosed cases to care and treatment (only 36% ART coverage), and c) poor adherence to ART with corresponding low viral suppression (only 23% viral suppression).

To be more strategic with PEPFAR investments the team grouped countries by the type or intensity of PEPFAR support. The difference in intensity does not necessarily denote a different

level of PEPFAR resources, but a difference in approach to support as some countries are closer to sustaining their own response and reaching the 90-90-90 goals. In addition during ROP16 development, the regional program used available HIV cascade data for the region to further narrow the programmatic focus by country according to the most critical gaps in reaching 90-90-90 in each location. See country-specific descriptions below.

High Intensity Countries (Capacity Building across the Cascade)**: Guatemala, Honduras, and Nicaragua**

The high intensity countries is characterized by a higher burden of disease, a larger segment of key populations, and demonstrating more critical TA needs to address gaps in the national response. These countries have serious limitations across their cascade and while they have made some improvements, they continue to need intensive TA in order to build their capacity to implement an effective response for each of the pillars of the cascade, especially in the case of Guatemala and Nicaragua. Honduras is a slightly different case as the country has faced real challenges in identifying HIV positive individuals but once they are identified and linked into a comprehensive care and treatment site, they stay connected to treatment and are adherent. While Honduras is a high intensity country, the priority focus for PEPFAR investments is in the first pillar of the cascade to improve testing yields. These three countries have already adopted CD4 <500 threshold and are moving towards adopting Test & Start (T&S) as official policy, which in practice is actually already been implemented in some facilities.

Guatemala, the most populous nation in the region, with a population of approximately 16 million, has an estimated adult prevalence of 0.5%, and an adult incidence of 0.03%. The estimated number of people living with HIV in 2014 was 47,800 (60% diagnosed); nearly 17,000 were on ART by the end of that year (33% ART coverage) and near 9,000 have reached viral suppression (18%). There are an estimated 2,900 new infections each year, while annual AIDS-related deaths are estimated at 1,700. TGW and MSM are prioritized as key populations for PEPFAR. Although the country has not adopted T&S, the two main HIV reference hospitals have provided treatment for all regardless of CD4 count in practice. All other treatment sites follow national treatment guidelines (CD4<500). Based on available data, PEPFAR will invest across all pillars of the cascade in Guatemala.

Honduras, the second most populous nation**,** has a population of approximately 8 million, an estimated adult prevalence of 0.4%, and an adult incidence of 0.01%. An estimated 23,000 people were living with HIV in 2014 (53% diagnosed); nearly 10,000 individuals were on ART by the end of the same year (42% ART coverage) and near 8,000 have reached viral suppression (34%). There are an estimated 1,000 new infections per year, while annual AIDS-related deaths are estimated at 1,200. The county follows the WHO 2013 treatment guidelines (CD4 <500) and has not adopted T&S yet. Specific geographic areas of the country report high prevalence, particularly the Caribbean North coast, where the Garifuna ethnic group is concentrated. TGW, MSM, and FSW are prioritized as key populations for PEPFAR, and Garifuna is a priority population for intervention. The biggest cascade gap in Honduras is in reaching the first 90, case-finding among PLHIV.

Nicaragua has a population of 6 million, an estimated adult prevalence of 0.3%, and an adult incidence of 0.02%. An estimated 11,000 people were living with HIV in 2014 and 70% of them have been diagnosed, demonstrating significant progress towards reaching the first 90% goal. Despite the successes in HIV case finding, only 2,500 individuals were on ART by the end of the year 2014 (22% ART coverage, the lowest in the region), and only 1,200 have reached viral suppression (12%, also the lowest in the region). The country is currently updating the national

HIV treatment guidelines to reflect the change from a CD4 count <350 to a CD4 count <500. However, in practice, treatment is provided to all PLHIV with a CD4 count <500. The country reports the highest prevalence rates among TGW and MSM, and has demonstrated a drop in newly reported cases among bisexual men and FSW. Based on the available cascade data, PEPFAR will focus its investment in strengthening all pillars of the cascade prioritizing effective linkages to care and treatment for identified PLHIV, especially between community and facility settings.

Medium Intensity Countries (Supporting Sustainability)**: El Salvador and Panama**
Medium Intensity countries are countries that have made significant improvements across their clinical cascade towards sustainability but still need PEPFAR support to maintain what they have achieved to date. These countries do not need TA in all areas of their cascade and PEPFAR will focus on strategic TA for the remaining gaps but also continue to work with the countries on sustainability as the Sustainability Index and Dashboard show that these countries have more capacity to sustain their response with strategic and targeted support. They are also best positioned to initiate Test and Start in the region.

El Salvador has a population of 6.3 million and an estimated adult prevalence of 0.5% and an adult incidence of 0.02%. Almost 21,000 people were living with HIV in 2014 (69% already diagnosed); over 6,500 individuals were on ART by the end of the year (31% ART coverage), and 4,500 have reached viral suppression (22%). There are an estimated fewer than 1,000 new infections per year and less than 500 annual AIDS-related deaths. TGW, MSM and FSW are prioritized for PEPFAR's investments. According to national HIV guidelines, treatment is prioritized for PLHIV with a CD4 count <350 but it's provided to all PLHIV with a CD4 count <500. Based on national data, PEPFAR will focus its investment on identifying HIV+ KPs and linking them to treatment services. El Salvador is in a good position to adopt T&S soon if stakeholders are able to support start up.

Panama has a population of 3.8 million and after Belize, the highest adult prevalence of 0.6% and an adult incidence of 0.03%, with near 17,000 people living with HIV in 2014 (82% diagnosed, highest in the region); 8,200 individuals were on ART by the end of 2014 (50% ART coverage, highest in the prioritized countries), and 5,300 have reached viral suppression (32%). Based on national HIV guidelines, only PLHIV with a CD4 count <350 are eligible for treatment although in practice treatment is provided to all PLHIV with a CD4 count <500 and to all PLHIV regardless of CD4 count at the main HIV reference hospital. The country reports the highest prevalence rates among MSM and TGW in the region, and also the highest cumulative AIDS related mortality rate (67%). Out of the five prioritized countries, Panama is the closest to reaching the 90-90-90 goals for the first two pillars of the cascade, and considering their financial resources they have the potential to be the first country in the region to roll out T&S and PEPFAR technical assistance will be focused on helping support T&S and concentrated on linking all positive individuals to treatment.

El Salvador

Table 1.1.1 El Salvador - Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	6,369,224		884,044		923,534		2,501,612		2,060,034		Dirección General de Estadísticas y Censos, 2010 (Proyecciones 2015)
Prevalence (%)		0.5									UNAIDS, 2014
AIDS Deaths (per year)	<500 (<100-<1000)										UNAIDS, 2014
PLHIV	21,000 (13,000-29,000)		<1000				9200		11800		UNAIDS, 2014
Incidence Rate (Yr)		0.02 (<0.01-0.05)									UNAIDS, 2014
New Infections (Yr)	<1000 (<200-<1100)										UNAIDS, 2014
Annual births	127,700										WHO Statistical Profile, 2015
% >= 1 ANC visit		94									UNICEF, 2015 (2008-2012)
Pregnant women needing ARVs	<500-<1000										UNICEF, 2012**
Orphans (maternal, paternal, double)	NA										
TB cases (Yr)	2206										WHO Global Report 2015
TB/HIV Co-infection	203 <500	5.3									WHO Global Report 2015 UNAIDS, 2014
Males Circumcised	NA										
Key Populations											
Total MSM*	55,878 16,835										MOT, 2013 Spectrum 2014
MSM HIV Prevalence San Salvador San Miguel		10.8 8.8:									ECVC, 2010
Total TG	2 765										Spectrum 2014
TG HIV Prevalence		25.8									
Total FSW	25,467 13,305										MOT, 2013 Spectrum 2014
FSW HIV Prevalence San Salvador Sonsonate/Acajutla		5.7 2.5									ECVC, 2010

Table 1.1.1 El Salvador - Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Priority Populations											
TB patients Prevalence (includes HIV+TB)	Estimated: 3,100 Notified: 2206 Co-infected: 203	9%									WHO Global Report, 2015
FSW	25,467 13,305	**2.5-5.7**									MOT, 2013 Spectrum 2014 **ECVC, 2010**
WHO Statistical Profile by Country, updated January 2015 *Aidsinfo.unaids.org, 2014* *WHO Global Tuberculosis Report 2015* *UNICEF Global Report 2015* *GARP Report El Salvador 2015*											

Guatemala

Table 1.1.1 Guatemala - Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	15,806,675	100	3,106, 183	19.7	3,211, 309	20.3	4,981, 096	31.5	4,508, 087	28.5	INE 2014 estimation
Prevalence (%)		0.5		NA		NA		NA		NA	UNAIDS 2014
AIDS Deaths (per year)	1700 (1100-2600)										UNAIDS 2014
PLHIV	49,000 (34,000-69,000)		3,000				18,000		28,000		UNAIDS 2014
Incidence Rate adults 15-49 (Yr.)		0.03 (0.02-0.05)		NA		NA		NA		NA	UNAIDS 2014
New Infections (Yr.)	2,900 (1,500-4,600)										UNAIDS 2014
Annual births	480,200										WHO Statistical Profile 2015
% >= 1 ANC visit	NA	93.2									UNICEF 2015 (2008-2012)
Pregnant women needing ARVs	1,000-4,600										UNICEF 2012
TB cases (Yr.)	3163										WHO Global Report 2015
TB/HIV Co-infection	243 <1000		NA	NA	NA	NA	NA	NA	NA	NA	WHO Global Report 2015 UNAIDS 2014
Males Circumcised		5.6%			NA	NA			NA	5.6%	ENSMI-2008/09
Key Populations											
Total MSM*	141,153										MOT, 2013 MSM: 4%, TG: 0.14%
MSM HIV Prevalence Guatemala City Coatepeque		8.9% 2.8%									ECVC, 2013
TG estimation											

Table 1.1.1 Guatemala - Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
TG prevalence	4,940	23.8%									ECVC, 2013
Total FSW	36,015										MOT, 2013 0.93%
FSW HIV Prevalence Guatemala City: Escuintlla Pto. Sn José Malacatán Tecún Umán		1.1 3.7 2.0									ECVC, 2013
Priority Populations											
TB patients	Estimated: 17,000 Notified: 3,369 Co-infected: 243	10%									WHO Global Report, 2015
WHO Statistical Profile by Country, updated January 2015 *Aidsinfo.unaids.org, 2014* *WHO Global Tuberculosis Report 2015* *UNICEF Global Report 2015* *GARP Guatemala 2015*											

Honduras

Table 1.1.1 Honduras - Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	8,215,313	100	1,532,388	18.7	1,580,453	19.2	2,634,986	32.1	2,467,486	30.0	INE, 2011+
Prevalence 15-49 (%)		0.4									UNAIDS, 2014
AIDS Deaths (per year)	1200 (1000-1600)										UNAIDS, 2014
PLHIV	23000		1900				9300		11800		UNAIDS, 2014
Incidence Rate 15-49 (Yr)		0.01 (0.01-0.02)									UNAIDS, 2014
New Infections (Yr)	<1000 (<500-<1000)										UNAIDS, 2014
Annual births	209,000	100									WHO Statistical Profile, 2015
% >= 1 ANC visit		96.6									UNICEF, 2015 (2008-2012)
Pregnant women needing ARVs	<500-<1000										UNICEF, 2012**
Orphans (maternal, paternal, double)	NA		NA		NA		NA		NA		
TB cases (Yr)	2820										WHO Global Report 2015
TB/HIV Co-infection	263 <500										WHO Global Report 2015 UNAIDS, 2014
Key Populations											
Total MSM	54,953										MOT, 2013
MSM HIV Prevalence Tegucigalpa San Pedro Sula La Ceiba:		6.9 10.7 11.7									ECVC, 2012
Total TG	2,706										
TG HIV Prevalence Tegucigalpa		17.2 23.6									ECVC 2012

Table 1.1.1 Honduras - Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
San Pedro Sula La Ceiba:		33.3									
Total FSW											MOT, 2013 0.7%
Tegucigalpa San Pedro Sula La Ceiba	15,013	3.3 6.7 15.3									ECVC, 2012
Priority Populations											
TB patients	Estimated: 6,000 Notified: 2820 Co-infected: 263	4.3									WHO Global Report, 2015
Garifuna Urban, men: Urban, women: Rural men: Rural, women:	46 448	4.4 4.6 1.6 4.9									ECVC, 2012

WHO Statistical Profile by Country, updated January 2015
Aidsinfo.unaids.org, 2014
WHO Global Tuberculosis Report 2015
UNICEF Annual Report 2015
GARP Report Honduras 2015

Nicaragua

Table 1.1.1 Nicaragua - Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	6,180,406	100	973,721	15.6	1,012,950	16.4	2,156,848	34.9	2,036,887	*33.1*	INIDE,2007 2015 Estimation
Prevalence 15-49 (%)		0.3									UNAIDS, 2014*
AIDS Deaths (per year)	<500 (<1000)										UNAIDS, 2014*
PLHIV	10,000 (7,600-15,000)		150		150		2,700		7,000		UNAIDS, 2014*
Incidence Rate among adults 15-49 (Yr)		0.02 (0.01-0.03)									WHO Statistical Profile 2015**
New Infections (Yr)	<1000 (<500-1200)										WHO Statistical Profile 2015**
Annual births		138,300									WHO Statistical Profile 2015**
% >= 1 ANC visit		90.2									UNICEF, 2015 (2008-2012)
Pregnant women needing ARVs	(1)176 (2)200-500										(1)Spectrum 2014. National Health Statistics, 2013 (2)UNICEF, 2012**
Orphans (maternal, paternal, double)	1,712										Spectrum 2014. National Health Statistics, 2013
TB cases (Yr)	2632										WHO Global Report 2015
TB/HIV Co-infection	<100 75	2.3									WHO Statistical Profile 2015 WHO Global Report 2015
Key Populations											
Total MSM											
MSM HIV Prevalence	57,742	9.76									GARP 2015
Total TGW	5,489	18.6									GARP 2015
Total FSW	17,047	2.3									GARP 2015

WHO Statistical Profile by Country, updated January 2015
Aidsinfo.unaids.org, 2014
GARP Report Nicaragua, 2015

Panama

Table 1.1.1 Panama - Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	3,975,404	100	534,169	13.4	557,255	14.0	1,445,540	36.3	1,438,440	36.3	National Institute for Statatistis and Census 2015+
Prevalence(%)		0.6									UNAIDS, 2014
AIDS Deaths (per year)	**<1,000 (500-1000)**										UNAIDS, 2014
PLHIV	**17,000** (13,000-24,000)										UNAIDS 2014
Incidence Rate 15-49 (Yr)		0.03 (0.02-0.05)									UNAIDS 2014
New Infections (Yr)	**<1,000 (<500-1000)**										UNAIDS, 2014
Annual births	75,200										WHO Statistical Profile, 2015
% >= 1 ANC visit	---	95.8									UNICEF, 2015 (2008-2012)
Pregnant women needing ARVs	200-500										UNICEF, 2012**
TB cases (Yr)	1519										WHO Global Report 2014***
TB/HIV Co-infection	175 <500										WHO Global Report 2014*** UNAIDS, 2014
Key Populations											
Total MSM	27,104										MOT, 2013
MSM HIV Prevalence		**18.7**									MSM surveys
Total FSW	17,985										MOT, 2013
FSW HIV Prevalence		**0.7**									MSM surveys
Priority Populations											
TB patients	Estimated: 2,400 Notified: 1,519 Co-infected: 224	13									WHO Global Report 2015

WHO Statistical Profile by Country, updated January 2015,Aidsinfo.unaids.org, 2014, GARP Report Panama 2015, UNICEF Global Report 2015

El Salvador

Table 1.1.2 El Salvador - Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	6,369,224 2013	0.5% ECVC 2008	**20 874** MOH 2014	**14 403** Diagnosed	**6 471** MOH 2014		**4 592** MOH 2014	115,911 GARP 2013	1,442 GARP 2013	ND
			21,000 UNAIDS 2014	11,180 MoH 2013	7,196 MoH 2013		5980 MOH 2013			
Population less than 15 years	1,946,967 INEC 2013	ND	1,000 UNAIDS 2014	ND	ND	ND	ND	ND	ND	ND
Pregnant Women	119,559 INEC 2013	ND	166 GARP 2013	166	166	ND	ND	82,969 MoH2013	166 MoH2013	166 MoH2013
MSM	47,817 MOT 2013	8.8-10.8	4973 MOT2013	ND	ND	ND	ND	ND	ND	ND
FSW	27,324 MOT2013	3.14% 2012 2.5-5.7 2008	858 MOT2013	ND	ND	ND	ND	ND	ND	ND
TRANS	1000 MOT 2013	25.8% 2008.	258 MOT2013	ND	ND	ND	ND	ND	ND	ND

Guatemala

Table 1.1.2 Guatemala - Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	15 806 675 INE 2014	0.5 UNAIDS 2014	**47 800** MOH 2014	**28 537** diagnosed MOH 2014	**19 965** MOH 2014		**8 747** MOH 2014	367,381 GARP 2014	1842 GARP 2014	2375 GARP 2014
			49 000 UNAIDS 2014	18 325 Adherence study –AS- 2013	16,386 AS	16,386 AS	9,639 AS			
Population less than 15 years	6,029,350 WB 2013	0.06 2014	3,349 MOH2014	ND	184 GARP 2014	ND	ND	ND	ND	ND
Pregnant Women	587,792 WB 2013	0.35 GARP 2014	1,820 MOH2014	ND	394	ND	ND	107,051 MOH 2013	195 MOH 2013	195
MSM	112,738 MOT 2012	2.08-8.9 ECVC2013	10,627 MOT 2012	ND	ND	ND	ND	631 MOH 2013	51 MOH2013	ND
FSW	22,563 MOT 2012	1.1-3.7% ECVC 2013	1,219 MOT 2012	ND	ND	ND	ND	14,918 MOH 2013	10 MOH 2013	ND
TRANS	1,509 MOT 2012	23.8% ECVC 2013	728 MOT 2012	ND	ND	ND	ND	132 MOH 2013	3 MOH 2013	ND

Honduras

Table 1.1.2 HONDURAS 2014 - Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV SPECTRUM (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	8 555 072 2013	0.4 UNAI DS 2014	**23 020** MOH 2014	**12 167** diagnosed	**9 752** MOH 2014		**7 935** MOH 2014	184 287	663	
			23 000 UNAIDS 2014		9 926 GARP 2014	8 219 GARP 2014	7 405 GARP 2014			
Population less than 15 years			1 614		700	661	111			
Pregnant Women	209 000	0.17 GARP 2014			487	201		181 620	227	106
MSM	54 953	6.9 10.7 11.7								
FSW	15 013	3, 6.7 15.3								
TRANS	2 706	6.8								
GARIFUNA	46 448	1.6-4.9%								

Nicaragua

Table 1.1.2 NICARAGUA 2014 - Cascade of HIV diagnosis, care and treatment (12 months) 2014										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	6 080 000 INIDE 2014	0.3 UNAIDS 2014	11 130 MOH 2014	**7 762** diagnosed MOH 2014	**2 502** MOH 2014		**1295** MOH 2014	264 237 MOH 2014	1 019 MOH 2014	487 MOH 2014
			10 036 UNAIDS 2014	6 984 GARP 2014	2 935 GARP 2014		1 155 GARP 2014			
Population less than 15 years	1 954 112	<0.03	<500 UNAIDS 2014	138	138 MOH 2014					
Pregnant Women	130 443 MOH 2014	0.07	136		107 MOH 2014			111 825 MOH 2014	74 MOH 2014	
MSM	57 742 CONISIDA 2014	9.76	5636		1691 30%			25 868 44.8% MOH 2014	106 10% MOH 2014	
TRANS	5 482 CONISIDA 2014	6.8	373		112 30%				10 1% MOH 2014	
FSW	17 047 CONISIDA 2014	2.3	392		118 30%			12 512 73.4% MOH2014	10 1% MOH 2014	

Panama

Table 1.1.2 Panama - Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV SPECTRUM (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	3 850 735 INEC 2013	0.6 UNAIDS 2014	**16 565** MOH 2014	**13 583** Diagnosed	**8283** MOH 2014		**5 301** MOH 2014	282 540 PNVS, 2013	834 GARP 2014	ND
			17 000 UNAIDS2014	9 756 PNVS 2013	6 411 GARP 2014	7 782 2013	4 954 2013			
Population less than 15 years	1 082 973 INEC 2013	0.09	1,000 UNAIDS 2014	ND	260 GARP 2014	ND	ND	ND	2 4 5 MOH 2013	ND
Pregnant Women	85 794 INEC 2013	0.3 GARP 2014	200 2014	ND	224 GARP 2014	ND	ND	68 822 GARP 2014	224 GARP 2014	175 GARP 2014
MSM	33,300 MOT2013	19.8 CLAM 2013	6 664 2013	ND	ND	ND	ND	2697 8.1% GARP 2014	135 15.9% GARP 2014	ND
FSW	1,700 MOT 2013	1.94 ICGES, 2010	420 2013	ND	ND	ND	ND	1 540 90.6% GARP 2014	9 CLAM, 2013	ND
TRANS	600 MOT 2013	31.6% GORGAS 2013	200 MOT 2013	ND	ND	ND	ND	40 6.7% GARP 2014	ND	ND

Table 1.1.3 Guidelines & current practice for initiating Antiretroviral Treatment (ART) for people living with HIV in Central American Countries- April 2016

No.		El Salvador[1]	Guatemala[2]	Honduras	Nicaragua[3]	Panamá[4]
1	Current national guidelines updated per WHO/PAHO 2015 directive: Initiate ART regardless of clinical stage or CD4	No	No	No[5]	No	No
2	Current national protocol updated per 2013 WHO/PAHO directive: Initiate ART if CD4 is ≤ 500/mm3. As a priority, all individuals with clinical disease (WHO Stage 3 or 4) or if CD4 ≤ 350/mm3	Yes	Yes	Yes	No	No
3	Publication year of current guidelines	2014	2013	2014	2009	2011
4	Current official guidelines for initiating ART	CD4 < 500 cl/mm3 (CD4 < 350 is priority)	CD4 < 500 cl/mm3	CD4 < 500 cl/mm3	CD4 < 350 cl/mm3	CD4 < 350 cl/mm3
5	Guidelines that are currently used in practice at service delivery sites (as reported by NAPs)	CD4 < 500 cl/mm3	CD4 < 500 cl/mm3	CD4 < 500 cl/mm3	CD4 < 500 cl/mm3	CD4 < 500 cl/mm3 (CD4 < 350 is priority)
6	The NAP reports clinical practice related to the WHO 2015 Recommendation for initiating treatment	YES	YES	No	No	Yes [6]

[1] Guía Clínica para la Atención Integral en Salud de las personas con VIH. Ministry of Health, 2014, El Salvador.
[2] Manual de Tratamiento Antirretroviral y de infecciones Oportunistas en Guatemala. Ministerio de Salud Pública y Asistencia Social, Programa Nacional de Prevención y control de las ITS-VIH y Sida Guatemala, 2013.
[3] Guía de Terapia Antirretroviral en Adultos con VIH, 2009. Ministry of Health , Nicaragua.
[4] Normas para el Manejo Terapéutico de las Personas con VIH en la República de Panamá. Ministerio de Salud, 2011.
[5] At a technical level, Honduras has expressed there should be no problem to start Treat and Start but they have not yet been adopted.
[6] Nevertheless the new protocol that will be approved and launched in country still includes CD4 count and VL as criteria to initiate ART.

1.2 Investment Profile

An analysis of the NASA studies in the region clearly demonstrates that the countries have been progressively increasing their domestic investment, which covers the majority of the costs of the HIV response; however, great differences exist between countries. While Panama covers more than 90% of their overall costs with host-country resources, Honduras, Guatemala, and Nicaragua still depend on other funding sources to cover between 34% and 47% of their national response. It is important to note that in the whole region, host country resources mainly go to cover care and treatment for positive individuals and prevention of mother to child transmission. KP prevention, strategic information, and laboratory reagents represent examples of areas where countries invest little to none of their own resources and are dependent on international donors to cover costs. The region's principal donor is the Global Fund, while PEPFAR's investment only represents 6% of the total spent in HIV for the region, as per last available information. Furthermore, in the current GF grants agreement, all countries in the region have an ARV transition plan , with progressively increasing national contributions aimed at promoting the full absorption of ARV cots; challenges still persist with the progressive absorption of reagents, such as CD4 and viral load, as well as in a lesser extent for commodities and supplies targeting key populations.

Table 1.2.1: NASA

	PEPFAR	%	GLOBAL FUND	%	MOH	%	Other	%
Guatemala (2013)	2,990,122	5.2	15,268,110	26.6	37,604,286	65.5	1,508,819	2.6
Honduras (2012)	5,006,709	13.1	8,795,571	23.0	20,318,291	53.2	4,054,988	10.6
El Salvador (2014)	1,565,784	2.5	8,866,867	13.9	48,823,576	76.8	4,338,498	6.8
Panama (2014)	1,821,846	4.7	1,006,551	2.6	35,468,026	92.4	86,435	0.2
Nicaragua (2013)	2,057,206	7.7	5,882,153	22.1	16,836,412	63.4	1,792,117	6.7

Table 1.2.1 Investment Profile by Program Areas (Region)					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	97,743,920 (43.6%)	0.1%	10.8%	88.0%	1.1%
Community-based care, treatment, and support	518,298 (0.2%)	0.0%	7.4%	68.3%	24.4%
PMTCT	14,278,528 (6.4%)	0.0%	14.1%	73.6%	12.3%
HTS	7,441,917 (3.3%)	0.8%	5.8%	91.0%	2.3%
VMMC	-				
Priority population prevention	15,812,851 (7.1%)	12.5%	18.8%	49.9%	18.8%
Key population prevention	7,430,920 (3.3%)	29.3%	57.6%	10.7%	2.4%
OVC	2,635,224 (1.2%)	0.0%	92.8%	3.6%	3.5%
SI, Surveys and Surveillance	10,977,065 (4.9%)	37.7%	35.7%	18.6%	7.9%
HSS	67,253,645	7.4%	19.6%	66.3%	6.7%
TOTAL	**224,092,368.31**	**6.0%**	**17.8%**	**71.0%**	**5.3%**

Table 1.2.1 Investment Profile by Program Areas (El Salvador, 2014)					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	29,201,204 (45.9%)		6.7%	92.9%	0.4%
Community-based care, treatment, and support	383,605 (0.6%)		9.6%	86.9%	3.5%
PMTCT	1,829,887 (2.9%)		16.8%	81.2%	2.1%
HTS	3,619,281 (5.7%)	1.5%	3.0%	93.5%	2.1%
VMMC	-				
Priority population prevention	2,571,277 (4.0%)	2.8%	11.8%	5.7%	79.7%
Key population prevention	1,818,099 (2.9%)	8.6%	82.6%	6.2%	2.6%
OVC	99,222 (0.2%)		58.1%	41.9%	
SI, Surveys and Surveillance	424,212 (0.7%)	50.4%	11.8%	24.0%	13.9%
HSS	23,647,938 (37.2%)	4.5%	19.3%	68.0%	8.2%
TOTAL	**63,594,725.00**	**2.5%**	**13.9%**	**76.8%**	**6.8%**

Table 1.2.1 Investment Profile by Program Areas (Guatemala, 2013)					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	29,100,264 (50.7%)	0.0%	19.7%	80.3%	0.1%
Community-based care, treatment, and support	0	0.0%		100.0%	0.0%
PMTCT	4,947,793 (8.6%)	0.0%	26.8%	72.2%	1.0%
HTS	1,564,461 (2.7%)	0.0%	0.0%	99.9%	0.1%
VMMC	-				
Priority population prevention	10,597,173 (18.5%)	5.9%	21.1%	71.5%	1.4%
Key population prevention	1,087,421 (1.9%)	12.7%	61.4%	21.2%	4.7%
OVC	51,259 (0.1%)	0.0%	0.0%	100.0%	0.0%
SI, Surveys and Surveillance	1,571,697 (2.7%)	32.8%	39.5%	1.7%	26.0%
HSS	8,451,243 (14.7%)	20.2%	55.5%	14.4%	9.8%
TOTAL	**57,371,337.66**	**5.2%**	**26.6%**	**65.5%**	**2.6%**

Table 1.2.1 Investment Profile by Program Areas (Honduras, 2012)					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	11,503,435 (30.1%)		11.3%	80.3%	8.4%
Community-based care, treatment, and support	112,842 (0.3%)				100.0%
PMTCT	2,088,163 (5.5%)		8.1%	90.3%	1.6%
HTS	1,188,819 (3.1%)		27.5%	64.3%	8.1%
Priority population prevention	1,829,992 (4.8%)	47.0%	12.6%		40.4%
Key population prevention	2,083,759 (5.5%)	66.4%	19.6%	10.1%	3.9%
OVC	2,481,832 (6.5%)		96.3%		3.7%
SI, Surveys and Surveillance	6,202,664 (16.2%)	43.8%	29.9%	21.5%	4.8%
HSS	10,684,054 (28.0%)	0.4%	19.8%	64.5%	15.3%
TOTAL	**38,175,560.00**	**13.1%**	**23.0%**	**53.2%**	**10.6%**

Table 1.2.1 Investment Profile by Program Areas (Nicaragua, 2013)					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	4,580,006 (17.2%)		33.7%	66.3%	
Community-based care, treatment, and support	1,485 (0.0%)		100.0%		
PMTCT	5,140,942 (19.4%)		4.1%	64.1%	31.8%
HTS	1,032,200 (3.9%)	0.6%		99.4%	
Priority population prevention	643,752 (2.4%)	64.8%	31.2%		3.9%
Key population prevention	1,946,103 (7.3%)	24.4%	75.2%	0.3%	
OVC	2,911 (0.0%)			100.0%	
SI, Surveys and Surveillance	2,270,183 (8.5%)	11.9%	61.5%	25.7%	0.9%
HSS	10,950,306 (41.2%)	8.1%	9.7%	81.1%	1.0%
TOTAL	**26,567,888.00**	**7.7%**	**22.1%**	**63.4%**	**6.7%**

Table 1.2.1 Investment Profile by Program Areas (Panama, 2014)					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	23,359,011 (60.9%)	0.5%		99.5%	
Community-based care, treatment, and support	20,341 (0.1%)			100.0%	
PMTCT	271,743 (0.7%)			100.0%	
HTS	37,156 (0.1%)			100.0%	
Priority population prevention	170,657 (0.4%)	1.3%		98.7%	
Key population prevention	495,538 (1.3%)	3.9%	48.1%	48.0%	
SI, Surveys and Surveillance	508,309 (1.3%)	83.0%			17.0%
HSS	13,520,104 (35.2%)	9.3%	5.7%	85.1%	
TOTAL	**38,382,857.65**	**4.7%**	**2.6%**	**92.4%**	**0.2%**

Table 1.2.2 Procurement Profile for Key Commodities

Guatemala

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP*	% Other
ARVs	$1,901,124.30		55	45	
Rapid test kits	$352,383.36		80	20	
Other drugs					
Lab reagents	$967,526.82		20	80	
Condoms	$454,615.38		33	67	
VMMC** kits	NA				
Other commodities	NA				
Total	**$3,675,647.86**		**46**	**54**	

National Purchasing plan 2015 - Streamlining of funds requested by the CCM to cover gap in the 2015 MOH budget. Includes purchases at the central level;

El Salvador

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP*	% Other
ARVs	$2,558,151		12%	88%	0%
Rapid test kits	$488,275		28%	70%	2%
Other drugs	$348,888		77%	18%	5%
Lab reagents	$1,750,258		63%	37%	0%
Condoms	$213,586		37%	45%	19%
VMMC** kits	N/A				
Other commodities	$745,089		36%	55%	9%
Total	**$6,227,705**		**35%**	**62%**	**2%**

Until 2014, GF procured using UNDP. In 2015 GF procured using PAHO, Plan International and UACI (Procurement Unit of MOH). National Government procures international purchases using PAHO and local suppliers

Honduras

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP*	% Other
ARVs	$1,679,552		10.4	89.6	
Rapid test kits	NA				
Other drugs	NA				
Lab reagents	NA				
Condoms	$461,691		23.3	76.7	
VMMC** kits	NA				
Other commodities	NA				
Total	**$2,141,243**		**13**	**87**	

Source: Unidad de Logística de la SESAL, National AIDS Program & GF, 2014

Panama

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP*	% Other
ARVs	$ 5,211,158	0		100	
Rapid test kits	$ 31,440	0	2	98	
Other drugs	IQ	0			
Lab reagents	IQ	0			
Condoms	$ 94,149	0	12	88	
VMMC** kits	NA	0			
Other commodities	IQ	0			

Total	**$ 5,336,747**	**0**	**0.2**	**99.8**	

Source: Provision de Suministros MINSA and PR of Global Fund (Cicatelli) 2014

Nicaragua

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
ARVs	$877,938		100		
Rapid test kits	$1,173,890	2.7	97.3		
Other drugs					
Lab reagents					
Condoms	$18,000	100			
VMMC kits					
Other commodities (lubricants)	$5,259	100			
Total	**2,075,087**	**2.6**	**97.4**		

Source: Estimations from information related with commodities in Concept note presented to Global Fund

Due to the variety of data collection and sources of information, it is difficult to obtain all the information for these tables and consolidate this into one table for the entire region, but some relevant information could be obtained from these.

Related with the ARV treatment in Honduras, Guatemala, El Salvador, and Panama, the government covers an average of > 75% of the expenses. Nicaragua depends on Global Fund to procure ARV treatments, but in the latest Concept Note the country shows a gradual absorption plan of patients in ARV treatment from the government in the next few years.

Some countries in the Region still depend on external resources to procure and obtain supplies related with Prevention activities (Rapid test kits, Condoms), but there are plans of gradual absorption of these expenses in the future.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources							Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
		Guatemala	Honduras	El Salvador	Panama	Nicaragua	Costa Rica	Belize				
USAID MCH	4,978,225	4,000,000	978,225							Honduras:1		
Family Planning	7,577,365	6,500,000	1,077,365							Honduras: 1		
Nutrition	4,500,000	4,500,000										
USAID Democracy	500,000	500,000										
CDC NCD	6,990,930	3,314,926	58,879	219,680	3,314,926	29,900		52,619				
Peace Corps	6,909,871	1,850,254	No PC presence	No health program	1,008,507	2,840,254	No health program	1,210,856				
MCC												
Private Sector												
PEPFAR Central Initiatives (KPIS)	820,898	820,898								Guatemala: 1		To develop and evaluate a pilot intervention to improve treatment adherence in MSM and Transgender women in Guatemala City.

1.3 National Sustainability Profile

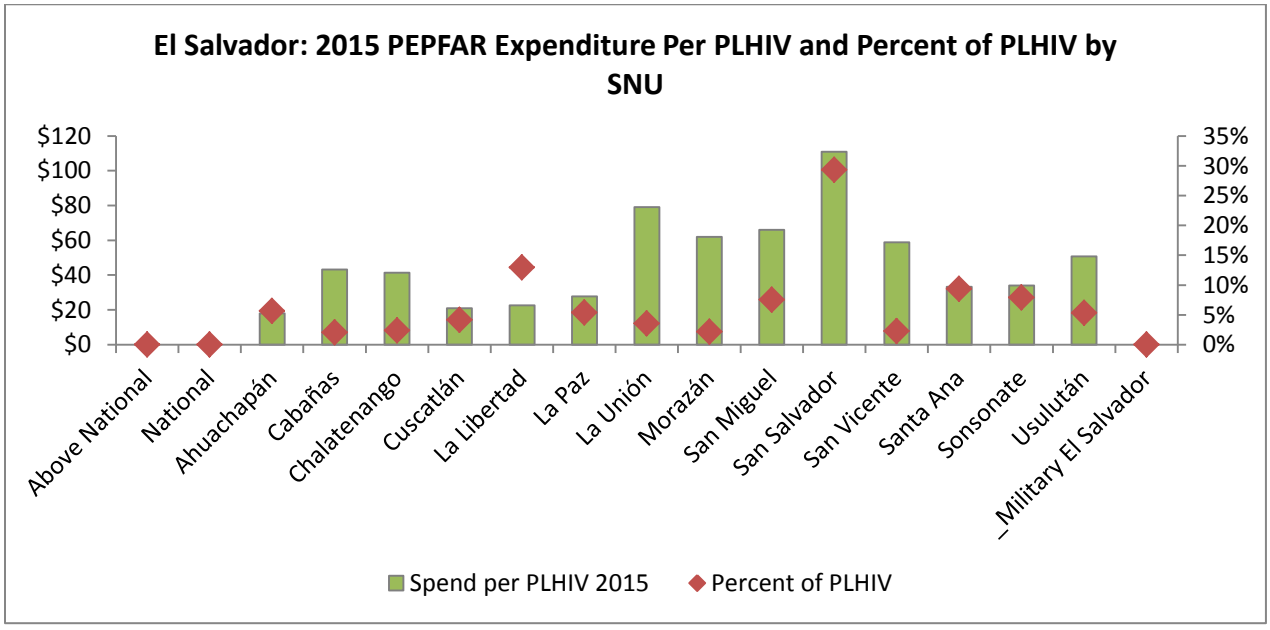
In light of the regional nature of the PEPFAR Central America program, Sustainability Index and Dashboard (SID) meetings were organized in the 5 countries where PEPFAR will continue its presence in FY2017: Guatemala, Honduras, Nicaragua, El Salvador, and Panama. A diverse group of stakeholders was convened in each country to ensure a balanced representation from government, multilateral partners, international development agencies, academic institutions and civil society. Government representatives included political and technical-level officers from the Ministry of Health as well as other key entities, like the Ministry of Finance. In addition representatives from UNAIDS, the Pan-American Health Organization, Global Fund Principal Recipients, Country Coordination Mechanisms and Regional Coordination Mechanisms, and other agencies participated on behalf of the development community, and civil society representatives included PLHIV and KP organizations. Participants were briefed on SID objectives and structure, and then broken into smaller groups to discuss and complete the domains, and finally presented their work in a plenary session where a consensus was reached to score each element after enriching dialogue. The SID tool was translated to Spanish to assure complete understanding, discussion and full participation by the audience. PEPFAR team members facilitated the meeting and worked with local implementing partners to draft, validate, and complete the final report.

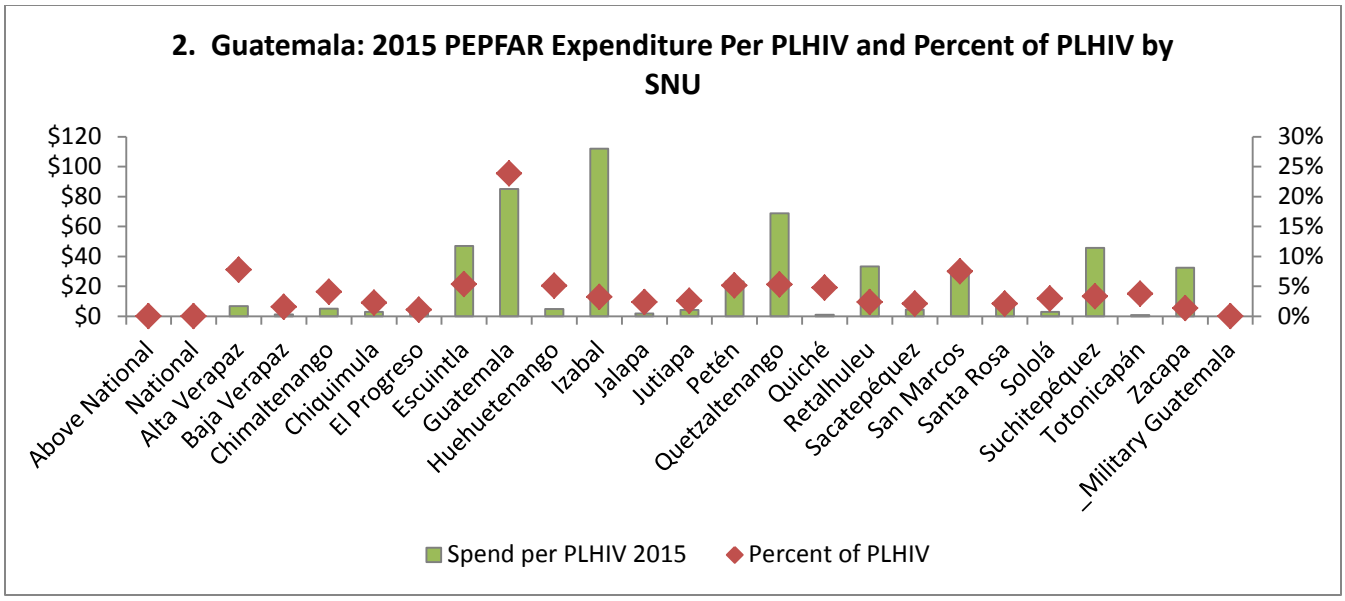
While SID results vary by country, the following elements emerged as sustainability strengths from a regional perspective, with a green score in the following areas: Planning and Coordination, Public Access to Information, Technical and Allocative Efficiencies, and Performance Data. The main sustainability vulnerabilities at a regional level were Private Sector Engagement, Service Delivery, Commodity Security and Supply Chain, and Domestic Resource Mobilization. Outliers with low scores (<4) in critical areas emerged in specific countries, like Quality Management in Nicaragua and Guatemala and Laboratory in Honduras. The PEPFAR team regards as priorities those elements that directly impact host government ability to reach 90-90-90 goals, mainly service delivery (HTS and linkage to care among KP), supply chain security, quality management (adherence), and laboratory (viral load). Both PEPFAR and Global Fund have invested in these areas in the past, particularly in pioneering the establishment of clinical services tailored for key populations and improving the quality of HIV care services. In FY2017, the PEPFAR team will further address these vulnerabilities by focusing on more efficient interventions that respond to country-specific needs exposed in country cascades and the SID, which are described in greater detail in section 6.0.

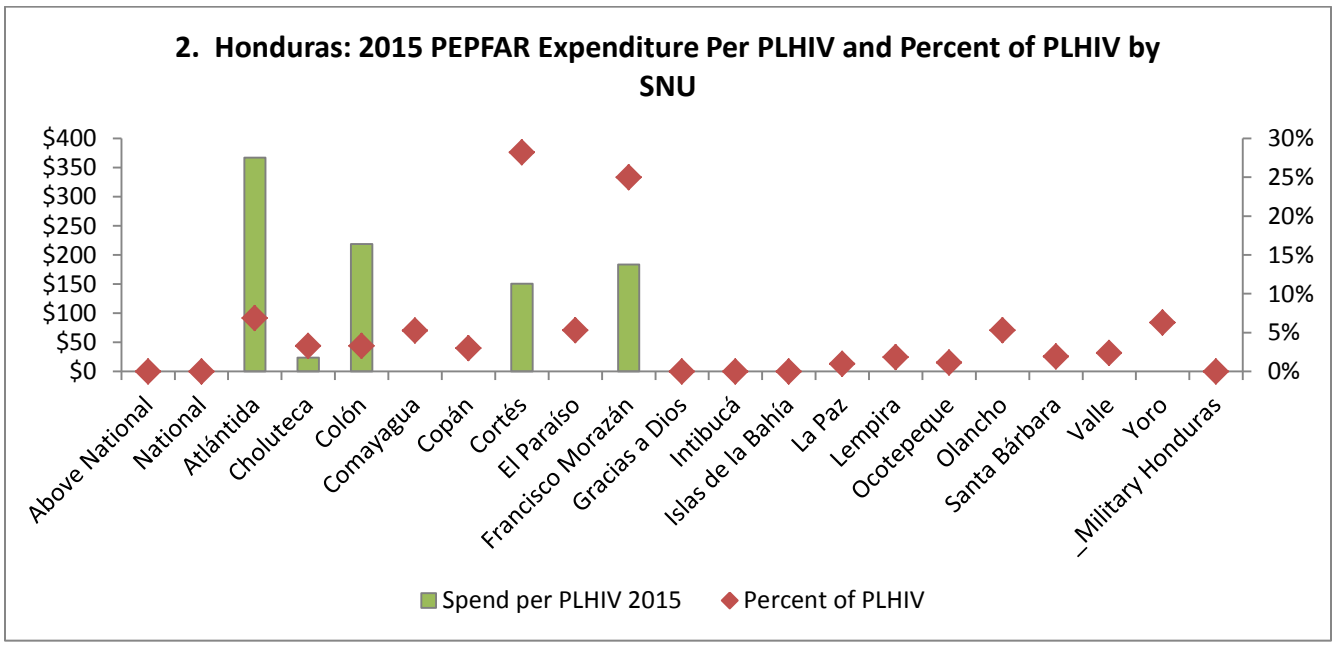
1.4 Alignment of PEPFAR investments geographically to disease burden

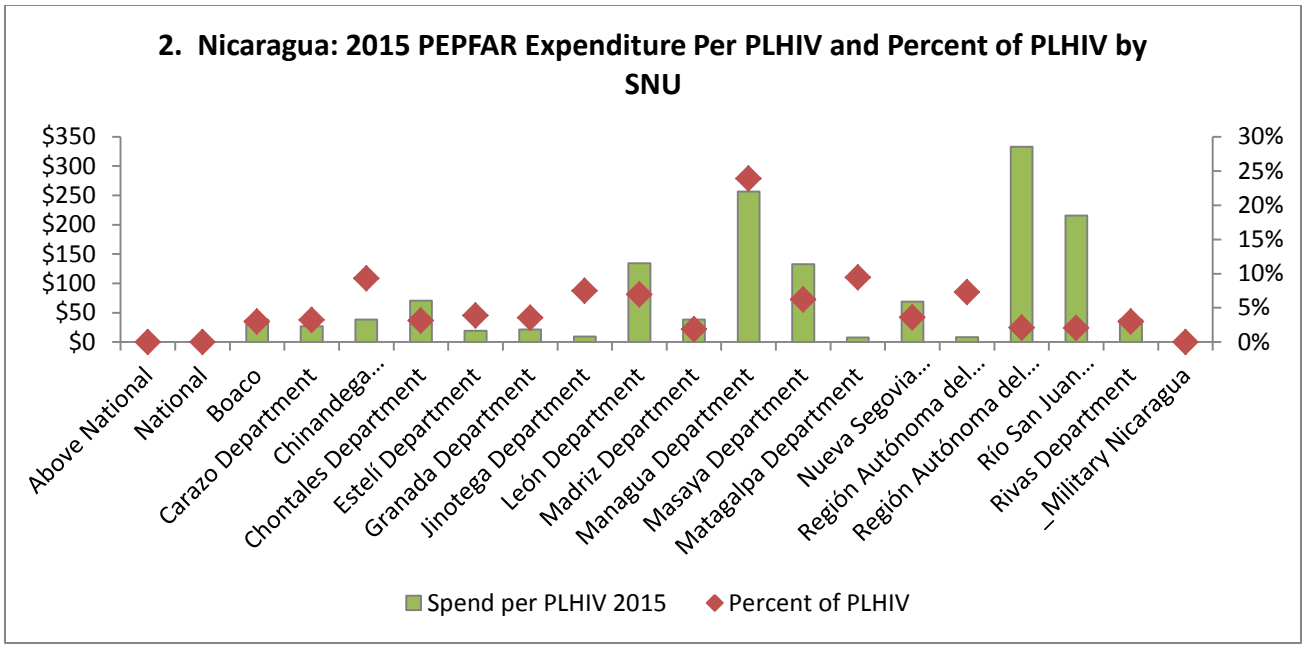
Tables in this section present PEPFAR expenditure per PLHIV and percent of PLHIV by SNU in FY15 in five Central American countries. As FY15 was a transitional year in which implementing mechanisms refocused geographically from 80 departments/provinces to 13 per the geographic pivot, many of the incongruences between expenditures and HIV burden evident in these tables have been addressed in FY16. The PEPFAR team expects further alignment during FY16 as PEPFAR has already transitioned out of Costa Rica, will transition out of Belize, and has drilled down to the municipality level in the remaining five countries.

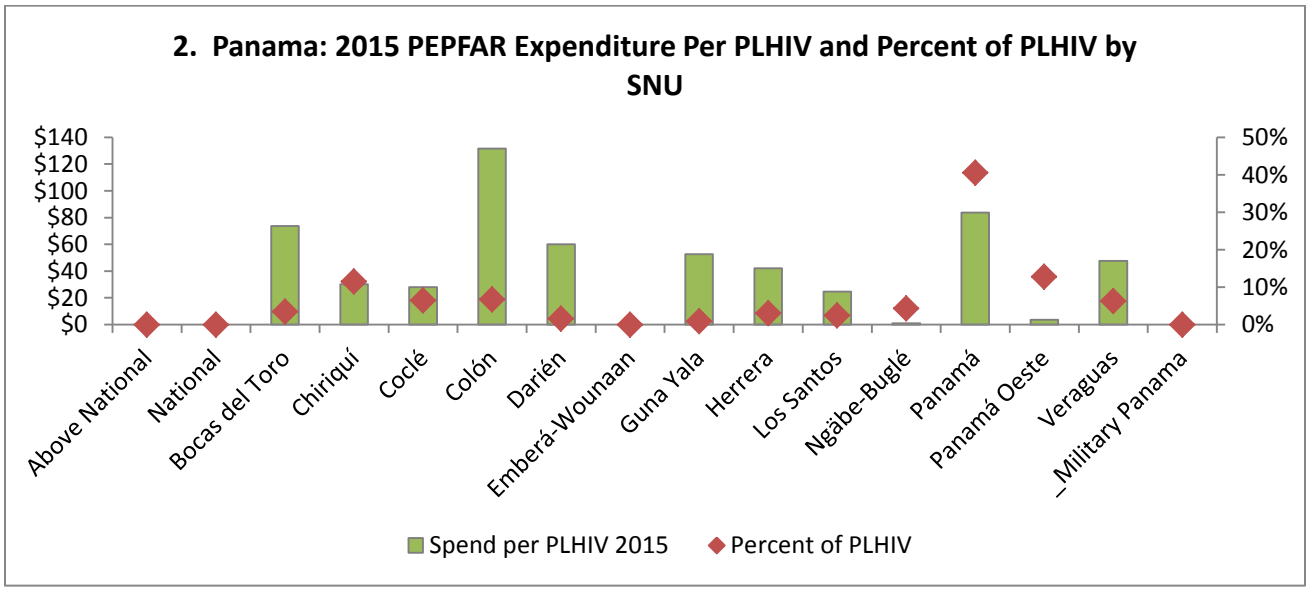
In FY 2015, expenditure per PLHIV across SNUs varied from $1.0 to $112 in Guatemala; $24 to $367 in Honduras; and, $21 to $111 in El Salvador. PEPFAR invested funds in national and above-national activities, with an average of $51.70 dollars spent per PLHIV in Guatemala, $62.55 in Honduras, and $156.38 in Nicaragua. These amounts were based on the estimated number of PLHIV in each country and in each SNU, *not* on actual number of PLHIV reached by PEPFAR. Overall a clear correlation was not found between PEPFAR expenditures and PLHIV in SNUs; some SNUs showed low expenditures in services to PLHIV (2 in Guatemala, 2 in Honduras, 1 in El Salvador and 2 in Nicaragua), whereas some SNUs have high costs (3 SNUs in Guatemala, 2 in Honduras, and 4 in El Salvador).




2. Guatemala: 2015 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU
$120
$100
$80
$60
$40
$20
$0
30%
25%
20%
15%
10%
5%
0%
Above National
National
Alta Verapaz
Baja Verapaz
Chimaltenango
Chiquimula
El Progreso
Escuintla
Guatemala
Huehuetenango
Izabal
Jalapa
Jutiapa
Petén
Quetzaltenango
Quiché
Retalhuleu
Sacatepéquez
San Marcos
Santa Rosa
Sololá
Suchitepéquez
Totonicapán
Zacapa
_Military Guatemala
Spend per PLHIV 2015
Percent of PLHIV


2. Honduras: 2015 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU
$400
$350
$300
$250
$200
$150
$100
$50
$0
30%
25%
20%
15%
10%
5%
0%
Above National
National
Atlántida
Choluteca
Colón
Comayagua
Copán
Cortés
El Paraíso
Francisco Morazán
Gracias a Dios
Intibucá
Islas de la Bahía
La Paz
Lempira
Ocotepeque
Olancho
Santa Bárbara
Valle
Yoro
_Military Honduras
Spend per PLHIV 2015
Percent of PLHIV


2. Nicaragua: 2015 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU
$350
$300
$250
$200
$150
$100
$50
$0
30%
25%
20%
15%
10%
5%
0%
Above National
National
Boaco
Carazo Department
Chinandega...
Chontales Department
Estelí Department
Granada Department
Jinotega Department
León Department
Madriz Department
Managua Department
Masaya Department
Matagalpa Department
Nueva Segovia...
Región Autónoma del...
Región Autónoma del...
Río San Juan...
Rivas Department
_Military Nicaragua
Spend per PLHIV 2015
Percent of PLHIV


2. Panama: 2015 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU
$140
$120
$100
$80
$60
$40
$20
$0
50%
40%
30%
20%
10%
0%
Above National
National
Bocas del Toro
Chiriquí
Coclé
Colón
Darién
Emberá-Wounaan
Guna Yala
Herrera
Los Santos
Ngäbe-Buglé
Panamá
Panamá Oeste
Veraguas
_Military Panama
Spend per PLHIV 2015
Percent of PLHIV

1.5 Stakeholder Engagement

The strategy for the regional program includes continued on-going engagement to leverage the influence of the regional bodies, especially COMISCA and the RCM, to influence policy and implementation in all countries especially in the context of initiating Test and Start. As COMISCA is made up of the Ministers of the Health for all countries from the region, resolutions and commitments made by COMISCA at the regional level can then be leveraged to affect national policy and implementation.

Throughout the FY2016 ROP development process, the PEPFAR Central America Regional Team fully engaged with stakeholders, including the five country governments, multi-lateral stakeholders like GF implementers , PAHO, UNAIDS, civil society members representing key populations, private sector representatives, and regional entities such as COMISCA and its HIV technical advisory body, the Regional Coordinating Mechanism (RCM), made up of multi-sectoral representatives such as PAHO who plays an important and influential technical advisory role in the region and at the national levels.

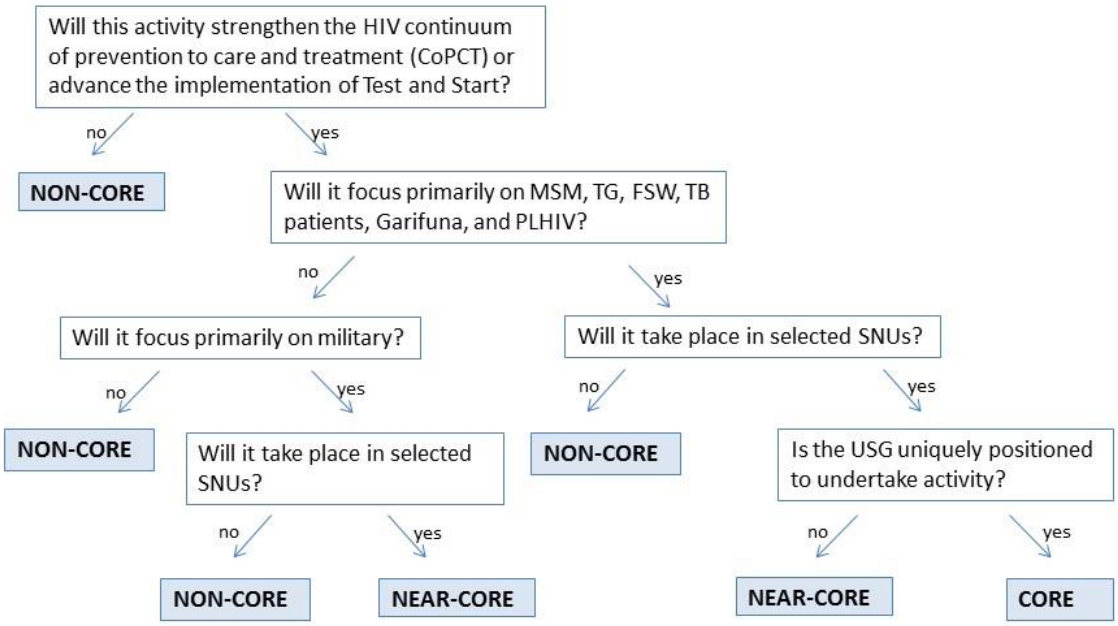
This engagement has been ongoing since PEPFAR started in the region and is not only done during the ROP development phase, but also during the implementation phase as well, including the initiation of quarterly meetings in FY2016 to share PEPFAR data. Regional team members participate in all virtual RCM monthly meetings and in-person meetings every six months. The PEPFAR team hosted several comprehensive stakeholder meetings in each country pre-ROP16 to discuss current PEPFAR support to the country, share APR15 data, upcoming changes in ROP16 and how PEPFAR complements Global Fund projects and fits within regional strategies that countries have agreed to through COMISCA. These meetings were held in each of the five countries and work groups were established to discuss how best leverage all resources to improve the national response. Based on those recommendations from stakeholders and civil society, the Global Fund implementers and PEPFAR funded projects agreed on adjustments to some current activities to better respond to identified weaknesses. These meetings at the national level also served as a platform for starting ROP16 discussion and all the feedback was incorporated into the ROP16 planning, especially through target setting and decisions on which high burden SNUs to continue PEPFAR support.

In addition, achieving the target of 80% coverage is only possible through close collaboration with partners such as the Global Fund, UNAIDS, host-country governments and civil society organizations. To that end, PEPFAR will continue to work closely with all countries and key stakeholders, particularly to secure Global Fund financing and will provide support for external TA for both concept note development and implementation.

2.0 Core, Near-Core and Non-Core Activities

The PEPFAR Central America program defined core, near-core, and non-core activities for program implementation in FY 2017 based on the expected impact of the activity towards achieving country-level 90-90-90 targets and sustained epidemic control. For this exercise, a decision tree (see below) was developed to aid in the analysis of disease burden and HIV prevalence among sub-populations, gaps in the continuum of prevention to care and treatment (CoPCT in-country investments and PEPFAR's unique ability to impact the continuum response cascade), and feasibility of implementing priority policies focusing on Test and Start and new service delivery models. As a result, core activities will focus on specific pillars of the cascade identified in section 1.1 serving key populations, TB patients, Garifuna ethnic population, and PLHIV in selected SNUs in High and Medium Intensity countries. Near-Core activities will focus on military personnel. Activities that will not strengthen the CoPCT and that are not deemed as significant to the national HIV response are considered as non-core and will not be funded in FY 2017. Please see Appendix A for full list of core, near-core, and non-core activities and transition plans.

Figure 1. Decision Tree: core, near-core, non-core activities in the Central America Region



3.0 Geographic and Population Prioritization

Based on the epidemiological profile and to implement the PEPFAR 3.0 strategy, PEPFAR team in consultation and dialogue with external stakeholders, has prioritized investing PEPFAR resources in the highest disease burden areas where PEPFAR can have the most impact among populations with the greatest need. This prioritization allows limited resources to be invested strategically for the greatest impact on epidemic control.

The PEPFAR Central America team will maintain its regional approach in FY 2017 but has modified its footprint and level of support to align investments and support to more targeted activities in the 30 highest burden SNUs (municipalities). These 30 SNUs across the region account for 44% of the PLHIV burden, high concentrations of priority populations, and include areas where the data demonstrate that PEPFAR can have the biggest impact for its investment. During this process, PEPFAR applied the following criteria:

- Disease burden, total size of PLHIV and prevalence
- Underserved populations (estimated size of KPs, HIV-infected KPs , and KPs on treatment)
- Impact of investment (resource distribution vs results)
- Cascade gaps for KPs and PLHIV (unmet need)
- Financial contribution from Global Fund and national governments
- Country's economic threshold

While Costa Rica has advanced the most in the region towards the 90-90-90 goals and has the fewest gaps across the HIV cascade, Belize has the least proportional unmet need in the region. Therefore, PEPFAR support will be re-directed to priority SNUs in the other five countries in the region and the program has re-allocated funding based on the above-mentioned criteria.

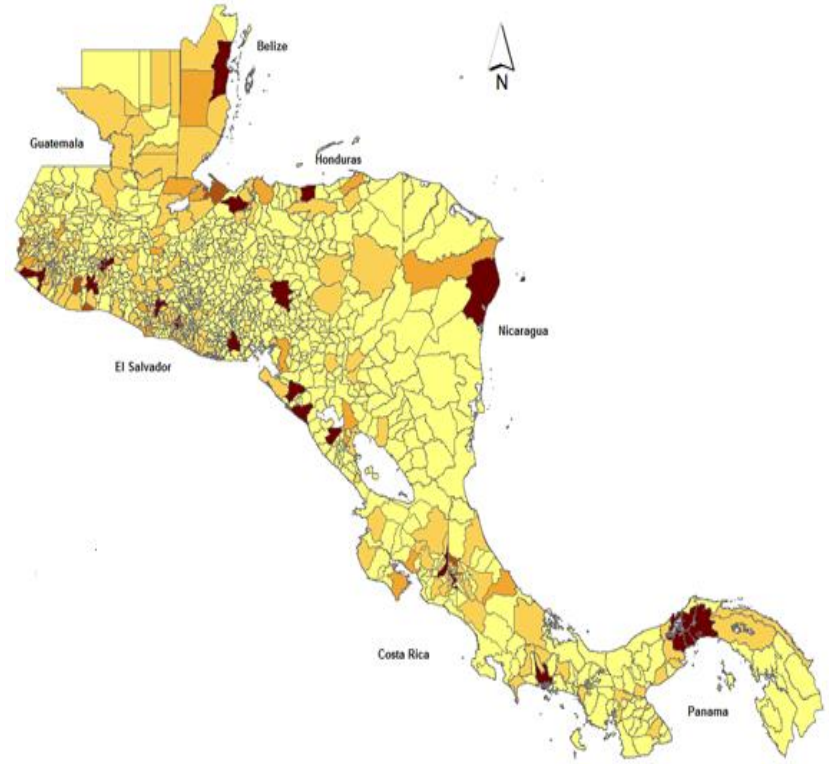
Of 722 SNUs in the region, as a first step, PEPFAR selected SNUs with at least 40 reported HIV positive cases in 2014 (n=24). Given the need to support all pillars of the cascade and work with KPs and Garifuna populations, of the remaining 698 non-selected SNUs, we added 3 SNUs with a care and treatment service delivery site, 2 SNUs with at least 1,250 KP size estimates, and 1 SNU with strong Garifuna ethnic minority population presence to the original list of 24 SNUs for a total of 30 SNUs. Of the 30 SNUs selected, 23 were already included in FY 2016. The next step was to prioritize support to increase treatment coverage at facility-level services that directly serve KPs and PLHIV. TA for above-site support was programmatically aligned to address key systems barriers impeding achievement of ROP FY2016 targets and implementation of priority policies of Test and Start and new service delivery models.

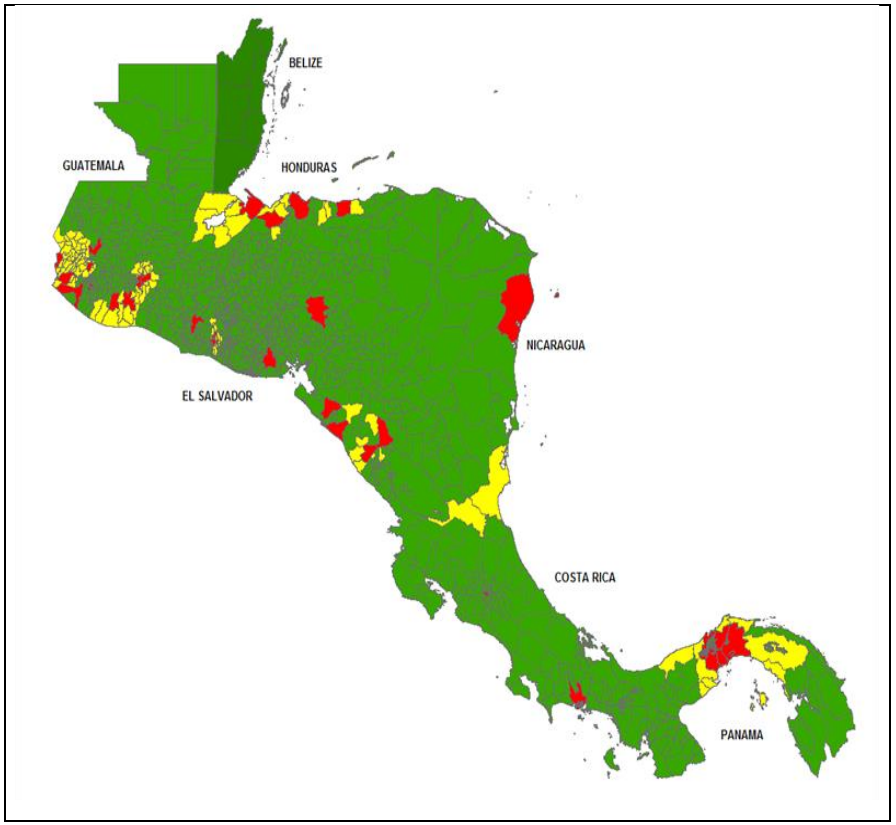
Table 3.1. Distribution of PLHIV, KP, KP HIV+, KP on treatment, unmet need, Global Fund and PEPFAR targets, and PLHIV on treatment in Central America (7 highlighted municipalities in blue are new for FY 2017)

New Municipality

No.	Country	Department	Municipality	HIV+ cases notified 2014	PLHIV Estimate	MSM Estimate	FSW Estimate	TG Estimate	KP HIV+ Estimate	KP HIV+ Tx Estimate	Gap 80% KP HIV+ without Tx	PEPFAR KP HIV+ TARGET	TARGET KP PP HIV+	PLHIV on TX (2014/2015 data)
1	El Salvador	San Salvador	Apopa	50	815	485	381	79	71	23	42	33	33	
2	El Salvador	San Salvador	Soyapango	60	978	789	620	128	125	39	73	69	69	
3	El Salvador	San Salvador	San Salvador	147	2,397	758	595	123	120	38	70	53	69	6423
4	El Salvador	San Salvador	Mejicanos	49	799	417	328	68	61	19	36	28	28	
5	El Salvador	Santa Ana	Santa Ana	55	897	758	596	123	103	33	60	51	51	788
6	El Salvador	San Miguel	San Miguel	61	995	718	564	117	97	31	57	48	48	485
7	Guatemala	Guatemala	Guatemala	342	8,904	9,286	2,262	267	864	259	302	252	252	6665
8	Guatemala	Guatemala	Villa Nueva	56	1,458	5,163	1,258	148	480	144	120	92	92	
9	Guatemala	Guatemala	Mixco	63	1,640	4,593	1,119	132	427	128	107	83	83	
10	Guatemala	Quetzaltenango	Quetzaltenango	20	521	1,414	345	57	63	19	32	25	25	1222
11	Guatemala	Quetzaltenango	Coatepeque	22	573	1,251	305	50	56	17	28	22	32	1589
12	Guatemala	Escuintla	Escuintla	95	2,473	1,046	255	50	74	22	37	30	42	592
13	Guatemala	Izabal	Puerto Barrios	38	989	956	233	72	42	12	21	16	16	667
14	Guatemala	San Marcos	Malacatán	37	963	582	142	31	23	7	12	10	20	428
15	Guatemala	Retalhuleu	Retalhuleu	41	1,067	542	132	29	39	12	19	18	18	140
16	Honduras	Francisco Morazan	Distrito Central	152	4,693	6,282	2,550	0	518	164	199	177	202	1991
17	Honduras	Cortes	San Pedro Sula	148	4,569	4,123	1,588	0	548	175	208	194	231	2220
18	Honduras	Atlantida	La Ceiba	57	1,760	1,140	446	0	202	67	94	94	120	672
19	Honduras	Atlantida	Tela	21	648	161	64	0	29	10	13	4	22	378
20	Nicaragua	Managua	Managua	541	5,328	12,543	13,138	3,681	848	254	339	149	149	1112
21	Nicaragua	Managua	Tipitapa	23	227	1,641	1,719	482	111	33	44	44	44	
22	Nicaragua	Leon	León	50	492	1,865	553	140	102	30	41	18	18	190
23	Nicaragua	Chinandega	Chinandega	52	512	1,403	300	162	150	45	60	31	31	218
24	Nicaragua	Atlantico Norte	Puerto Cabezas	65	640	519	338	45	81	24	32	10	10	78
25	Panama	Panama	Panamá	557	6,264	3,849	1,267	132	438	131	219	89	119	5782
26	Panama	Panama	San Miguelito	241	2,710	1,377	453	47	157	47	78	37	37	37
27	Panama	Panama Oeste	Arraiján	137	1,541	965	318	33	110	33	55	45	45	
28	Panama	Panama Oeste	La Chorrrera	85	956	706	232	24	80	24	40	33	33	288
29	Panama	Colón	Colón	124	1,394	903	297	31	103	31	51	30	30	611
30	Panama	Chiriqui	David	57	641	633	208	22	72	22	36	23	23	595
				3,446	**57,846**	**66,866**	**32,606**	**6,275**	**6,191**	**1,894**	**2,525**	**1,810**	**1,994**	**33,171**

Figure 3.2. New PLHIV diagnosis by Municipality (2014) compared to FY 2017 Geographic Focus

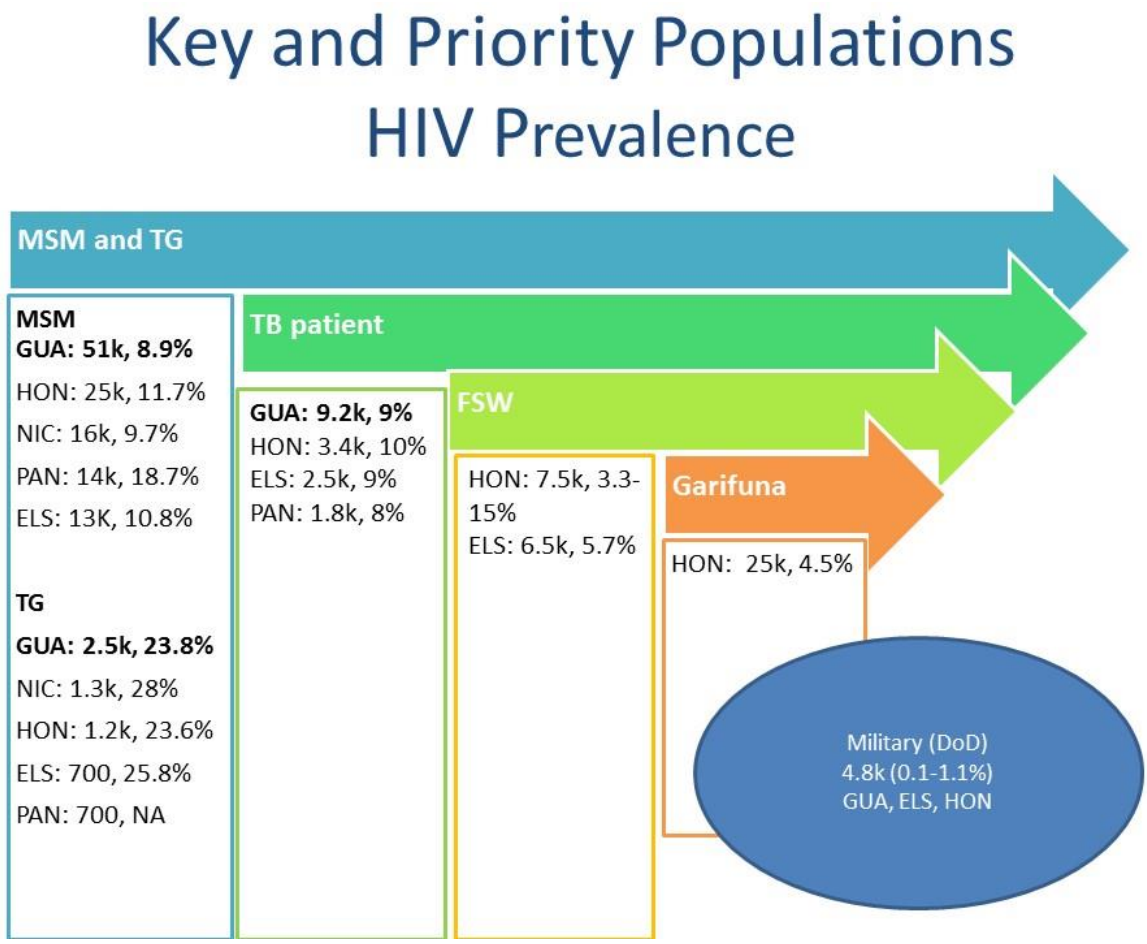




Legend
CENTRAL AMERICA
Num. cases
0 - 4
5 - 20
21 - 29
30 - 40
41 - 600

Legend
CENTRAL AMERICA
PEPFAR FY 17
No Intervention
Municipalities FY 16
Municipalities FY 17

Figure 3.3. FY17 Key & Priority Population Focus



In addition to MSM and TGW, the PEPFAR Central America Program will continue to support the following priority populations:

1. Garifuna (Honduras)
2. TB patients (Guatemala, El Salvador, Honduras, Nicaragua and Panama)
3. FSW (El Salvador and Honduras)
4. Military (El Salvador, Honduras, and Guatemala)

1. Garifunas (Honduras)

The Garifuna population is one of eight ethnic groups in Honduras; they are of African origin and live mostly in communities along the Northern Caribbean coast. Several studies in Honduras have shown a high HIV burden among the Garifuna population, as a result of individual behavioral and social factors that increase their risk of HIV infection. The sexual behavioral surveillance survey (BSS) conducted in 2012 found an HIV prevalence of 4.5% among the urban Garifuna population and 4.6% in the rural population, an increase from 4.2% and 2.5% respectively. This prevalence is significantly higher than the 0.5% prevalence found in the general population. An ethnographic study conducted in 2004 identified social factors that potentially contribute to the high HIV prevalence in the Garifuna population, mainly associated with gender inequality, male migration for employment, sexual violence, alcohol and drug use,

difficulty for women to negotiate condom use with their sexual partners, multiple sexual partners, and early initiation of sexual intercourse, transactional sex, and low condom use. Based on the available information about these vulnerabilities and risk factors, and data demonstrating a high HIV prevalence among the Garifuna, there is a need to strengthen national strategies for HIV case finding targeted to this population, along with linkages to care and treatment services. A special emphasis will be made to target HIV testing in community settings to reach those hidden pockets with the highest risk.

2. Tuberculosis (TB) Patients (Guatemala, El Salvador, Honduras, Nicaragua, and Panama)

In 2013, 13% of people who developed TB worldwide were co-infected with HIV. According to the WHO Central America country profiles, the TB prevalence rate (per 100,000) varies from 15 (Costa Rica) to 110 (Guatemala) per 100,000, with a mean of 59.29 per 100,000**.** The countries with the highest TB/HIV incidence rate (per 100,000) are Panama (6.3), Guatemala (5.9), and Honduras (5.6). There are gaps in the implementation of effective interventions to reduce the burden of HIV-associated TB. Undiagnosed TB disease, where detection rate is low (36% in Guatemala, 68% in Honduras), can pose a high risk for PLHIV. In a recent review during intensified TB case finding (ICF) in resource-limited settings, the yield of HIV-associated TB showed an 8% median prevalence of TB disease among PLHIV attending HIV care and treatment clinics (range up to 25% in some of these clinics). As a result of investment alignment and site yield/volume analyses and regional context, in FY 2017 PEPFAR has prioritized core activities in in priority SNUs to provide HTS and ensure linkage to care of HIV+ TB patients.

3. FSW (Honduras and El Salvador)

FSW will be prioritized only in Honduras and El Salvador, where HIV prevalence is high among this population. According to the 2013 Modes of Transmission study (MOT), a HIV prevalence of 0.7% was found among a total of 15,0000 FSW in Honduras. However, according to the 2012 BSS Honduras survey, HIV prevalence among FSW varied between 3.3 to 15.3 percent, depending on location (Tegucigalpa, 3.3; San Pedro Sula, 6.7 and La Ceiba, 15.3). According to the 2013 MOT in El Salvador, the estimated number of FSW was 25,467 and the BSS survey in 2010 showed an HIV prevalence of 2.5% in Acajutla and 5.7% in San Salvador. FSWs attend KP-focused (VICITS) clinics in Honduras and El Salvador where they receive HTS services, care and treatment for STDs and also are linked to HIV care and treatment.

4. Military (El Salvador, Guatemala, and Honduras)

The Department of Defense's epidemiological investment, and site yield analysis has led to significant changes in the DOD program for FY 2017, accelerating the shift of key program activities to militaries with a heightened focus on ensuring a rapid, yet responsible and sustainable transition. DOD will use ROP16 funds to transition all near-core activities from local implementing partners to their military in-country counterparts. DOD will implement TA activities providing directly through their staff in the region and support from HQ.

DOD has transitioned all general HIV prevention activities to the militaries and will no longer provide direct or TA support for mobile or voluntary counseling and testing activities. These non-core activities will be replaced with training at the national/above site level to support HIV surveillance, monitoring and evaluation and data for decision making, to support the HIV response at military level to ensure sustainability and continuum of the HIV program.

DOD is transitioning out of support of the Nicaragua and Belize Military Programs and will focus on countries with a higher HIV burden. DoD will be using remaining funds from ROP15 to support strategic planning in Guatemala, Honduras, and El Salvador and finalize the SABERS study programed planned for Belize.

DOD will also support a Training of Trainers Spanish language Military International HIV Training Program (MIHTP) course in the U.S. for three host nation military personnel participants (1 each from Honduras, Guatemala, and El Salvador) with the aim of providing local training in HIV clinical management in the region.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for scale-up locations and populations

As a regional operating unit, the Central America PEPFAR team was tasked with selecting high-burden SNU for inclusion in ROP16. For the first time, the team obtained municipality level data and was thus, able to drill down and conduct a finer SNU analysis- a key improvement from ROP15. The team ranked all municipalities in El Salvador, Guatemala, Honduras, Nicaragua, and Panama using three criteria: 40 or more notified HIV cases in 2014 (the latest year for which all countries had complete data), above 70 percentile of PLHIV regional estimate[7], and above 70 percentile of KP size regional estimate[8]. Thirty municipalities were selected through this multifaceted approach. Belize was excluded because of its low burden of disease and Costa Rica because of its satisfactory performance in different pillars of the cascade.

Regarding priority populations, the team decided to maintain its focus on MSM and TGW, the two groups with highest HIV prevalence across the region; FSW in El Salvador and Honduras, the two countries with highest HIV prevalence among this group; TB patients, whose HIV positivity rate hovers around 10% throughout the region; the Garifuna in Honduras, an ethnic minority with a 4.5% HIV prevalence rate; and people living with HIV for interventions in the latter pillars of the cascade.

Once priority locations and populations were determined, the team set unmet need targets for HTS and treatment. To do so, we multiplied the estimated number of KPs and priority populations in each municipality by HIV prevalence in each of these groups, to obtain the estimated number of each KPs living with HIV in each municipality. Using results from bio-behavioral surveys, we estimated how many of these KP were already aware of their HIV status, and we multiplied this result by 80% to determine the unmet need for HTS - the gap of KP to diagnose. We subtracted from this number the estimated number of positives expected to be diagnosed through Global Fund interventions; thus, obtaining the PEPFAR target of new HIV cases to be diagnosed during FY17 to reach country targets for the first pillar. This is another improvement as we were not able to obtain municipality level targets from Ministries of Health for ROP15. Based on this number, the team used historical HIV positivity ratios (HIV+/Tested) and PEPFAR indicator performance data (tested/reached in facility and community sites) to calculate HTS_TST and KP_PREV targets. Of note, reaching the first 90 has been a top priority for PEPFAR and national programs in our region since FY15. We did not adjust our HTC targets to reflect our country tier system, but instead we set our targets based on the calculated unmet need from national estimates and programmatic data to support countries achieve their first 90 by 2020.

A similar approach was employed to set targets for the Garifuna and TB patients, albeit with some differences. For the Garifuna, actual census data was used instead of estimates of population size, while World Bank TB case detection rates were used for TB patients instead of bio-behavioral survey results.

[7] PLHIV by SNU were estimated by applying the percentage of the total population in each SNU to national PLHIV Spectrum estimates.

[8] SNU level KP estimates were used when available. Otherwise, number of KP by SNU were estimated by applying the percentage of notified HIV cases in each SNU during 2104 to national KP estimates.

Treatment targets were established based on national cascade performance data, the cohort at treatment centers in prioritized municipalities, and the expected number of newly diagnosed cases expected to be linked to care and treatment. Countries with the largest drop offs between diagnosis to and enrollment in care were prioritized to address this gap. On the other hand, no treatment targets were set for FY 2017 in countries with satisfactory performance in linkages to care and adherence to treatment, like Honduras and El Salvador. These efficiency gains freed funding to be used in addressing the most pressing gaps in other pillars of the cascade.

In order to maximize achievement and impact in each pillar of the 90-90-90 targets, the PEPFAR Central America team will employ a mix of evidence-based approaches in community and facility settings and at site and above site levels. For the first 90, PEPFAR will increase HIV testing yields among KP through the use of evidence-based information technology communication tools, including a social media platform which has been demonstrated to reach broad segments of the MSM population and peer-to-peer outreach work through engagement with CBOs to increase effectiveness of HIV case finding. Additionally, we will employ enhanced behavior assessment strategies to identify individuals at greatest HIV risk, adapt clinic hours and days tailored for increased accessibility to KP, add KP-friendly locations, expand provider initiated testing and counseling (PITC) to presumptive TB cases, support index testing, and creatively use social media and peer networks to promote HIV testing.

For the second 90, to increase ART coverage amongPLHIV, PEPFAR will advocate with partner governments to adopt Test and Start policies as a key strategy for epidemic control. PEPFAR will also expand the use of peer health navigators to link diagnosed individuals to treatment, integrate ARV services at select KP-specialized clinics, intensify systems for tracking PLHIV who have defaulted from care or treatment and link them back into clinical services, support differentiated HIV service delivery approaches (i.e., fast track drug refills, decentralized drug delivery at lower level health facilities, decentralized drug delivery by health facility staff in communities), improve access to fungal OI and TB screening and testing, build and strengthen clinical capacity of health providers in the management of HIV through online case-based studies, quarterly virtual mentorship, and training sessions1`, including OI and ART, enhance information systems to better monitor HIV outcomes, specifically among KPs including piloting the use of unique identifier codes to better track KPs through the cascade, improve national capacity to monitor and improve the quality of HIV services, and decrease stigma and discrimination among HIV providers. For the third 90, PEPFAR will increase capacity for monitoring viral suppression, as well as expand access, improve the quality of viral load testing and strengthen information systems to monitor viral load.

One of the main limitations to establishing municipality-level targets is the lack of PLHIV and KP estimates below the national level. PEPFAR is working closely with Ministries of Health, UNAIDS, PAHO, and Global Fund to develop robust estimates through studies and data triangulation. Another limitation is that unique identifier codes are not in place in all countries which allows for the potential of double-counting individuals and hinders the ability to track KP through the cascade to monitor impact. A key assumption of our performance framework is that Global Fund grantees will reach their KP prevention and HTS targets. If they do, joint GF-PEPFAR results will allow priority SNUs to reach 80% coverage for the second pillar of the cascade among KPs. PEPFAR is working closely with Global Fund to coordinate these efforts and avoid duplication.

In FY 2017, the PEPFAR team will support Panama to adopt and roll out an initial implementation of Test and Start by continuing to integrate ARV for all PLHIV into KP-focused clinics and by improving the retention of unlinked PLHIV. Currently, PEPFAR is supporting

rapid readiness assessments to implement ART in five KP-focused clinics as a strategy to decentralize ARV treatment to lower level health facilities. The objective of the assessment is to assist sites and programs in rapidly assessing the critical elements for effective care system and delivery and identifying those elements that need implementing or further strengthening or development prior to T&S implementation. The assessment tool reviews 6 domains: site leadership and model; services and clinical care; health information management; human resource capacity; lab capacity; and drug management and procurement. Site preparation for integration of ARV services is critical for an effective treatment delivery system. . Results of the evaluation will be used to support in-service trainings on HIV medicine to physicians; identify and adopt operational procedures for HIV care, ARV use, required laboratory tests, and patient appointments; select program indicators and develop appropriate system for monitoring and evaluating HIV treatment; develop a formal plan for program quality management, and create an implementation timeline at KP-focused clinics. Lessons learned and best practices from these efforts will be identified and applied to support T&S scale up via the RCM and COMISCA to the rest of Panama and throughout the Central America region.

Table 4.1.1 ART targets in Scale-Up Sub-national Units for Epidemic Control

Country /SNU (municipality)	Total PLHIV	Expected current on ART (APR FY16)	Additional patients required for 80% ART coverage (Total PLHIV *0.8-Current on ART)	Target current on ART (APR FY17) TX_CURRENT	ART Coverage (APR FY17) (Expected/Target Current on ART*100)
Guatemala	**18,588**	**11,303**	**3,567**	**10,173**	**90%**
Guatemala	8,904	6,665		5,999	
Villa Nueva[1]	1,458	-		-	
Mixco[1]	1,640	-		-	
Quetzaltenango	521	1,222		1,100	
Coatepeque	573	1,589		1,430	
Escuintla	2,473	592		533	
Puerto Barrios	989	667		600	
Malacatán	963	428		385	
Retalhuleu	1,067	140		126	
Nicaragua	**7,199**	**1,598**	**4,161**	**1,438**	**90%**
Managua	5,328	1,112		1,001	
Tipitapa[1]	227	-		-	
León	492	190		171	
Chinandega	512	218		196	
Puerto Cabezas	640	78		70	
Panamá	**13,506**	**7,313**	**3,492**	**6,582**	**90%**
Panamá	6,264	5,782		5,204	
San Miguelito	2,710	37		33	
Arraiján[1]	1,541	-		-	
La Chorrera	956	288		259	
Colón	1,394	611		550	
David	641	595		536	
TOTAL	**39,293**	**20,214**	**11,220**	**18,193**	**90%**

Note: Table only includes countries with FY17 activities targeting 2nd pillar. [1] SNUs with no ART sites

Table 4.1.2 Entry Stream for Newly Initiating Adults and Pediatric ART Patients in Scale-up Districts in the Region			
Entry Streams for ART enrollment	**Tested for HIV (APR FY 17)**	**Identified positives (APR FY 17)**	**Newly initiated (APR FY17)**
Adults			
Key Population	35,803	1,810	817
TB patients	2,540	127	
Garifuna	1,425	57	
TOTAL	**39,768**	**1,994**	**817**

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (Scale-up SNUs)**	**Coverage Goal (in FY17)**	**FY 17 Target**
KP_PREV: MSM	66,866	80	55,025
KP_PREV: FSW	6,578	80	3,457
KP_PREV: TGW	6,275	80	4,528
PP_PREV: GARIFUNA	25,378	80	2,615
Total	**105,097**	**80**	**64,443**

Program Area Summaries

4.2 – Prevention

Prevention services provides a platform for identifying new HIV infected KP and linking newly diagnosed PLHIV into the care and treatment cascade, which is the critical first step in achieving 90-90-90 and epidemic control. Since 2014, the Joint HIV Approach (Global Fund, UNAIDS, PEPFAR, PAHO and COMISCA/SICA) set an 80% coverage goal for prevention services to KP in the Central America Region through a defined minimum package of services. Ongoing discussions with the Global Fund implementers and countries in identifying and agreeing on a set of priority locations for KP prevention efforts has implications for PEPFAR to adequately support countries to reach the level of saturation in the high burden SNUs.

Prevention services for KP and PP will continue to be provided across a dramatically reduced but focused number of community and facility sites. In all countries, the Combination Prevention package in community settings is provided by NGOs and includes: at least one BCC activity, on-site HTS and referral to complementary or structural services regarding human rights, stigma and discrimination, attention and care for gender-based violence, STI diagnosis and treatment, family planning, alcohol and drugs programs, legal services, etc. Emphasis will be put on linking positive people to HIV clinical services for treatment and care. PEPFAR also provides TA through a coaching initiative to NGOs receiving Global Fund grants for prevention services. In some countries in the region, PEPFAR, Global Fund and country supported community prevention data have been already integrated through the use of unique registry system, allowing accurate calculation of prevention service coverage.

In FY14, PEPFAR's contribution to prevention services to KP, including KPCF funds, varied from 11% in Guatemala to 57% in Nicaragua. After analysis of epidemiologic, programmatic and site yield data, the regional program prioritized geographic areas to concentrate TA efforts in FY 2016 to get the higher number of KP reached with prevention services and HIV positives cases identified (at least 4 positive cases per site). In FY 2017, PEPFAR contribution to prevention services in priority SNUs will range from 8% in Honduras to 27% in Nicaragua.

Five countries implement the STI surveillance, prevention and control strategy (VICITS), which also includes the provision of a combination prevention package (STI diagnosis and treatment, condom promotion and distribution, HTS, ARV referral, and a second-generation HIV surveillance information system for KP and PLHIV). VICITS data have been integrated into the MoH data structure, allowing MoH officials to merge these data with national HIV databases to monitor HIV epidemic trends among KPs and identify the number of KPs linked to care and treatment. VICITS provide tailored services to KPs at MoH-owned facilities in high KP concentrated SNUs. In FY17, PEPFAR will continue to support already established MoH-owned VICITS clinics that have been effective and efficient in identifying at least 4 HIV positives and new MoH-owned clinics that are located in SNUS with high KP concentration. This data-driven approach will allow PEPFAR to strategically target KP concentrated SNUs where HIV is most prevalent and in which we can achieve sustainability and the greatest impact for our investment.

An important challenge to note in the region is the sustainability of the national responses across Central American countries, given that PEPFAR continues to fill gaps in the area of KP. Future investments should be maintained to guarantee KP access to prevention services. The current strategy is to build capacity among local civil society organizations and to advocate for increased participation of the public sector. The potential of the public sector to sustain prevention services for KP remains low, as discussed at the Sustainability Index workshops in each country. The domain for domestic resource mobilization graded low across the board, with an exception in Honduras. The Global Fund has asked some Central American countries to propose mid-term sustainability plans for prevention services to KPs while for others these are currently being discussed. Weaknesses in NGO capacity to refer KPs to other services have been identified during SIMS implementation visits and immediate action plans for remediation have been put in place.

In FY2017, PEPFAR will continue to tailor innovative strategies to reach hidden layers of MSMs & TGW including social media promotion in Facebook, WhatsApp, and Twitter in all countries in order to improve key population coverage rates. PEFPAR partners have had significant success in identifying hidden MSM using 'cyber-educators', who have been able to access closed areas of social media geared towards MSM where they send prevention messages, invite MSM to get tested and offer support such as accompanying them to a testing site. The use of specific tools to conduct online outreach with MSM and TGW will be developed and conducted. PEPFAR will continue to provide technical assistance to governments to implement outreach strategies beyond the clinical settings and to identify areas to increase quality, and improve and track coverage.

4.5 – HIV Testing and Counseling

The primary challenge for FY 2017 is to increase yields across HIV Testing Services (HTS) programming in Central America. In particular, the team is prioritizing the implementation of innovative community-based strategies for case finding among hidden key and priority populations across the region.

HIV testing and counseling for key and priority populations will continue to be provided across a range of community and facility-based settings. In comparison to FY15 HTS results, PEPFAR will be more strategic in providing HTS services in selected high burden SNUs for community prevention and at MoH-owned KP-friendly clinics in high-burden SNUs.

PEPFAR's approach includes in-service training at facility levels (i.e., VICITS), peer educators working at the community level, and NGOs, mobile labs, supply, provision and distribution of rapid tests kits, mobilization to support HTS, and linking/tracking people tested to the appropriate MoH services. Counseling and testing services at the community level are reaching KPs in hot spots such as: brothels, night clubs, markets, cruising areas, etc. As part of the Central American HIV Sustainability Strategy launched in 2012, Central American governments are increasing their participation in HTS provision, which remains limited in reaching KP, while PEPFAR and Global Fund currently are focusing HTS efforts mainly in KP.

In order to increase yield in community settings, PEPFAR will implement a two-pronged approach, through in-person engagement using a peer-to-peer outreach and through the use of virtual networks and information technology communication strategies. The peer-to-peer strategies will be implemented through CBOs selected for their perceived standing in the community as well as their experience with and access to key and priority populations of interest and background in HIV prevention. The CSOs will identify high risk or HIV positive KP peer recruiters who will work with CSO staff to reach an additional three to five KP peers in their social and sexual network who are at high risk for acquiring HIV or who have not been tested for HIV within the last 6 months. The recruiters will look for KPs who are not linked to the organizations themselves and are potentially part of a "hidden" KP group. Recruiters will be given incentives when their identified KPs consent to HTS. The peers who are brought in by the recruiters have the potential to become recruiters themselves based on their risk factors and their social and sexual network. The use of KP peer recruiters will allow PEPFAR to engage hard-to-reach and hidden KPs and to offer one-on-one HTS and linkage to care, thus improving yield. A similar peer approach will be used among the Garifuna as well and the USG will work to obtain better information about higher risk Garifuna sub-groups to ensure interventions are strategically targeted for those groups.

Through the CBOs, KPs will be able to access rapid HIV tests at the CBO sites, KP-friendly health centers or in the comfort of their own home or office by making use of the CBO's personalized mobile HIV-testing services. This approach will help ensure upmost confidentiality and comfort for the KPs. Beginning in FY17, each KP tested by the CBO on or off-site, will be assigned a Unique Identifier Code (UIC) hosted on an online secure platform. The UIC will be linked to either their fingerprint or national ID to track KP's through CBOS and facility systems while protecting his/her identity. If the HIV test is negative, the UIC will allow the CBO to track the user in follow-up visits to ensure prevention services and counseling are provided and avoid duplication. If the HIV test is positive, the UIC will facilitate tracking of the individual through the HIV cascade to viral suppression with the support of KP peer navigator, who will personally accompany the newly diagnosed individual to treatment and care services.

Social media and other information technology communication tools will also be implemented to help the CSOs reach a greater range of KPs through discrete mediums. The use of these tools, such as social media sites, mobile apps, SMS messaging, and websites, will help refer users towards the CBOs to access rapid HIV test in a cost-free, discreet and effective manner. PEPFAR partner's cyber-educators provide on-line contacts with a printable or virtual voucher, which they can present for a free HIV test at PEPFAR partner clinics and if positive they are immediately linked to care and treatment services.

4.6 - Facility and Community-based Care and Support

In FY 2017, PEPFAR will continue to target programming around approaches linking KP PLIV into care, both newly diagnosed PLHIV and PLHIV who have previous enrolled but since defaulted from services. To improve linkages to HIV care and treatment for KPs in the region, the PEPFAR package of services includes accompanying of newly diagnosed KPP PLHIV who test positive in supported NGO, private sector sites, or public sector VICITS clinics to enroll in comprehensive care and treatment clinics. Most of the countries in the region have measured the cascade in accordance with the latest WHO guidance, and national and regional plans are being developed to close gaps and barriers for ensuring comprehensive care and treatment services. Facility and community networks are working together to improve referral and follow up at both the community and household level.

The Continuum of Care (CoC) approach for PLHIV identified through prevention efforts at facility and community level includes a network of linked, coordinated HIV care, treatment and support services for PLHIVs and KPs provided by collaborating organizations or other key stakeholders. Care currently includes the use of mobile CD4 testing to identify patients in need of treatment according to national guidelines (while advocating at national level for implementation of Test and Start policies). The enrollment target will include several entries to the CoC: clinical care patients not on ART, TB-HIV patients not on ART and through HTS programs linked to prevention platforms. Work with PLHIV support groups and peer navigators to provide community- based case management and adherence support services (including adherence counseling and retention support, treatment literacy education and intensive community- and home- based follow- up) for HIV- positive KPs will help to improve treatment initiation and retention by improving the access to better quality, more integrated HIV prevention, care and treatment services closer to home in welcoming settings that protect PLHIV privacy. PEPFAR will support KP-led Community Based Organizations (CBOs) in the development of trained peer educators and navigators who can help KPs at risk for HIV access HTS and support their navigation of HIV services across the entire cascade. These peers will be able to address the multi-faceted needs of KPs in a non-stigmatizing way.

The regional program will continue to provide TA to a number of public sector health facilities to strengthen linkages to care and treatment and improve the quality of services. Facilities are selected for their HIV burden and proximity and appropriateness for serving key populations. A Memorandum of Understanding (MOU) between the facilities and local CBOs will ensure a successful referral/counter referral system. In the facility setting, PEPFAR will improve case finding among KP groups and emphasize the intervention stages of "treat and retain" as key steps to ensure long-term ART adherence that results in suppressed viral load and enhanced quality of life. A KP peer navigator will continue working with each CBO in coordination with the health facilities that PEPFAR will be supporting.

PEPFAR will work to strengthen the partnership between civil society organizations and identified KP-friendly healthcare facilities to link KP living with HIV to peer navigators and

support groups from their first contact with health care providers. Working with these health units, PEPFAR will create a community-clinic-community referral system which will include a referral/counter referral system in order to track KPs, with their consent, through the cascade.

The need for updated protocols in the region represents a challenge for the implementation of T&S, although several countries have already expressed their interest and commitment to initiating T&S as soon as possible and PEPFAR will be actively advocating with all countries to ensure their adoption of T&S as soon as possible. In FY17, PEPFAR will update the official protocols in at least two countries. The implementation of Test and Start will be piloted in Panama and expand to the rest of the region throughout the year.

The timing of ART start should reflect evidence-based guidelines that include rapid start for persons with OIs, pregnancy, or TB. For asymptomatic persons, consideration of early/same day ART initiation awaits evidence-based studies conducted in programmatic settings. Patient buy-in and understanding are valued and counseling should reflect this without requiring compulsory systematized "literacy training".

We will support the different information systems existing in the region and create a module of ARVs monitoring, we will also support the programs to update the databases, improving quality and making a friendly information system.

4.7 - TB/HIV and other Opportunistic Infections (OI)

Tuberculosis (TB) is the leading cause of morbidity and mortality among persons living with HIV (PLHIV). The risk of developing TB among PLHIV is 20–37 times higher compared with HIV-uninfected people. In the region, an estimated 9-21% of TB patients who test for HIV received a positive result. WHO Policies recommend that all PLHIV be regularly screened for TB as a routine component of every clinical visit using a clinical algorithm and that PLHIV with at least one of these symptoms (i.e., presumptive TB) should be further evaluated for TB disease. If positive, they should initiate TB treatment, and if negative, they should be given IPT (isoniazid preventive therapy). IPT has the potential to decrease TB-related cases and deaths in PLHIV and it is recommended that PLHIV without active TB should receive at least 6 months of IPT. Overall, the TB/HIV activities will support the countries in achieving the 90/90/90 goals through:

- support of provider-initiated HIV testing and counseling for confirmed and presumptive TB patients, closing the gap of undiagnosed TB/HIV patients.
- support of the integration of TB/HIV care and treatment, PEPFAR will support the number of people that receive ART and ensure linkage and retention of HIV+ TB patients.
- Given that TB has been shown to increase HIV viral load, PEPFAR will support viral suppression among PLHIV through TB preventive measures such as IPT and TB IC support.

TB and HIV services in the region are provided at separate sites in most locations. Currently, TB clinic staff provide HIV testing and IPT in some cases, but they are not able to start ART. Similarly, in ART clinic settings, although TB screening is not routinely performed, symptomatic patients are tested for TB, and if positive, they are referred to the TB clinic for treatment. Due to the lack of integration of TB and HIV services, it is a challenge to implement TB/HIV collaborative activities, monitor linkage to care of HIV+ TB patients, and create a unified reporting system.

Global Fund supports TB/HIV collaborative activities in the region such as TB treatment, and staff salaries of TB/HIV supervisors. PAHO also provides TA so countries can follow the WHO TB/HIV guidelines and report on global indicators. There remain gaps in the support needed for countries in the region where PEPFAR can collaborate such as: TA to review and validate TB/HIV national guidelines, laboratory strengthening, monitoring and evaluation, data management and training for healthcare staff to reduce HIV burden among TB patients, and interventions to reduce TB burden among PLHIV. PEPFAR will provide TA to high burden priority SNUs in HTS to better identify HIV infection among TB patients.

In FY2017, PEPFAR will focus on the following core activities for TB/HIV with the ultimate goal of increasing ART coverage of TB/HIV co-infected to 100% in the following 2 years. The technical assistance will be provided to three SNUs in Guatemala (Escuintla, Malacatan, and Coatepeque), two SNUs in Honduras (Francisco Morazan and San Pedro Sula), one SNU in El Salvador (San Salvador), one SNU in Nicaragua (Managua), and two SNUs in Panama (Panama City, Colon):

1. Ensure provider-initiated HIV testing and counseling for presumptive TB or TB disease in eleven TB clinics: Guatemala (3), Honduras (4), El Salvador (3) and Panama (1).
2. Ensure that 100% of identified TB/HIV patients start ART .
3. Ensure that 100% of all PLHIV are screened for TB using the 4-symptom screening tool at each clinic visit; and implement, track, and report on TB screening of PLHIV in nine HIV clinics in Guatemala (3), Honduras (4), El Salvador (1), Nicaragua (1), and Panama (3).
4. Follow-up for PLHIV that screen positive for TB with diagnostic tests and link to care to initiate treatment.
5. Expand interventions to improve early diagnosis and treatment of TB among PLHIV and support scale-up of Xpert MTB/RIF testing in Guatemala and Honduras.
6. Support isoniazid preventive therapy (IPT) for PLHIV who do not have active TB disease in nine HIV clinics in Guatemala (3), Honduras (2), El Salvador (1), Nicaragua (1), and Panama (2).
7. Support the integration of TB/HIV care and treatment to ensure linkage and retention of HIV+ TB patients by providing TA to TB and HIV national programs, and supporting the implementation of national TB/HIV guidelines (Guatemala, Honduras, Panama, and El Salvador).
8. Support TB infection control (TB IC) measures to prevent transmission of TB in healthcare and community settings by training health care workers, conducting risk assessments and implementing local TBIC plans throughout the region.
9. Strengthen TB/HIV program monitoring and evaluation (M&E) by providing tools and creating efficient referral and counter-referral systems in TB and HIV clinics.

Other OIs which are important in the region are fungal infections. PEPFAR will support this activity because fungal OIs such as Histoplasma and Cryptococcus are endemic in the region and fungal OIs are among the most frequent causes of death among PLHIV. Histoplasmosis and TB present with similar clinical features and regular diagnostic tools for histoplasmosis take too long (culture take up to 6 weeks). Therefore, HIV patients are misdiagnosed and do not receive appropriate treatment on time. In addition, the co-infection of TB and fungal OI (histoplasmosis and cryptococcosis) is high among HIV patients; one study shows that 22% of HIV patients were co-infected with TB and fungal OI.

Many challenges exist in the region including low access to quick diagnostic tools, and shortage of fungal disease treatments. Therefore, PEPFAR will strengthen laboratories throughout the

region in the diagnosis of fungal OIs and will strengthen information health systems and surveillance of fungal OIs among PLHIV. PEPFAR will continue supporting Guatemala, Honduras and El Salvador by providing laboratory trainings, lab tests and supplies, as well as trainings for clinicians in fungal OIs. In addition, PEPFAR will scale up this support in Panama and Nicaragua. Finally, PEPFAR will provide TA to Ministries of Health and National Laboratories in screening and preventive treatment of OIs to help prevent morbidity and mortality caused by fungal OIs among PLHIV.

4.8 – Adult Treatment

Over the past few years, access to ART has increased with funding provided by partner governments and the Global Fund. The total number of patients on ART currently reported by the National AIDS Programs in the region is slightly over 41,000. While UNAIDS in 2013 reported that ART coverage in the region ranges from 50% (El Salvador) to almost 76% (Costa Rica and Panama), all countries report that there are no waiting lists for treatment and ART is available for all eligible patients (although the CD4 <500 rule is still the official policy).

Treatment is provided free of charge at public hospitals at both Ministry of Health and Social Security facilities, and in most countries care and treatment services are offered in Comprehensive Care Centers. While all Comprehensive Care Centers are physically located on hospital grounds, integration with other hospital services and structures vary widely between and within countries. Comprehensive Care Centers often have a team of interdisciplinary staff which include physicians, pharmacists, social workers, psychologists and nurses and often include nutritionists, gynecologists, and other specialists.

Additionally, the new 2015 WHO treatment guidelines will increase the number of PLHIV eligible to initiate ART. The projections of adults in the region needing ART, according with the new guidelines are 130,000; is a significant increase as compared with the 2010 WHO Guidelines. PEPFAR will provide TA to MOHs in the region to be prepared to scale up the number of PLHIV enrolled in treatment and to initiate the adoption of Test and Start. The team will also conduct cost-effectiveness studies to demonstrate the cost efficiency of adopting Test & Start.

Technical assistance for local PLHIV groups will be provided to ensure their work continues to be a part of the continuum of care and that PLHIV are engaged in all levels of decision making and implementation of care programs and can advocate for quality care. These groups will implement training for community counselors, educational activities for PLHIV, home visits, coordination with the MOH, promotion of adherence to ARV treatment, psychological support, reduction of stigma and discrimination at community level, nutrition, family counseling, and HIV prevention.

By partnering and building capacity of both private and public sectors, PEPFAR is improving the Continuum of Care (CoC) and expanding the type and quality of services targeted to PLHIV and KPs. PEPFAR assists Ministries of Health and Social Security Institutes in the region to decentralize and ensure quality HIV care and treatment from tertiary care hospitals to secondary and primary levels through the implementation of performance improvement plans, and supportive supervision approach for HIV/AIDS services in health facilities across the region. Improving access to and the delivery of services will also improve client retention and adherence to care and treatment. Networks, where the participation of KPs is addressed, complements the circuit of the CoC of HIV treatment, and through networks the support

services of existing community and facility providers have been strengthened and empowered. This approach forms the foundation for service delivery and quality improvements and establishes frameworks for accountability between clients in the community and service delivery providers. As some countries look to decentralize services such as Honduras, PEPFAR will support the development of standards and protocols for HIV/AIDS treatment and management to ensure the quality of care and support efforts for certification and licensure of services where appropriate.

With a concentrated epidemic in the region, PEPFAR plays a crucial rule in addressing key structural barriers experienced by key populations in accessing treatment and the largest of those continues to be stigma and discrimination. PEPFAR will be working at the site level through trainings and the engagement of the abovementioned networks to change stigma and discrimination related attitudes and behaviors of health care providers and other health facility staff, and also at the national and regional levels to ensure that official policy emphasizes the right of all individuals to access treatment free of stigma. The key initial step to getting KPs on treatment is getting them tested and while PEPFAR continues to work to expand access to counseling and testing for KPs, PEPFAR will work together with Ministries of Health and civil society to offer KPs friendly counseling and testing services with referrals to care and treatment. PEPFAR will also be actively promoting a model where treatment will be provided in these KP friendly spaces.

Performance improvement strategies are being implemented at treatment sites with PEPFAR support to improve and maintain the quality of care. PEPFAR is working to strengthen supply chain management to ensure ARVs and other key commodities are available for not only treatment, but as well for prevention and care. PEPFAR is building laboratory capacity in areas such as genotyping and viral load testing to support treatment and accurately identify drug resistance and treatment failure. PEPFAR supports in-service training to ensure that clinicians are properly prepared to provide quality treatment services

While governments cover the costs for care and treatment, with support of the Global Fund, PEPFAR supports the improvements in the distribution systems and warehousing. Both Global Fund grants and PEPFAR projects aim at ensuring KPs friendly services are available in care and treatment sites as well as quality services provided for PLHIV. Additional programs will assist in the adherence and support for PLHIV through support to networks and community groups of KPs and PLHIV. Prevention with Positive efforts support in keeping them closely connected to care centers.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

PEPFAR's approach in Central America prioritizes the delivery of a comprehensive package of prevention, care and treatment services in facility and community settings, primarily targeting key and priority populations complemented by wrap-around support to improve the quality of services with the expectation that KP and PP will benefit significantly from this investment.

Community Level
As described in Section 4, PEPFAR efforts at the community-level are focused on reaching individuals at highest risk among key and priority populations for more effective case-finding leading to higher yield testing and ultimately greater impact. The community is also a critical setting for activities leading to the achievement of 90-90-90 targets for ART coverage and viral suppression, in particular leveraging engagement with KP and PP networks to more effectively track PLHIV who have defaulted from care and relink them into the HIV service cascade.

For identification of PLHIV, the community-based approach is two-pronged, through the use of virtual networks and information technology communication strategies as well as in-person engagement through the employment of peer-to-peer outreach, usually through the context of a CBO with appropriate community standing and access to the hidden segments of the population. Peers from the community of interest will be deployed to engage others at high-risk and offer testing at a variety of locales for increased acceptability and uptake, including at the hotspot, the client's home, the CBO, or the facility. When feasible in the context of the national program, incentives will be used to increase the effectiveness of the peers' engagement with high risk individuals.

Efforts to increase ART coverage and ultimately viral suppression among PLHIV on ART, PEPFAR creates meaningful partnerships between community groups and facilities to ensure smooth and effective linkage to ART for newly diagnosed PLHIV as well as tracking and relinking of PLHIV who have defaulted. One component of this is the support for enhanced information systems, including implementation of unique identifier codes that allow for improved tracking of individuals as they move in and out of the system. A second component is the implementation of systems for regularly identifying patients who have defaulted from care and deployment of peer navigators to find and relink these PLHIV for new initiation and/or re-engagement with HIV treatment.

Facility level
At the facility, PEPFAR ensures that prevention, care, and treatment services provided either in KP-specific or general clinical settings, are comprehensive, of high quality, accessible and appropriate for key and priority populations, and free of stigma and discrimination.

PEPFAR supports a facility-based prevention package that includes index testing, testing of presumptive TB cases, and extended clinic hours for increased access and uptake by KP. PEPFAR increases ART coverage by ensuring ART initiation is according to national guidelines while simultaneously working at national level to improve national policies, including the aggressive promotion of T&S to eliminate leaks in the cascade between diagnosis and ART initiation and for greater impact. PEPFAR's package of support to increase ART coverage and

retention includes technical assistance to facilities to implement systems for routine QA/QI, system activities, ongoing clinical mentorship and training to improve HRH, strengthening of lab networks with a focus on improved access to high quality viral load testing, and enhancement of health information systems. Notably, PEPFAR will increase ART coverage and retention through its support for the decentralization of ART services, including the fast tracking of drug refills and integration of ARV services into KP-focused clinics. PEPFAR will also promote innovative drug delivery models beginning with the implementation of a study to measure feasibility, costs, and benefits of WHO recommended service delivery models among KPs at lower level health facilities and by health facility staff in communities. These differentiated treatment approaches will be models to be scaled up in the region through the Regional Coordinating Mechanism.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

As a technical assistance program, system investments represent a central part of PEPFAR strategic support in the Central America region. For FY 2017, the regional team has analyzed the gaps at the regional, national and sub-national levels to see where our systems support can achieve the greatest impact for the 90-90-90 goals with a focus on the KP clinical cascade in all countries.

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

While the countries in the region face similar challenges, PEPFAR team has identified programmatic gaps per country and systems investments by country. The below summary will highlight programmatic gaps found in one or more countries, while the tables detail each gap and proposed activities by country.

QUALITY & HUMAN RESOURCE CAPACITY

The need to improve the quality of services for KPs across the clinical cascade was identified as a major gap in all five countries, although the specific barriers were slightly different. In El Salvador, the quality of services are low with stigma and discrimination being highlighted as the major issue to be addressed along with lack of country led-analysis on how to improve quality and institutionalize quality improvement. In Guatemala, the lack of quality HIV clinical services represents a major gap with a specific focus on the quality for laboratory services and like El Salvador stigma and discrimination from health care providers constitutes a barrier to improving quality. The fact that quality assurance and quality improvement are not part of the Guatemala national HIV/AIDS strategy is also an important barrier. In Honduras, the quality related gap is that HIV services are not deemed comprehensive by PLHIV and barriers include lack of comprehensive QA/QI plans at HIV care and treatment centers. In addition, limited training among health workers to provide counseling on disclosure and couples/family counseling, stigma and discrimination, and gender-based violence and lack of comprehensive STI prevention, diagnosis, and treatment services for PLHIV means that PLHIV perceive the services to be of low quality. In Nicaragua the lack of quality sustainable coverage of care and treatment services for PLHIV is the gap with the barriers of low quality services including lack of technical capacity and services are not sustainable due to the fact that civil society participation is highly dependent on external support. In Panama, the poor quality of HIV services was also cited as a major gap with the barriers being lack of country-led analysis on the quality of HIV services and lack of civil society engagement to improve quality. In addition a barrier to improving the quality of services is the lack of sufficient qualified personnel to work in HIV/AIDS. In Guatemala, the lack of qualified personnel to work in HIV/AIDS with a special emphasis on supply chain and laboratory was deemed a significant enough issue to represent another programmatic gap. The related barriers are lack of laboratory HR capacity, low investments in the national supply chain plan, and lack of human resource sustainability, especially in terms of training.

The lack of quality services with issues like stigma and discrimination and unqualified human resources have a direct impact on the cascade for key populations and the ability of countries in the region to link successfully link individuals to treatment and to retain them in treatment. PEPFAR has identified strategic activities to help address these gaps in each country.

STRATEGIC INFORMATION

In three countries, a programmatic gap identified related to lack of strategic information regarding the cascade. In El Salvador, while the information system has many strengths, the lack of overall strategic information on the KP specific cascade represents a gap and barriers include the lack of accurate of KP strategic information and then the fact that KP information is not used appropriately for decision-making. In Guatemala, the lack of updated HIV care and treatment data remains a gap with consistent delays in inputting data into the MANGUA (national MoH) information system and a lack of adequate quality control procedures of information systems at HIV care and treatment centers. A lack of standardized information systems across the HIV Continuum of Care is a major gap in Honduras with a lack of unique identifiers to track KP individuals through the Continuum of Care; non-standardized data collection tools and procedures and a lack of adequate quality control procedures for information systems at HIV care and treatment centers. Having the necessary data is key to improving the KP cascade and PEPFAR will help build capacity in strategic information with the activities proposed.

INSUFFICIENT TESTING AMONG TRANSGENDER WOMEN AND MSM POPULATIONS

In El Salvador, Nicaragua and Panama, testing for TGW and MSM represents a major programmatic gap and in all three countries barriers include low levels of HIV diagnoses among KPs, stigma and discrimination in health facilities where testing takes place, and NGO financial dependence to provide preventative services, including testing or the need for support from non-traditional sectors to help cover funding gaps in services for KPs. Finding HIV+ individuals in these two key populations is a priority for PEPFAR and the activities proposed will help address the systems barriers that impact the ability to test and treat these KPs.

In addition to these gaps found across several countries, Guatemala also had a gap related to strengthening civil society and non-traditional sector involvement in HIV/AIDS programs with barriers including, the fact that civil society organizations are highly dependent on external support and there is an overall low investment in KP programs and there is low participation of non-traditional sectors in the national HIV/AIDS response. In Panama, lack of laboratory capacity for HTS, baseline CD4, routine VL and TB diagnostics represented an additional programmatic gap with barriers identified as lack of laboratory HR capacity and low quality of laboratory services so still related to the recurring issues of quality and human resource capacity previously mentioned.

#1. EL SALVADOR

Table 6.1.1a Key Programmatic Gap #1 in El Salvador: Low Quality of Services with Stigma & Discrimination						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Lack of country-led analysis on the quality of HIV services	1. A national and subnational QA/QI plan is being implemented and patient adherence will be improved 2. QA/QI plans and systematic evaluations will be used to improve performance	Quality improvement for community-based services for KP care and treatment including program assessment	HBHC	$15,000	*[REDACTED]*	**Result:** Proven improvement of the quality of HIV clinics through yearly measurements **Goal**: 85% of PEPFAR-supported clinical sites with quality improvement activities implemented that address clinical HIV program processes or outcomes
		Support the implementation of policies to improve the quality of the KP focused cascade	HBHC	$40,000	*[REDACTED]*	**Result:** Create quality improvement plans and have them executed. **Goal**: 85% of PEPFAR-supported clinical sites with quality improvement activities implemented that address clinical HIV program processes or outcomes
		External QA Proficiency Panels	HLAB	$2,163	*[REDACTED]*	1 facility will receive satisfactory score in HIV proficiency testing by the end of FY17
		Continuous Quality Assurance	HLAB	$40,391	*[REDACTED]*	3 participating laboratories will increase SLMTA score by 30% compared to baseline by the end of FY17
Stigma and discrimination from health service providers towards PLHIV	1. Patients report less stigma and improve ART adherence	Analysis of barriers on adherence to treatment with focus on KPs	HBHC	$47,350	*[REDACTED]*	**Result:** Plans to improve adherence of key populations living with HIV by clinic. **Goal:** 85% of PLHIV who reported care free of stigma and discrimination by HIV service providers
		Facility- and community-based activities to improve the reach and retention of KP in treatment to achieve viral load suppression	HBHC	$116,420	*[REDACTED]*	**Result:** People living with HIV that have abandoned treatment and have returned to treatment. **Goal:** 3750 adults currently receiving

						antiretroviral therapy (ART)
		Capacity building of civil society organizations that interact with the health system to improve access for KPs	HVOP	$34,405	*[REDACTED]*	4 civil society organizations trained in provision of quality care for KPs (Data source: MIS)
		Awareness and training on Gender, Stigma and Discrimination for health care providers to improve quality and access to services for KPs	HVOP	$30,000	*[REDACTED]*	**Result:** HIV clinics personnel certified in competencies and sensitized on gender and stigma and discrimination subjects. **Goal**: 25 healthcare workers that have successfully completed gender, stigma and discrimination in-service training.
		Expand and institutionalize the Coordinated Community Response (CCR) to support adherence to ARVs with a focus on KPs.	HBHC	$48,000	*[REDACTED]*	**Result:** NGOs, Community Based Organizations, Support Groups or self support groups that coordinate with HIV clinics to reduce stigma and discrimination and improve adherence of people living with HIV. **Goal:** 85% of HIV clinics that have coordinated with NGO, CBO and support groups, specific actions based on the analysis of strategic information to improve adherence, prevention with PLWH, and social environment with KP
		Support and defend the rights of HIV-infected and -affected individuals, MSM, Transgender population and FSWs	OHSS	$44,500	*[REDACTED]*	Two advocacy and information policy campaigns aimed at eliminating stigma and discrimination against PLHIV and KP through HIV positive policy changes and political support.
		Provide technical assistance for implementation of HIV related Gender-Based Violence protocols with focus on KPs	HVOP	$54,500	*[REDACTED]*	Two barriers removed for the implementation of HIV related Gender/Based Violence for KP in the health facilities supported by PEPFAR
TOTAL				S472,729		

Table 6.1.1b Key Programmatic Gap #2 in El Salvador: Lack of adequate strategic information on KP cascade

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism	Milestone
Lack of accurate KP strategic information	1. Information for HIV continuum of care cascades for KPs at all PEPFAR-supported facilities and municipalities by the end of FY17.	Share methods, tools, and other useful information, improve M&E skills and knowledge; and share best practices and lessons learned to ensure proper monitoring of KP focused cascade	OHSS	$39,500	*[REDACTED]*	At least ten HIV studies on the following topics: continuum of care studies, surveillance, stigma and discrimination survey, other survey data or at least a summary report of data and analysis; are made available to stakeholders and targeted audiences in a timely way in municipalities supported by PEPFAR.
		Modes of Transmission	HVOP	$18,000	*[REDACTED]*	At least two dissemination events to targeted audiences on updated information decision-making tools and presentations with results of MoT estimations (updated with the Investment case) and the number of expected HIV new infections in KP at national level and municipalities supported by PEPFAR.
		HIV Case-Based Reporting	HVSI	$34,580	*[REDACTED]*	1 analysis of the cascade disaggregated by municipality and key population will be conducted by the end of FY 17
		Support for the National Strategic Information Forum	OHSS	$5,000	*[REDACTED]*	At least two forum implemented at the national level to delivery strategic information on the HIV continuum of care, investment case and stigma and discrimination studies and others, are made available to stakeholders and decision makers in a timely way at the national level and municipalities supported by PEPFAR.
KP information not used appropriately for decision making	1. MoH using accurate information for HIV continuum of care cascades KPs at all PEPFAR-supported facilities and municipalities by the end of FY17.	Training in Using Information for Decision Making with a focus on information related to KPs	OHSS	$8,500	*[REDACTED]*	Two training workshops implemented, on the use of strategic information related to KP addressed to decision makers at the municipalities supported by PEPFAR.
		Provide technical assistance to develop and implement monitoring and evaluation (M&E) plans to ensure focus on KPs and monitoring of the KP cascade.	OHSS	$39,500	*[REDACTED]*	Annual M&E report prepared by the host country government to monitor and report the HIV continuum of care indicators, highlighting KP situation.

		Regional HIV Data Use and Trainings	HVSI	$7,500	*[REDACTED]*	2 persons will be trained in the Introduction of Economic Evaluation and the application of cost analysis in addressing program policy questions, and the use of GIS to map HIV burden by municipality by the end of FY17
		Trainings workshops for HIV Surveillance, Data Analysis and Data QA	HVSI	14,850	*[REDACTED]*	Medical Staff will be trained in HIV Surveillance, Data Analysis and Data quality Assurance to improve HIV prevention and Treatment program in Military Personnel to produce reliable periodic report for decision making based on evidence
TOTAL				$167,430		

Table 6.1.1c Key Programmatic Gap #3 in El Salvador: Insufficient testing among transgender and MSM populations						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Low level of diagnosis among KP - particularly transgender and MSM populations	1. Increased focus on KP and high-concentration areas 2. KP diagnosis improved 3. Innovative approaches to such social media tools and peer educators are used to identify KP	TRAC (Tracking Results Continuously) for MSM, TG, FSW, MAR, PLWHA to assess the impact of interventions for KP CoC with focus on the first two pillars of the cascade	HVOP	$123,353	*[REDACTED]*	61.3% of MSM and 87.9% of Trans who received an HIV test (Data source: TRaC 2015-2016)
		Support to national and regional HIV/AIDS strategic planning to ensure focus on Key Populations, the cascade and the recommendations of the new WHO guidance.	OHSS	$34,500	*[REDACTED]*	A five years National Strategic Plan updated to respond to HIV KP cascade and the new WHO guidance. Annual NASA Report published and monitoring investment in KP.
		Increase HIV diagnosis through incidence testing	HVCT	$57,327	*[REDACTED]*	464 rapid HIV incidence tests will be conducted by the end of FY17
		Rapid Test Quality Improvement (RTQI)	HLAB	82,693	*[REDACTED]*	80% of staff at each participating laboratory implementing RTQII will be trained by the end of FY17
		Support to Global Fund programs and activities, and donor coordination to ensure focus on KPs in prevention programs	HVOP	36,000	*[REDACTED]*	50 individuals from GF sub-recipients and others trained in prevention and health services topics (Data source: MIS)
Stigma and discrimination in health facilities where HTS takes place	1. Legal framework improved: Transgender Identity Law promoted and approved. 2. Providers have been sensitized and trained in	Provide legal and advocacy assistance to Key Population groups to reduce stigma & discrimination & ensure KP access to services	HVOP	$54,500	*[REDACTED]*	At least three positive policy changes implemented to reduce stigma & discrimination & ensure KP access to HIV services in health facilities
		Stigma and Discrimination Index to Assess Improvement in Reducing Stigma & Discrimination towards KPs	HVOP	$6,500	*[REDACTED]*	One study report on stigma and discrimination index highlighting on the situation of KP published, and targeted dissemination among key actors of the national HIV response.

	gender norms	Reduction of Stigma & Discrimination towards KP including training	HVOP	$40,000	*[REDACTED]*	75% Percent of people working in institutions/facilities (e.g., managers, health care workers) trained who are not uncomfortable working with or treating KPs. (Data source: Pre-post test)
Low participation of non-health sectors in the national response to HIV to help cover KP services funding gap	Non-health sector participates actively in the national response	Increased involvement of the Ministry of Finance and non-health public sectors in the HIV response, including transfer of work with private sector to the Ministry of Labor in each country to continue to develop HIV workplace policies.	OHSS	$54,500	*[REDACTED]*	Ministry of Finance conduct at least two events to discuss about HIV financing and sustainability strategies. Business sector and Ministry of Labor agreement for promoting the continuation of the development of HIV workplace policies.
		Support for the UNAIDS-led Investment Case Development	OHSS	23,500	*[REDACTED]*	One secondary analysis published and targeted dissemination to compare the HIV cost effective investments alternatives and results to promote policy changes and practices.
TOTAL				$512,873		

#2. GUATEMALA

Table 6.1.2a Key Programmatic Gap #1 in Guatemala: Lack of Updated HIV Care and Treatment Data						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Consistent delays in inputting data into MANGUA information system	1. HIV continuum of care cascades at all PEPFAR-supported facilities and municipalities by the end of FY17	HIV Case-Based Reporting	HVSI	$34,580	*[REDACTED]*	1 analysis of the cascade disaggregated by municipality and key population will be conducted by the end of FY 17
		National Strategic Information Forum	HVSI	$8,000	*[REDACTED]*	At least two forum implemented at the national level to delivery strategic information on the HIV continuum of care, investment case and stigma and discrimination studies and others, are made available to stakeholders and decision makers in a timely way at the national level and municipalities supported by PEPFAR.
		Support for the National Report on Basic Indicators	HVSI	$5,000	*[REDACTED]*	One report published of the host country of HIV epidemiological data, surveys and surveillance indicators prioritized including the cascade indicators.
Lack of adequate quality control procedures of information systems at HIV care and treatment centers	1. HIV continuum of care cascades at all PEPFAR-supported facilities and municipalities by the end of FY17.	Training in Using Information for Decision Making	HVSI	$12,400	*[REDACTED]*	Two training workshops implemented, on the use of strategic information related to KP addressed to decision makers at the municipalities supported by PEPFAR.
		Share methods, tools, and other useful information; improve M&E skills and knowledge; and share best practices and lessons learned to ensure proper monitoring of KP focused cascade	HVSI	$65,000	*[REDACTED]*	At least 10 HIV studies on the following topics: continuum of care studies, surveillance, stigma and discrimination survey, other survey data or at least a summary report of data and analysis; are made available to stakeholders and targeted audiences in a timely way in municipalities supported by PEPFAR.
		Regional HIV Data Use and Trainings	HVSI	$28,534	*[REDACTED]*	6 persons will be trained in the Introduction of Economic Evaluation and the application of cost analysis in addressing program policy questions, and the use of GIS to map HIV burden by municipality by the end of FY17 (two persons

						from Belize, Costa Rica, and Guatemala)
		Trainings workshops for HIV Surveillance, Data Analysis and Data QA	OHSS	$14,850	*[REDACTED]*	Three training workshops implemented, on strategic information addressed to Military Health Staff to improve the decision making process based on evidence
		Provide technical assistance to develop and implement monitoring and evaluation (M&E) plans to ensure focus on KPs and monitoring of the KP cascade.	HVSI	$85,000	*[REDACTED]*	Annual M&E report prepared by the host country government to monitor and report the HIV continuum of care indicators, highlighting KP situation.
		Modes of Transmission	HVCT	$18,300	*[REDACTED]*	At least two dissemination events to targeted audiences on updated information decision-making tools and presentations with results of MoT estimations (updated with the Investment case) and the number of expected HIV new infections in KP at national level and municipalities supported by PEPFAR.
		TA to support HIV Military Commissions in Strategic Planning, M&E and Data for Decision Making	HVSI	$7,000	*[REDACTED]*	At least two annual meetings to review programmatic and epidemiologic data on HIV prevention and treatment in military population to improve strategic planning
TOTAL				$278,664		

Table 6.1.2b Key Programmatic Gap #2 in Guatemala: Lack of Quality HIV Clinical Services						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Quality assurance and quality improvement are not part of the national HIV/AIDS strategy	1. Quality processes (particularly focused on HIV/AIDS) are institutionalized by the MOH	Support the implementation of policies to improve the quality of services in the KP focused cascade	HBHC	$55,000	*[REDACTED]*	**Result**: Create quality improvement plans that are executed. **Goal:** 85 % of PEPFAR-supported clinical sites with quality improvement activities implemented that address clinical HIV program processes or outcomes
		Expand and institutionalize the "Optimizing Performance and Quality" (OPQ) methodology to improve the quality of services for KPs	HBHC	$220,000	*[REDACTED]*	**Result**: Institutionalize in the country the quality methodology **Goal:** 1 country institutionalized the OPQ strategy
		Assessment to Measure Quality Improvements in services at health facilities for PLWHA for project M&E	HBHC	$25,000	*[REDACTED]*	**Result:** Proven improvement of the quality of HIV clinics through yearly measurements **Goal:** 85 % of PEPFAR-supported clinical sites with quality improvement activities implemented that address clinical HIV program processes or outcomes
		Site-level assessment of infection prevention, care, and treatment in selected health facilities.	HBHC	$35,000	*[REDACTED]*	**Result:** Reduction of nosocomial infections in regards to the previous year report **Goal:** 85% of selected hospitals that reported at least a 25% reduction of nosocomial infections or are maintained within a range of 4% in the past year
		Infection prevention, care and treatment in selected health facilities at the site level (based on assessment findings)	HBHC	$80,000	*[REDACTED]*	**Result:** Competency certified personnel in the reduction of nosocomial infections. **Goal**: 24hospital health workers who successfully completed in-service training in epidemiological surveillance of nosocomial infections and biosafety
Stigma & Discrimination from Health Care Providers	1. Patients report a decrease in stigma & discrimination in health facilities 2.Increased uptake	Stigma and Discrimination reduction towards KP at Site level	HVOP	$80,000	*[REDACTED]*	75% Percent of people working in institutions/facilities (e.g., managers, health care workers) trained who are not uncomfortable working with or treating KPs. (Data

	in services by KPs					source: Pre-Post Test)
		Provide legal and advocacy assistance to Key Populations to reduce stigma & discrimination & ensure KP access to services	OHSS	$85,000	*[REDACTED]*	At least three positive policy changes implemented to reduce stigma & discrimination & ensure KP access to HIV services in health facilities
		Stigma and Discrimination Index to Assess Improvement	HVOP	$10,900	*[REDACTED]*	One study report on stigma and discrimination index highlighting on the situation of KP published, and targeted dissemination among key actors of the national HIV response.
		Support and defend the rights of HIV-infected and -affected individuals, MSM, Transgender population and FSWs	HVOP	$75,000	*[REDACTED]*	Two advocacy and information policy campaigns aimed at eliminating stigma and discrimination against PLHIV and KP through HIV positive policy changes and political support.
		Awareness and training on Gender, Stigma and Discrimination for health care providers to improve quality and access to services for KPs	HVOP	$35,000	*[REDACTED]*	**Result:** HIV clinics personnel certified in competencies and sensitized on gender and stigma and discrimination subjects. **Goal:** 40 healthcare workers that have successfully completed gender, stigma and discrimination in-service training.
		Provide technical assistance for HIV-related Gender-Based Violence protocols with focus on KPs	HVOP	$90,000	*[REDACTED]*	Two barriers removed for the implementation of HIV related Gender/Based Violence for KP in the health facilities supported by PEPFAR
Quality of laboratory services	1. Laboratory quality improvement activities and proficiency testing program will be implemented to guarantee the quality of lab	Continuous Quality Assurance	HLAB	$40,391	*[REDACTED]*	3 participating laboratories will increase SLMTA score by 30% compared to baseline by the end of FY17
		External QA Proficiency Panels	HLAB	$10,823	*[REDACTED]*	3 facilities will receive satisfactory score in HIV proficiency testing by the end of FY17

	services and achieve national/international accreditation	Viral Load strengthening	HTXS	$44,273		1 report of the rapid assessment will be developed and submitted for country approval by the end of FY17
TOTAL				$886,387		

Table 6.1.2c Key Programmatic Gap #3 in Guatemala: Strengthening Civil Society and Non-Health Sector Involvement in HIV/AIDS Programs

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism	Milestone
Civil society organizations are highly dependent on external support and low investment in KP programs	1. CSOs will reduce their dependence on external support by increasing their engagement with other funding sources. 2.Investment in KP increased every year	Capacity building of civil society organizations that interact with the health system to improve the access of services for KPs	HVOP	$100,000	*[REDACTED]*	6 Number of civil society organizations trained in provision of quality care for KPs (Data source: MIS)
		Support legal assistance to advise Key Population civil society groups and strengthen their organizational capacity	HVOP	$65,000	*[REDACTED]*	Ten key CSOs of PLWH and KP supported and linked to entrepreneurship environment and leading public activities
		Support to Global Fund programs and activities, and donor coordination to ensure focus on KPs in prevention programs	HVOP	$80,000	*[REDACTED]*	20 Individuals from GF sub-recipients and others trained in prevention and health services topics (Data source: MIS)
		Support national and regional HIV/AIDS strategic planning to ensure focus on Key Populations the cascade and the recommendations of the new WHO guidance.	OHSS	$75,000	*[REDACTED]*	A five years National Strategic Plan updated to respond to HIV KP cascade and the new WHO guidance. Annual NASA Report published and monitoring investment in KP.

Low participation of non-health sectors in the national HIV/AIDS response	1. The non-health sector will actively participate in the national HIV/AIDS response	Increased involvement of the Ministry of Finance and non-health public sectors in the HIV response, including transfer of work with private sector to the Ministry of Labor in each country to continue to develop HIV workplace policies.	OHSS	$40,000	*[REDACTED]*	Ministry of Finance conduct at least two events to discuss about HIV financing and sustainability strategies. Business sector and Ministry of Labor agreement for promoting the continuation of the development of HIV workplace policies.
TOTAL				$360,000		

Table 6.1.2d Key Programmatic Gap 4 in Guatemala: Lack of Qualified Personnel to Work in HIV/AIDS Including Supply Chain and Laboratory

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism	Milestone
Laboratory HR capacity	1. Qualified and routine monitoring will be used to monitor the workforce's ability to conduct laboratory testing (HIV/VL/CD4/TB) 2. Support in-service training and mentorship for implementation of new technologies, HIV testing, VL, CD4, biosafety, TB culture, TB smear microscopy, and Gene Xpert	Fungal Co-Infection Tests, Training, and Follow-up	HBHC	$177,945	*[REDACTED]*	3,810 PLHIV will be tested for crypto or histo by the end of FY17
		TB Screening and TBIC Trainings and Follow-up	HLAB	$113,568	*[REDACTED]*	20 HCW will be trained in TB screening and diagnostics by the end of FY17
		Increase HIV diagnosis through HIV incidence testing	HVCT	$47,784	*[REDACTED]*	366 rapid HIV incidence tests will be conducted by the end of FY17
Low investments in Supply Chain plan	1. Long-term plan for Supply Chain Management is budgeted and adhered to	Supply Chain Human Resource Capacity Development	HTXS	$75,000	*[REDACTED]*	**Milestone** - Logistics Functions and Responsibilities transfer approved by High Level MOH authority.

						- Training program completed and approved. - 20 LMU staff trained and certified in the program. SCM Network Design completed and approved.
		ARV Supply Chain Key Performance Indicators	HTXS	$8,000	*[REDACTED]*	- 5% Stock out rate. - 80% LMIS Reporting rate. - 80% Order Fulfillment rate. - 1% Stock Expired (Quantities & Costs) 75% On-Time Delivery rate
		Train Health Center providers in relevant HIV/AIDS service components (OPQ, STD, biosafety, etc.) to improve the quality of services for KPs	HBHC	$55,000	*[REDACTED]*	**Result:** HIV clinics personnel are certified in competencies. **Goal:** 80 healthcare workers that have successfully completed OPQ, STD, Opportunistic infections, biosafety, etc. in-service training.
		HIV Staging & Management In-Service Training (IST)	HTXS	$100,710	*[REDACTED]*	40 physicians will complete the HIV medicine course by the end of FY17
		Training of Trainers for HIV Clinical Management	OHSS	$12,000	*[REDACTED]*	One physician to participate in a ToT training program in HIV/AIDS clinical management and learn about epidemiological surveillance, laboratory diagnoses of HIV, caring for HIV patients and setting up prevention programs.
TOTAL				$590,007		

#3. HONDURAS

Table 6.1.3a Key Programmatic Gap #1 in Honduras: Lack of Standardized Information Systems across the HIV Continuum of Care						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Lack of unique identifiers to track individuals through the Continuum of Care among KPs	1. KPs referred from community to facility and vice versa; adequately linked to services in all PEPFAR-supported SNUs 2. Increased MOH and PEPFAR capacity to monitor KPs reached in PEPFAR-supported SNUs by basing analysis on de-duplicated data	Support the public strategic information system to track KPs throughout the entire cascade	HVSI	$400,000	*[REDACTED]*	• One Client Tracking System (CTS) supported and implemented in three municipalities
		HIV Case-Based Reporting	HVSI	$34,580	*[REDACTED]*	1 analysis of the cascade disaggregated by municipality and key population will be conducted by the end of FY 17
Non-standardized data collection tools and procedures	1. Updated and standardized MoH guidelines on HIV data collection tools and procedures followed in all PEPFAR-supported SNUs	Needs assessment of the information system in the prioritized areas	HVSI	$10,000	*[REDACTED]*	•Health facilities and NGOs data collection and reporting requirements assessed. The milestone is the assessment of 10 facilities and 6 local NGOs
		Health Information Systems (HIS)	HVSI	$62,993	*[REDACTED]*	40 HCWs will be trained in appropriate data collection procedures as described in the National MOH guidelines by the end of FY17
Lack of adequate quality control procedures for information systems at HIV care and treatment centers	1. MoH capable of developing HIV Continuum of Care cascades and the facility, municipality, and national level without external consultant support based on its	Training in Using Information for Decision Making	HBHC	$28,100	*[REDACTED]*	•Develop a National Model for Monitoring & Evaluation System (M&E) developed The milestone is the National Model for M&E developed •National and regional teams of the MOH's Unidad de Gestión de la Información (UGI) trained and supported in the use of the information for decision-making.

	programmatic data					The milestone is 40 people trained
		Regional HIV Data Use and Trainings	HVSI	$7,326	*[REDACTED]*	2 persons will be trained in the Introduction of Economic Evaluation and the application of cost analysis in addressing program policy questions, and the use of GIS to map HIV burden by municipality by the end of FY17
		Trainings workshops for HIV Surveillance, Data Analysis and Data QA	OHSS	$14,850	*[REDACTED]*	Three training workshops implemented, on strategic information addressed to Military Health Staff to improve the decision making process based on evidence
TOTAL				$557,849		

Table 6.1.3b Key Programmatic Gap #2 in Honduras: HIV services not deemed comprehensive by PLHIV						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**MIlestone**
Scarce training among health workers to provide counseling on disclosure and couples/family counseling, stigma and discrimination, and gender-based violence	1. Increased number of newly diagnosed HIV cases through disclosure, couples and family counseling for PLHIV at PEPFAR-supported HIV care and treatment centers	Support the community-based response for KPs who experience gender-based violence (GBV)	HVOP	$28,100	*[REDACTED]*	•Health facilities and NGOs lead by or working with KP trained in the GBV approach 50 people trained
		Reduction of Stigma & Discrimination towards KPs	HVOP	$28,100	*[REDACTED]*	75 service providers at health facilities and NGOs led by or working with KPs trained in the provision of stigma-free services to KPs
		Analysis & Development of Profiles of KP among the Garifuna population	HVOP	$146,625	*[REDACTED]*	Studies on understanding the profile of KPs within the Garifuna population designed and completed
Lack of comprehensive QA/QI plans at HIV care and treatment centers	1. Improved client satisfaction and adherence to treatment at PEPFAR-supported HIV care and treatment centers	Provide TA for QI/QA to increase quality of care and access to cascade services to KPs.	HBHC	$130,000	*[REDACTED]*	•Health facilities with existing QA/QI plans to increase quality of services to KPs and receiving TA from the project 10 Health Units increase in at least 25% in QA/QI
		Capacity building of civil society organizations that interact with the health system to improve quality for KPs	HBHC	$6,500	*[REDACTED]*	Relevant CSOs receive capacity building training in order to improve quality of services to KPs 25 people trained
		Continuous Quality Assurance	HLAB	$29,692	*[REDACTED]*	4 participating laboratories will increase SLMTA score by 30% compared to baseline by the end of FY17.

		External QA Proficiency Panels	HLAB	$2,164	*[REDACTED]*	1 facility will receive satisfactory score in HIV proficiency testing by the end of FY17.
		Fungal Co-Infection Tests, Training, and Follow-up	HBHC	$113,753	*[REDACTED]*	1,782 PLHIV will be tested for crypto or histo by the end of FY17
		TB Screening and TBIC Trainings and Follow-up	HLAB	$60,070	*[REDACTED]*	8 HCW will be trained in TB screening and diagnosis by the end of FY17
		Viral Load strengthening	HTXS	$52,510	*[REDACTED]*	1 report of the rapid assessment will be developed and submitted for country approval by the end of FY17
Lack of comprehensive STI prevention, diagnosis, and treatment services for PLHIV	1. Increased STI diagnosis and treatment capacity in PEPFAR-supported facilities 2. Reduction in STIs among PLHIV in PEPFAR-supported facilities	Increase HIV diagnosis through HIV Incidence Testing	HVCT	$52,603	*[REDACTED]*	330 rapid HIV incidence tests will be conducted by the end of FY17
TOTAL				$650,117		

#4. NICARAGUA

Table 6.1.4a Key Programmatic Gap #1 in Nicaragua: Lack of quality sustainable coverage of care and treatment services for PLHIV						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Low quality of HIV services	1. A national and subnational QA/QI plan is being implemented 2. Key MoH health personnel will lead QA/QI plans and systematic evaluations to improve performance	Continuous Quality Assurance	HLAB	$38,766	*[REDACTED]*	3 participating laboratories will increase SLMTA score by 30% compared to baseline by the end of FY17.
		External QA Proficiency Panels	HLAB	$3,029	*[REDACTED]*	1 facility will receive satisfactory score in HIV proficiency testing by the end of FY17.
		HIV Staging & Management In-Service Training (IST)	HTXS	$61,118	*[REDACTED]*	20 physicians will complete the HIV medicine course by the end of FY17
		Baseline CD4 Test and Trainings	HTXS	$40,946	*[REDACTED]*	278 PLHIV will receive a baseline CD4 test by the end of FY17
		Fungal Co-Infection Tests, Training, and Follow-up	HBHC	$60,367	*[REDACTED]*	595 PLHIV will be tested for crypto or histo by the end of FY17
		HIV Case-Based Reporting	HVSI	$34,580	*[REDACTED]*	1 analysis of the cascade disaggregated by municipality and key population will be conducted by the end of FY 17
		Regional HIV Data Use and Trainings	HVSI	$4,035	*[REDACTED]*	2 persons will be trained in the Introduction of Economic Evaluation and the application of cost analysis in addressing program policy questions, and the use of GIS to map HIV burden by municipality by the end of FY17
		TB Screening and TBIC Trainings and Follow-up	HLAB	$95,846	*[REDACTED]*	16 HCW will be trained in TB screening and diagnosis by the end of FY17
		Viral Load strengthening	HTXS	$43,493	*[REDACTED]*	1 report of the rapid assessment will be developed and submitted for country approval by the end of FY17

Civil society participation highly dependent on external support	1. CSOs will reduce their dependence on external support by increasing their engagement with other funding sources	Support for Updating UNAIDS Led Investment Case	HVSI	$20,500	*[REDACTED]*	One secondary analysis published and targeted dissemination to compare the HIV cost effective investments alternatives and results to promote policy changes and practices.
		Support for Global AIDS Response Progress Report	HVSI	$6,400	*[REDACTED]*	One report completed and updated of the host country of HIV epidemiological data, surveys and surveillance indicators according with GARPR methodology and cascade indicators.
TOTAL				$475,650		

Table 6.1.4b Key Programmatic Gap #2 in Nicaragua: Insufficient HIV testing among transgender and MSM populations						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Low level of HIV diagnoses among KPs	1. All KP hot-spots will be identified in order to receive prevention and testing services 2. KP diagnoses improve	Modes of Transmission	HVSI	$18,300	*[REDACTED]*	At least two dissemination events to targeted audiences on updated information decision-making tools and presentations with results of MoT estimations (updated with the Investment case) and the number of expected HIV new infections in KP at national level and municipalities supported by PEPFAR.
		Increase HIV diagnosis through HIV Incidence testing	HVCT	$48,611	*[REDACTED]*	804 rapid HIV incidence tests will be conducted by the end of FY17
Stigma and discrimination in health facilities	1. MoH Health Normative or Resolution to reduce S&D will be effectively implemented 2. Legal framework improved: Transgender Identity Law promoted and approved 3. KP leadership (particularly for TG) strengthened	Training course on gender norms (10 hours) for NGO personnel and community leaders and promoters	HBHC	$6,000	*[REDACTED]*	50 NGO personnel trained
		Knowledge management through social networks to address S&D, GBV prevention, adherence promotion,	HTXS	$12,000	*[REDACTED]*	Three plans implemented by KP NGOs (MSM, TG, PLHIV)
		Implementation of post exposure prophylaxis (PEP) protocol with focus on KPs	HVOP	$6,200	*[REDACTED]*	Two of barriers removed for the implementation of PEP protocol for KPs in the health facilities supported by PEPFAR
NGO financial dependence to provide preventative services	1. NGOs will provide low-cost prevention and testing services with an increased contribution from the MoH	Capacity building of civil society organizations to provide CoC HIV services	HVOP	$14,000	*[REDACTED]*	50 NGO personnel trained
		PrenvenSida final evaluation for CoC by NGOs	HBHC	$20,000	*[REDACTED]*	1 final report disseminated

TOTAL				$125,111		

#5. PANAMA

Table 6.1.5a Key Programmatic Gap #1 in Panama: Insufficient testing among transgender and MSM in hidden populations						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Low level of HIV diagnoses among KP	1. All KP hot-spots will be identified in order to receive prevention and testing services 2. KP HIV diagnoses improved	TRAC (Tracking Results Continuously) for MSM, TG, FSW, MAR, PLWHA to assess impact of interventions	HVOP	$60,000	*[REDACTED]*	18.3% of MSM and 11% of trans reached with Combination Prevention Interventions (Data Source TRaC 2015-2016)
		Increase HIV diagnosis through HIV incidence testing	HVCT	$53,476	*[REDACTED]*	1,321 rapid HIV incidence tests will be conducted by the end of FY17
		Modes of Transmission	HVOP	$18,000	*[REDACTED]*	At least two dissemination events to targeted audiences on updated information decision-making tools and presentations with results of MoT estimations (updated with the Investment case) and the number of expected HIV new infections in KP at national level and municipalities supported by PEPFAR.
		Support to Global Fund programs and activities, and donor coordination to ensure focus on KPs in prevention programs	HVOP	$20,000	*[REDACTED]*	20 individuals from GF sub-recipients and others trained in prevention and health services topics (Data source: MIS)
Stigma and discrimination in health facilities	1. MoH Health Normative or Resolution to reduce S&D effectively implemented 2. Legal framework	Stigma & Discrimination reduction towards KP	HVOP	$20,000	*[REDACTED]*	75% Percent of people working in institutions/facilities (e.g., managers, health care workers) trained who are not uncomfortable working with or treating KPs. (Data source: Pre-Post Test)
		Implementation of post exposure prophylaxis (PEP) protocol with focus on KPs	HVOP	$5,000	*[REDACTED]*	Two barriers removed for the implementation of PEP protocol for KPs in the health facilities supported by PEPFAR.

	improved: Transgender Identity Law promoted and approved					
		Provide legal and advocacy assistance to Key Population groups to reduce stigma & discrimination & ensure KP access to services	HVOP	$20,000	*[REDACTED]*	At least three positive policy changes implemented to reduce stigma & discrimination & ensure KP access to HIV services in health facilities
		Stigma and Discrimination Index to Assess Improvement	OHSS	$5000	*[REDACTED]*	One study report on stigma and discrimination index highlighting on the situation of KP published, and targeted dissemination among key actors of the national HIV response.
		Awareness and training on Gender, Stigma and Discrimination for health care providers to improve quality and access to services for KPs	HBHC	$15,000	*[REDACTED]*	**Result:** HIV clinics personnel certified in competencies and sensitized on gender and stigma and discrimination subjects. **Goal:** 24 healthcare workers that have successfully completed gender, stigma and discrimination in-service training.
		Provide technical assistance for implementation of HIV related Gender-Based Violence protocols with focus on KPs	HVOP	$20,000	*[REDACTED]*	Two barriers removed for the implementation of HIV related Gender/Based Violence for KP in the health facilities supported by PEPFAR
NGO financial dependence to provide preventative services	1. NGOs will provide low-cost prevention and testing services with an increased contribution from the MoH	Support to national and regional HIV/AIDS strategic planning to ensure focus on Key Populations the cascade and the recommendations of the new WHO guidance.	OHSS	$30,000	*[REDACTED]*	A five years National Strategic Plan updated to respond to HIV KP cascade and the new WHO guidance. Annual NASA Report published and monitoring investment in KP.
		Capacity building of civil society organizations that interact with the health system to improve access for KPs	HVOP	$20,000	*[REDACTED]*	4 civil society organizations trained in provision of quality care for KPs. (Data source: MIS)
		Support legal assistance to advise Key Population civil society groups and strengthen their organizational capacity	HVOP	$20,000	*[REDACTED]*	Five key CSOs of PLWH and KP supported and linked to entrepreneurship environment and leading public activities

TOTAL				$306,476		

Table 6.1.5b Key Programmatic Gap #2 in Panama: Poor quality of HIV services

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism	Milestone
Lack of sufficient qualified personnel to work in HIV/AIDS	1. Retention plan to reduce desertion in HIV/AIDS service delivery	Train Health Center providers in relevant HIV/AIDS service components (OPQ, STD, biosafety, etc.) to improve the quality of services for KPs	HBHC	$24,000	*[REDACTED]*	**Result:** HIV clinics personnel are certified in competencies. **Goal:** 60 healthcare workers that have successfully completed OPQ, STD, opportunistic infections, biosafety, etc. in-service training.
	2. Improved staff skills related to HIV/AIDS service provision	HIV Staging & Management In-Service Training (IST)	HTXS	$97,192	*[REDACTED]*	40 physicians will complete the HIV medicine course by the end of FY17
		Infection prevention, care and treatment in selected health facilities.	HTXS	$24,000	*[REDACTED]*	**Result:** Reduction of nosocomial infections in regards to the previous year's report. **Goal**: 85% of selected hospitals that reported at least a 25% reduction of nosocomial infections or are maintained within a range of 4% in the past year
Lack of country-led analysis on the quality of HIV services	1. The government will implement plans for training HIV health personnel with its own resources	Assessment to Measure Quality Improvements at Health Facilities in services to PLWHA for project M&E	HBHC	$10,000	*[REDACTED]*	**Result:** Proven improvement of the quality of HIV clinics through yearly measurements **Goal:** 85 % of PEPFAR-supported clinical sites with quality improvement activities implemented that address clinical HIV program processes or outcomes
		Analysis of barriers on adherence to treatment	HTXS	$47,000	*[REDACTED]*	**Result:** Plans to improve adherence of key populations living with HIV by clinic. **Goal:** 85% of PLWH who reported care free of stigma and discrimination by HIV service providers.

		Support the implementation of policies to improve the quality of health services in the KP-focused cascade	HBHC	$20,000	*[REDACTED]*	**Result:** Create quality improvement plans and have them executed. **Goal:** 85% of PEPFAR-supported clinical sites with quality improvement activities implemented that address clinical HIV program processes or outcomes
		Provide technical assistance to develop and implement monitoring and evaluation (M&E) plans to ensure focus on KPs and monitoring of the KP cascade.	OHSS	$15,000	*[REDACTED]*	Annual M&E report prepared by the host country government to monitor and report the HIV continuum of care indicators, highlighting KP situation.
		HIV Case-Based Reporting	HVSI	$34,580	*[REDACTED]*	1 analysis of the cascade disaggregated by municipality and key population will be conducted by the end of FY 17
		Regional HIV Data Use and Trainings	HVSI	$7,697	*[REDACTED]*	2 persons will be trained in the Introduction of Economic Evaluation and the application of cost analysis in addressing program policy questions, and the use of GIS to map HIV burden by municipality by the end of FY17
Lack of civil society engagement to improve quality	1.Improved engagement of civil society & improved quality and access to services for KPs	Capacity building of civil society organizations that interact with the health system to improve access for KPs	HVOP	$20,000	*[REDACTED]*	4 Number of civil society organizations trained in provision of quality care for KPs (Data source: MIS)
		Support legal assistance to advise Key Population civil society groups and strengthen their organizational capacity	HVOP	$20,000	*[REDACTED]*	Five key CSOs of PLWH and KP supported and linked to entrepreneurship environment and leading public activities
		Support and defend the rights of HIV-infected and -affected individuals, MSM, Transgender population and FSWs	HVOP	$25,000	*[REDACTED]*	Two advocacy and information policy campaigns aimed at eliminating stigma and discrimination against PLHIV and KP through HIV positive policy changes and political support.
		Continued technical assistance to Global Fund (GF) projects to ensure impact on KP cascade	OHSS	$20,000	*[REDACTED]*	CCM analyzing and reporting on implemented strategies to contribute to the KP cascade..

TOTAL				$429,334		

Table 6.1.5c Key Programmatic Gap #3 in Panama: Laboratory capacity for HTS, baseline CD4, routine VL and TB diagnostics

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism	Milestone
Laboratory HR capacity	1. Qualified and routine monitoring and competent laboratory workforce to conduct laboratory testing (HIV/VL/CD4/TB) 2. Support in-service training and mentorship for implementation of new technologies: HIV testing, VL, CD4, biosafety, TB culture, TB smear microscopy, and Gene Xpert	Fungal Co-Infection Tests, Training, and Follow-up	HBHC	$125,642	*[REDACTED]*	2,439 PLHIV will be tested for crypto or histo by the end of FY17
		TB Screening and TBIC Trainings and Follow-up	HBHC	$125,299	*[REDACTED]*	24 HCW will be trained in TB screening and diagnosis by the end of FY17
Quality of laboratory services	1. Laboratory quality improvement activities and proficiency of the testing program will be implemented to guarantee the quality of lab services and achieve national/international accreditation	Continuous Quality Assurance	HLAB	$29,692	*[REDACTED]*	5 participating laboratories will increase SLMTA score by 30% compared to baseline by the end of FY17
		Rapid Test Quality Improvement (RTQI)	HLAB	$77,233	*[REDACTED]*	80% of staff at each participating laboratory implementing RTQII will be trained by the end of FY17
		External QA Proficiency Panels	HLAB	$4,328	*[REDACTED]*	1 facility will receive satisfactory score in HIV proficiency testing by the end of FY17
TOTAL				$362,194		

6.2 Critical Systems Investments for Achieving Priority Policies

As with the programmatic gaps, the systems barriers that need to be addressed for the implementation of Test and Start (T&S) and New and efficient service delivery models were similar across the region. For most countries, the uncertain political support by authorities to transition to T&S represents a barrier to starting T&S and PEPFAR will address this issue with activities that focus on economic analysis and advocacy and for this issue, PEPFAR will leverage the regional platform to help move all countries as quickly as possible. For all five countries, a barrier lies in health systems that are currently inadequate to adopt T&S and proposed PEPFAR activities will fill these system gaps as soon as possible. In Guatemala, El Salvador and Panama, an inefficient supply chain management of ARVs is an additional barrier that must be addressed to prepare for a successful rollout of T&S. With the help of the strategic PEPFAR interventions proposed, the region is well positioned to implement T&S quickly.

For T&S, there is a specific table for each country while for Service Delivery Models; one table is presented for the region. The barriers identified for Service Delivery Models are similar to those selected for T&S and include lack of political support by authorities to support differentiated service delivery models, inadequate health systems to support differentiated treatment approaches and inflexible health systems to support differentiated drug delivery approaches.

Table 6.2.1a Test and Start – EL SALVADOR						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Uncertain political support by authorities to transition to Test and Start	1. Engage with MOF and other key stakeholders to prioritize HIV as a health issue and to implement T&S in 5 countries in the next 6 months.	Support for National AIDS Spending Assessment (NASA) Report	OHSS	$7,000	*[REDACTED]*	NASA study published and technical discussions with MOF and MoH on cost effective investments based on NASA results and the investment case.
	2. Revise current guidelines to include T&S in 5 countries in the next 12 months.	Analysis of National Financing Mechanism for Sustainability	OHSS	$15,500	*[REDACTED]*	One technical analysis published for increasing ceiling of current/new financing mechanisms or cost effective interventions for HIV sustainability and targeted discussions on financial issues to transition to T&S
	3. Conduct economic analyses to identify true financing gaps and projected costs in 5 countries in the next 12 months.	Support the Regional Sustainability Plan being implemented by the Regional Coordination Mechanism	OHSS	$62,208	*[REDACTED]*	One economic analysis published to identify financing gaps and projected costs in 5 host countries and deliver targeted information package to COMISCA to support a positive regional approach to T&S.
Inadequate health systems to adopt Test and Start	1. Pilot differentiated service delivery models to reduce clinical and laboratory staff workload in 2 countries in the next 6 months. 2. Conduct rapid assessment of viral load testing in all countries in the next 6 months	Program Assessment on quality improvement for community based services for care and treatment and adherence support	HBHC	$15,000	*[REDACTED]*	**Result:** Operational study completed **Goal:** El Salvador evaluates a community intervention program to support adherence for PLWH
		Strengthening Viral Load Cascade	HTXS	$44,086	*[REDACTED]*	1 report of the rapid assessment will be developed and submitted for country approval by the end of FY17
Inefficient supply chain management of ARVs	1. Facilitate regional purchase of ARVs at affordable prices for all countries in the next 12 months. 2. Strengthen supply chain system to support extended ART refills in all countries in the next 12 months.	Support to update Logistics related Guidelines and Norms for adoption of Test and Start	HBHC	$5,000	*[REDACTED]*	- Guidelines/Norms for HIV/AIDS Commodities FASP completed and approved. - 1 Forecasting exercise complete each year. - 4 Supply Plan updates each year (Quarterly). - 80% Forecast performance rate. 80% Supply Plan Fulfillment Rate.
		Logistics Management Information System	HTXS	$36,000	*[REDACTED]*	LMIS SOP Manual updated and approved.

		(LMIS) Improvement to strengthen supply chain				
		Support for the Report on ARV Supply Chain Key Performance Indicators	HTXS	$8,000	*[REDACTED]*	- List of KPI defined and approved: - 5% Stock out rate. - 80% LMIS Reporting rate. - 80% Order Fulfillment rate. - 1% Stock Expired (Quantities & Costs) - 75% On-Time Delivery rate. - 80% Forecast performance rate. - 80% Supply plan Fulfillment Rate.
		Supply Chain Human Resource Capacity Development	HTXS	$56,100	*[REDACTED]*	- Training program defined and approved (should include logistics topics applicable for the human resource level within the tiered network) - -80 SCM Staff trained and deemed competent.
		Support to improve ARVs supply planning process	HTXS	$30,000	*[REDACTED]*	- FASP Committee Defined - -Guidelines/Norms for HIV/AIDS Commodities FASP complied with.
TOTAL				$278,894		

Table 6.2.1b Test and Start – GUATEMALA						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Uncertain political support by authorities to transition to Test and Start	1. Engage with MOF and other key stakeholders to prioritize HIV as a health issue and to implement T&S in 5 countries in the next 6 months. 2. Revise current guidelines to include T&S in 5 countries in the next 12 months. 3. Conduct economic analyses to identify true financing gaps and projected costs in 5 countries in the next 12 months.	Support for National AIDS Spending Assessment (NASA) Report	OHSS	$11,500	*[REDACTED]*	NASA study published and technical discussions with MOF and MoH on cost effective investments based on NASA results and the investment case.
		Analysis of National Financing Mechanism for Sustainability	OHSS	$38,000	*[REDACTED]*	One technical analysis published for increasing ceiling of current/new financing mechanisms or cost effective interventions for HIV sustainability and targeted discussions on financial issues to transition to T&S
		Support the Regional Sustainability Plan being implemented by the Regional Coordination Mechanism	OHSS	$125,000	*[REDACTED]*	One economic analysis published to identify financing gaps and projected costs in 5 host countries and deliver targeted information package to COMISCA to support a positive regional approach to T&S.
		Support for the UNAIDS-led Investment Case Development	OHSS	$23,500	*[REDACTED]*	One secondary analysis published and targeted dissemination to compare the HIV cost effective investments alternatives and results to promote policy changes and practices.
Inadequate health systems to adopt Test and Start	1. Pilot differentiated service delivery models to reduce clinical and laboratory staff workload in 2 countries in the next 6 months. 2. Conduct rapid assessment of viral load testing in all countries in the next 6 months	Program Assessment on quality improvement for community based services for care and treatment and adherence support	HBHC	$35,000	*[REDACTED]*	**Result:** Operational study completed **Goal:** Guatemala evaluates a community intervention program to support adherence for PLWH
		Strengthening Viral Load Cascade	HTXS	$44,273	*[REDACTED]*	1 report of the rapid assessment will be developed and submitted for country

	3. Update health information systems in 5 countries in the next 12 months.					approval by the end of FY17
		Analysis of barriers to adherence to treatment	HTXS	$74,200	*[REDACTED]*	**Result:** Plans to improve adherence of key populations with HIV by clinic. **Indicator:** % of PLWH who reported care free of stigma and discrimination by HIV service providers. **Goal:** 85% of PLWH who reported care free of stigma and discrimination by HIV service providers.
Inefficient supply chain management of ARVs	1. Facilitate regional purchase of ARVs at affordable prices for all countries in the next 12 months. 2. Strengthen supply chain system to support extended ART refills in all countries in the next 12 months.	Support to update logistics-related Guidelines and Norms for the adoption of Test and Start	HTXS	$5,000	*[REDACTED]*	- Guidelines/Norms for HIV/AIDS Commodities FASP completed and approved. - 1 Forecasting exercise complete each year. - 4 Supply Plan updates each year (Quarterly). - 80% Forecast performance rate. 80% Supply plan Fulfillment Rate.
		Logistics Management Information System (LMIS) Improvement to strengthen supply chain	HTXS	$125,000	*[REDACTED]*	- LMIS SOP Manual updated and approved. - 5% Stock out rate. - 80% LMIS Reporting rate. - 80% Order Fulfillment rate. - 1% Stock Expired (Quantities & Costs) 75% On-Time Delivery rate.
		Support to improve ARVs supply planning process	HTXS	$80,000	*[REDACTED]*	- FASP Committee Defined Guidelines/Norms for HIV/AIDS Commodities FASP complied with.
TOTAL				$561,473		

Table 6.2.1b Test and Start – Honduras						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Inadequate health systems to adopt Test and Start	1. Pilot differentiated service delivery models to reduce clinical and laboratory staff workload in 2 countries in the next 6 months. 2. Conduct rapid assessment of viral load testing in all countries in the next 6 months 3. Update health information systems in 5 countries in the next 12 months	Baseline for KP CoC NGO model	HVOP	$37,375	*[REDACTED]*	•Manual of clinical services for KPs updated with the 90-90-90 model and test and start strategy adapted
		Strengthening Viral Load Cascade	HTXS	$52,510	*[REDACTED]*	1 report of the rapid assessment will be developed and submitted for country approval by the end of FY17
TOTAL				$89,885		

Table 6.2.1d Test and Start – Nicaragua						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Uncertain political support by authorities to transition to Test and Start	1. Engage with MOF and other key stakeholders to prioritize HIV as a health issue and to implement T&S in 5 countries in the next 6 months. 2. Revise current guidelines to include T&S in 5 countries in the next 12	Support for National AIDS Spending Assessment (NASA) Report	HVSI	$9,000	*[REDACTED]*	NASA study published and technical discussions with MOF and MoH on cost effective investments based on NASA results and the investment case.
		National Strategic Information Forum	HVSI	$6,300	*[REDACTED]*	At least two forum implemented at the national level to delivery strategic information on the HIV continuum of care, investment case and stigma and discrimination studies and others, are made

	months. 3. Conduct economic analyses to identify true financing gaps and projected costs in 5 countries in the next 12 months.					available to stakeholders and decision makers in a timely way at the national level and municipalities supported by PEPFAR.
Inadequate health systems to adopt Test and Start	1. Pilot differentiated service delivery models to reduce clinical and laboratory staff workload in 2 countries in the next 6 months. 2. Conduct rapid assessment of viral load testing in all countries in the next 6 months 3. Update health information systems in 5 countries in the next 12 months.	Annual Forum on BCC, S&D, GBV prevention, Combination Prevention and Care, HIV logistic and Quality Improvement, emphasizing TEST and START	HBHC	$10,000	*[REDACTED]*	120 KP leaders from 40 KP NGOs sharing information and best practices to promote Test and Start
		Strengthening Viral Load Cascade	HTXS	$43,493	*[REDACTED]*	1 report of the rapid assessment will be developed and submitted for country approval by the end of FY17
		Health Information Systems (HIS)	HVSI	$66,570	*[REDACTED]*	40 HCWs will be trained in appropriate data collection procedures as described in the National MOH guidelines by the end of FY17
TOTAL				$135,363		

Table 6.2.1e Test and Start – Panama						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Uncertain political support by authorities to transition to Test and Start	1. Engage with MOF and other key stakeholders to prioritize HIV as a health issue and to implement T&S in 5 countries in the next 6 months. 2. Revise current guidelines to include T&S in 5 countries in the next 12 months. 3. Conduct economic analyses to identify true financing gaps and projected costs in 5 countries in the next 12 months.	Support for National AIDS Spending Assessment (NASA) Report	OHSS	$7,000	*[REDACTED]*	NASA study published and technical discussions with MOF and MoH on cost effective investments based on NASA results and the investment case.
		Analysis of National Financing Mechanism for Sustainability	OHSS	$15,500	*[REDACTED]*	One technical analysis published for increasing ceiling of current/new financing mechanisms or cost effective interventions for HIV sustainability and targeted discussions on financial issues to transition to T&S
		Support for UNAIDS-Led Investment Case Development	OHSS	$23,500	*[REDACTED]*	One secondary analysis published and targeted dissemination to compare the HIV cost effective investments alternatives and results to promote policy changes and practices.
		Support the Regional Sustainability Plan being implemented by the Regional Coordination Mechanism	OHSS	$30,000	*[REDACTED]*	One economic analysis published to identify financing gaps and projected costs in 5 host countries and deliver targeted information package to COMISCA to support a positive regional approach to T&S.
Inadequate health systems to adopt Test and Start	1. Pilot differentiated service delivery models to reduce clinical and laboratory staff workload in 2 countries in the next 6 months. 2. Conduct rapid assessment of viral load testing in all countries in the next 6 months 3. Update health information systems in 5 countries in the next 12 months.	Program Assessment on quality improvement for community based services for care and treatment and adherence support	HBHC	$15,000	*[REDACTED]*	**Result:** Operational study completed **Goal:** Panama evaluates a community intervention program to support adherence for PLWH
		Strengthening Viral Load Cascade	HTXS	$42,214	*[REDACTED]*	1 report of the rapid assessment will be developed and submitted for country approval by the end of FY17
		Health Information Systems (HIS)	HVSI	$64,865	*[REDACTED]*	40 HCWs will be trained in appropriate data collection procedures as described in the National MOH guidelines by the end of FY17
Inefficient supply	1. Facilitate regional purchase of ARVs at	Support to update logistics-related	HTXS	$5,000	*[REDACTED]*	- Guidelines/Norms for HIV/AIDS Commodities FASP

chain management of ARVs	affordable prices for all countries in the next 12 months. 2. Strengthen supply chain system to support extended ART refills in all countries in the next 12 months.	Guidelines and Norms for the adoption of Test and Start				completed and approved. - 1 Forecasting exercise complete each year. - 4 Supply Plan updates each year (Quarterly). - 80% Forecast performance rate. 80% Supply plan Fulfillment Rate.
		Logistics Management Information System (LMIS) Improvement to strengthen supply chain	HTXS	$36,000	*[REDACTED]*	LMIS SOP Manual updated and approved.
		Support to improve ARVs supply planning process	HTXS	$30,000	*[REDACTED]*	- FASP Committee Defined - Guidelines/Norms for HIV/AIDS Commodities FASP complied with.
		Supply Chain Human Resource Capacity Development	HTXS	$20,000	*[REDACTED]*	- Training program defined and approved (should include logistics topics applicable for the human resource level within the tiered network) - 80 SCM Staff trained and deemed competent.
		ARV Supply Chain Key Performance Indicators	HTXS	$8,000	*[REDACTED]*	- List of KPI defined and approved: - 5% Stock out rate. - 80% LMIS Reporting rate. - 80% Order Fulfillment rate. - 1% Stock Expired (Quantities & Costs) - 75% On-Time Delivery rate. - 80% Forecast performance rate. - 80% Supply plan Fulfillment Rate.
TOTAL				$297,079		

Table 6.2.2 New and efficient service delivery models: Central America Region						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16 Activities & Country**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism**	**Milestone**
Lack of political support by authorities to support differentiated service delivery models	1. Revise current guidelines to include differentiated service delivery models in 5 countries in the next 12 months. 2. Conduct economic analyses to identify cost savings in 5 countries in the next 12 months.	Support for the National Sustainability Analysis (El Salvador, Guatemala & Panama)	OHSS	$17,000	*[REDACTED]*	One sustainability analysis report presented to COMISCA by Regional Coordinating Mechanism recommending cost effective interventions and differentiated service delivery models as part of strategies to reach sustainability.
		Expand and institutionalize the Coordinated Community Response (CCR) to support adherence to ARVs with a focus on KPs (Guatemala & Panama)	HBHC	$124,000	*[REDACTED]*	**Result:** NGOs, Community Based Organizations, Support Groups or self support groups that coordinate with HIV clinics to reduce stigma and discrimination and improve adherence of people living with HIV. **Goal:** 85 % of HIV clinics that have coordinated with NGO, CBO and support groups, specific actions based on the analysis of strategic information to improve adherence, prevention with PLWH, and social environment with KP
Inadequate health systems to support differentiated treatment approaches	1. Assess resource needs from patient and site-management perspective in 2 countries in the next 6 months. 2. Provide differentiated treatment services based on client flow for specific client groups in 2 countries in the next 12 months	Applied research on lessons learned on CoC provision by NGOs in Nicaragua (CD4, community survey, CoC by NGOs, HIV determinants among key populations, QI assessment, NGO sustainability, IT use)	HBHC	$30,000	*[REDACTED]*	Six reports published and disseminated

	3. Provide ARV services to KPs at VICITS clinics in 2 countries in the next 12 months.	Integration of ARV services at KP focused clinics	HTXS	$145,409	*[REDACTED]*	1,652 PLHIV will initiate treatment services at a VICITS clinic by the end of FY17
Inadequate health systems to support differentiated drug delivery approaches	1. Assess resource needs from patient and site-management perspective in 2 countries in the next 6 months. 2. Implement differentiated drug delivery services to KP using facility and community distribution groups in 2 countries in the next 12 months 3. Implement appointment spacing to reduce clinical consultation frequency in 2 countries in the next 12 months.	Facility- and community-based adherence activities to reach and retain KP in treatment to achieve viral load suppression (Guatemala & Panama)	HBHC	$425,000	*[REDACTED]*	**Result:** People living with HIV that have abandoned treatment and have returned to treatment. **Goal:** 16756 adults currently receiving antiretroviral therapy (ART)
		Facility- and community-based adherence activities to reach and retain KP in treatment to achieve viral load suppression-Nicaragua	HTXS	$428,460	*[REDACTED]*	At least 1800 adults linked to care and treatment
		Facility- and community-based adherence activities to reach and retain KP in treatment to achieve viral load suppression -Honduras	HTXS	$387,220	*[REDACTED]*	•Evidence-based models for adherence support to HIV+ KPs to achieve viral suppression developed, pilot-tested, and documented Model developed and starting its piloting implementation in at least 10 health units
TOTAL				$ 1,557,089		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3 Other Proposed Systems Investments –EL SALVADOR						
Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism**	**Milestone**
HRH - Systems/Institutional Investments						
Fungal Co-Infection Tests, Training, and Follow-up	Sustained Epi Control	Improved MoH HR Capacity	$130,840	HBHC	*[REDACTED]*	2,522 PLHIV will be tested for crypo or histo by the end of FY17
TB Screening and TBIC Trainings and Follow-up	Sustained Epi Control	Improved MoH HR Capacity	$135,283	HBHC	*[REDACTED]*	24 HCW will be trained in TB screening and diagnosis by the end of FY17
ToT Military International HIV Training Program (MIHTP) Mil-to-Mil cooperation	Sustained Epi Control	Strengthened cascade for military	$12,000	HBHC	*[REDACTED]*	One physician to participate in a ToT training program in HIV/AIDS clinical management and learn about epidemiological surveillance, laboratory diagnoses of HIV, caring for HIV patients and setting up prevention programs
Training workshops to Support Critical Components of HIV Military Programs for a Successful Response: HIV surveillance, Data Analysis and Data Quality Assurance	Sustained Epi Control	Strengthened cascade for military	$14,850	OHSS	*[REDACTED]*	Three training workshops implemented, on strategic information addressed to Military Health Staff to improve the decision making process based on evidence
[REDACTED]						
Continued technical assistance to Global Fund (GF) projects to ensure impact on KP cascade	Sustained Epi Control	Strengthened KP clinical cascade with GF resources	$34,500	OHSS	*[REDACTED]*	CCM analyzing and reporting on implemented strategies to contribute to the KP cascade.
[REDACTED]						
External QA Proficiency Panels	Sustained Epi Control	Institutionalization of lab QA processes	$2,163	HLAB	*[REDACTED]*	1 facility will receive satisfactory score in HIV proficiency testing by the end of FY17

	[REDACTED]					
Support for the Global AIDS Response Progress Report	Sustained Epi Control	Improved information for decision making	$4,500	HBHC	*[REDACTED]*	One report completed and updated of the host country of HIV epidemiological data, surveys and surveillance indicators according with GARPR methodology and cascade indicators.
Support for the National Report on Basic Indicators	Sustained Epi Control	Improved information for decision making	$4,000	OHSS	*[REDACTED]*	One report published of the host country of HIV epidemiological data, surveys and surveillance indicators prioritized including the cascade indicators.
TA to support critical components of HIV Military Programs for a successful response including Strategic Planning, M&E and use of Data for Decision Making	Sustained Epi Control	Capacity of military strengthened to ensure targeted strategic programming	$7,000	HVSI	*[REDACTED]*	Medical Staff will be trained in HIV Surveillance, Data Analysis and Data quality Assurance to improve HIV prevention and Treatment program in Military Personnel to produce reliable periodic report for decision making based on evidence
TOTAL			$345,136			

Table 6.3 Other Proposed Systems Investments –GUATEMALA						
Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism**	**Milestone**
HRH - Systems/Institutional Investments						
ToT Military International HIV Training Program (MIHTP) Mil-to-Mil cooperation	Sustained Epi Control	Strengthened cascade for military	$12,000	HBHC	*[REDACTED]*	One physician to participate in a ToT training program in HIV/AIDS clinical management and learn about epidemiological surveillance, laboratory diagnoses of HIV, caring for HIV patients and setting up prevention programs
Training workshops to Support Critical Components of HIV Military Programs for a Successful Response: HIV surveillance, Data Analysis and Data Quality Assurance	Sustained Epi Control	Strengthened cascade for military	$14,850	OHSS	*[REDACTED]*	Three training workshops implemented, on strategic information addressed to Military Health Staff to improve the decision making process based on evidence
Inst & Org Development						
Implementation of post exposure prophylaxis (PEP) protocol with focus on KPs	Sustained Epi Control	Infection of KPs prevented due to effective PEP protocol	$9500	HVOP	*[REDACTED]*	Two barriers removed for the implementation of PEP protocol for KPs in the health facilities supported by PEPFAR
Continued technical assistance to Global Fund (GF) projects to ensure impact on KP cascade	First 90	Strengthened KP clinical cascade with GF resources	$55,000	OHSS	*[REDACTED]*	CCM analyzing and reporting on implemented strategies to contribute to the KP cascade.
Support for the Global AIDS Response Progress Report	Sustained Epi Control	Use of data for decision making	$8,500	OHSS	*[REDACTED]*	One report completed and updated of the host country of HIV epidemiological data, surveys and surveillance indicators according with

						GARPR methodology and cascade indicators.
Strategic Information						
TRAC (Tracking Results Continuously) for MSM, TG, FSW, MAR, and PLWHA to assess the impact of intervention	First 90	Improved impact for first pillar of KP cascade	$120,000	HVOP	*[REDACTED]*	TRaC studies conducted in 2015-2016 and disseminated results
Baseline for New TA Model in KP Prevention/HTS	First 90	Improved HTS Yield	$20,000	HVOP	*[REDACTED]*	Improved HTS Yield by 3% Management Information System
TA to support critical components of HIV Military Programs for a successful response including Strategic Planning, M&E and use of Data for Decision Making	Sustained Epi Control	Improved information for decision making	$7000	HVSI	*[REDACTED]*	Medical Staff will be trained in HIV Surveillance, Data Analysis and Data quality Assurance to improve HIV prevention and Treatment program in Military Personnel to produce reliable periodic report for decision making based on evidence
Systems Development						
Provide technical assistance for HIV related Gender-Based Violence protocols with focus on KPs	Sustained Epi Control	Improved KP access to quality services	$54,500	HVOP	*[REDACTED]*	Two barriers removed for the implementation of HIV related Gender/Based Violence for KP in the health facilities supported by PEPFAR
TOTAL			$221,850			

Table 6.3 Other Proposed Systems Investments –HONDURAS						
Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism**	**Milestone**
HRH - Systems/Institutional Investments						
Fungal Co-Infection Tests, Training, and Follow-up	Sustained Epi Control	Improved MoH HR Capacity	$113,753	HBHC	*[REDACTED]*	1,782 PLHIV will be tested for crypto or histo by the end of FY17
TB Screening and TBIC Trainings and Follow-up	Sustained Epi Control	Improved MoH HR Capacity	$60,070	HBHC	*[REDACTED]*	8 HCW will be trained in TB screening and diagnosis by the end of FY17
ToT Military International HIV Training Program (MIHTP) Mil-to-Mil cooperation	Sustained Epi Control	Improved Clinical Cascade for Military	$12,000	HBHC	*[REDACTED]*	One physician to participate in a ToT training program in HIV/AIDS clinical management and learn about epidemiological surveillance, laboratory diagnoses of HIV, caring for HIV patients and setting up prevention programs
Training workshops to Support Critical Components of HIV Military Programs for a Successful Response: HIV surveillance, Data Analysis and Data Quality Assurance	Sustained Epi Control	Strengthened cascade for military	$14,850	OHSS	*[REDACTED]*	Three training workshops implemented, on strategic information addressed to Military Health Staff to improve the decision making process based on evidence
Strategic Information						
Assessment on the factors causing an increased HIV incidence among KP in La Ceiba	First 90	Improved reach for KP in La Ceiba	$96,025	HVOP	*[REDACTED]*	Study conducted & report completed
TA to support critical components of HIV Military Programs for a successful response including Strategic Planning, M&E and use of Data for Decision Making	Sustained Epi Control	Improved information for decision making	$7000	HVSI	*[REDACTED]*	Medical Staff will be trained in HIV Surveillance, Data Analysis and Data quality Assurance to improve HIV prevention and Treatment program in Military Personnel to produce reliable periodic report for decision making based on evidence
TOTAL			$296,698			

Table 6.3 Other Proposed Systems Investments –NICARAGUA						
Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism**	**Milestone**
HRH - Systems/Institutional Investments						
TB Screening and TBIC Trainings and Follow-up	Sustained Epi Control	Improved MoH HR Capacity	$95,846	HBHC	*[REDACTED]*	16 HCW will be trained in TB screening and diagnosis by the end of FY17
Strategic Information						
Training in Using Information for Decision Making	Sustained Epi Control	Improved information for decision making	$ 11,300	HVSI	*[REDACTED]*	Two training workshops implemented, on the use of strategic information related to KP addressed to decision makers at the municipalities supported by PEPFAR.
Support for the National Report on Basic Indicators	Sustained Epi Control	Improved information for decision making	$4000	HVSI	*[REDACTED]*	One report published of the host country of HIV epidemiological data, surveys and surveillance indicators prioritized including the cascade indicators.
Regional HIV Data Use and Trainings	Sustained Epi Control	Improved information for decision making	$4035	HVSI	*[REDACTED]*	2 persons will be trained in the Introduction of Economic Evaluation and the application of cost analysis in addressing program policy questions, and the use of GIS to map HIV burden by municipality by the end of FY17
TOTAL			$115,181			

Table 6.3 Other Proposed Systems Investments –PANAMA							
	Activity	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism**	**Milestone**
Strategic Information							
	Support for the Global AIDS Response Progress Report	Sustained Epi Control	Improved information for decision making	$4,500	HBHC	*[REDACTED]*	One report completed and updated of the host country of HIV epidemiological data, surveys and surveillance indicators according with GARPR methodology and cascade indicators.
	Training in Using Information for Decision Making	Sustained Epi Control	Improved information for decision making	$7,000	HVSI	*[REDACTED]*	Two training workshops implemented, on the use of strategic information related to KP addressed to decision makers at the municipalities supported by PEPFAR.
	Support for the National Report on Basic Indicators	Sustained Epi Control	Improved information for decision making	$2,500	HVSI	*[REDACTED]*	One report published of the host country of HIV epidemiological data, surveys and surveillance indicators prioritized including the cascade indicators.
	National Strategic Information Forum	Sustained Epi Control	Improved information for decision making	$4000	HVSI	*[REDACTED]*	At least two forum implemented at the national level to delivery strategic information on the HIV continuum of care, investment case and stigma and discrimination studies and others, are made available to stakeholders and decision makers in a timely way at the national level and municipalities supported by PEPFAR.
TOTAL				$18,000			

7.0 Staffing Plan

In November 2015, a staffing analysis was conducted by OGAC with representatives from each agency. Numerous recommendations were made regarding how the Central American Team should work better as a team, as well as maximize the capacity of current staff. Staffing needs were considered based on future demands in an era of increasing M&O, due to the planned New Embassy Compound (NEC) in Guatemala which will consolidate all US agencies into one space and through the use of the higher cost LNA mechanism for hiring a PEPFAR coordinator.

After the staffing analysis visit and subsequent discussions amongst HQ, it has been agreed that USAID/Guatemala will re-establish the direct hire HIV Team Lead position as a PSC and that CDC-CAR will convert a direct hire (DH) Program Deputy Director for Management & Science position to a Locally Employed Staff (LES) Health Economist position. A conversion memo for this change to LES has been signed by the US Ambassador, and the position description will be sent to HR for classification. In addition, CDC-CAR will continue to support a Public Health Analyst who serves 50% of his time as the interagency SI Liaison, as agreed by the interagency team in previous ROPs. USAID/Guatemala is in the final process of hiring two currently vacant LES positions, including one which was transferred from USAID/Nicaragua to the Guatemala regional office. DOD will maintain the current program manager in Guatemala but will not replace the one position from Nicaragua. And given that PC Guatemala has decided to withdraw from the PEPFAR program in ROP16, the current PC coordinator will be ending her contract in early FY2017.

PEPFAR Coordination Office in Guatemala: A significant change is the complete turnover of the PEPFAR Coordinator office during the summer of 2016. A new Coordinator is being recruited locally through The Embassy by using the Eligible Family Member (EFM) mechanism, as it saves time and money. However, if no local American qualifies, a PSC hire will need to be procured through OGAC. Furthermore, The Embassy has already announced the GF Liaison and administrative assistant position openings and those are in the hiring process. The GF Liaison position is funded through previous no-year HQ funds that was budgeted to hire an expat American. Since this position has been recruited locally, there is several years' worth of funds for this position.

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities (C)	Near-core Activities (NC)	Non-core Activities (NN)
Site level	Provide DSD and TA serving KP, Garifuna, and TB patients: HTS, care and treatment, and prevention		
Sub-National level	Targeted TA for KP, Garifuna, and TB patients: HTS and prevention		
National level	Targeted TA for KP, Garifuna, and TB patients in laboratory, strategic information, and health systems strengthening to support Test and Start	Targeted TA for military and in HIV surveillance, strategic information, and health systems strengthening to support Test and Start	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16

Program Area	Core Activities (C)	Near-core Activities (NC)	Non-core Activities (NN)
HTS			
HIV Testing and Counseling (HVCT)	1. Provide HTS and linkage services to KP, Garifuna, and TB patients across the range of community and facility-based settings. (R) 2. Support mobilization and creation of HTS service demand among KP and Garifuna using different methods including social media, peer networks, index testing, and mobile units. (R) 3. Increase HTS yield by testing TB confirmed and presumptive cases. (E,G,H,P) 4. Support Quality Assurance of HIV Rapid Tests (E,P) and biosafety measures for HIV testing (R)		1. Wiping the zone test. (N) 2. Health fairs 3. SMS for promotion
CARE AND TREATMENT			
HIV/TB (HVTB)	1. Support IDSA and NTB Isoniazid Preventive Therapy (IPT) for PLHIV without active TB in TB clinics. (R) 2. Screen and diagnose TB using WHO-recommended four TB symptom screening algorithm for PLHIV in HIV clinics. (R) 3. Link HIV+ TB patients to appropriate services and track linkages and treatment initiation in HIV and TB clinics. (R)		HTS among confirmed TB patients. (N)
Services related to prevention and treatment of OIs (HBHC)	1. Screen, diagnose and treat Cryptococcal and histoplasma disease among PLHIV in HIV clinics. (R) 2. Logistic support to meds management. (R)		
In-service training in care and treatment (HBHC)	Provide in-service trainings for individuals at the facility level serving PLHIV in care and treatment activities, including gender, s&d, screening, treatment, and Test & Start. (R)		Provide in-service trainings for individuals at the facility and community level serving PLHIV in c&t activities, including gender, s&d, screening, treatment and prevention of cervical cancer. (B,C) In Service Training ToT Military International Training to improve HIV treatment and care in Central America Region (G,E,H)

Adherence, retention, and clinical monitoring at the facility and community level (HTXS)	1. Support treatment adherence, retention in treatment, and clinical monitoring of treatment outcomes of PLHIV. (R) 2. Provide in-service trainings to ensure quality of ARV services. (R) 3. Peer community link for tracking HIV care and treatment service. (R) 4. Provide and VL equipment (P) and support optimization of timely and quality viral load services. (R) 5. Improve referral and community follow up of non-adherent PLHIV. (R)		
PREVENTION			
Condom marketing (HVOP)	Support accessibility and affordability of condoms for KP and Garifuna to prevent new HIV infections. (R)		
Combination prevention (HVOP)	1. Support HIV prevention activities (HIV testing, condoms, lubricants, behavior change, STI screening) targeting KP through peer outreach, small group prevention, and/or hotspot prevention activities. (R) 2. Link KP, Garifuna and TB patients to health services (FP, nutritionist, psychologists, endocrinologist, etc.) & structural services (legal services, advocacy, etc) to strengthen healthy behaviors related to HIV. (R) 3. Peer educators receiving a standardized supportive supervision including mentorship and training to better perform their role in outreach. (R)		
PEP (HVOP)	Support PEP implementation protocols for KP, Garifuna, and TB patients & victims of sexual violence to prevent new HIV infections, including M&E (R)		
NGO network building (HVOP)	Promote and strengthen social support networks of KP and Garifuna to adopt and maintain healthy behaviors and decrease vulnerability to prevent HIV as well as policy advocacy. (R)		
In-service training in prevention (HVOP)	Provide in-service trainings for individuals serving KP and Garifuna in prevention activities, including gender norms, stigma and discrimination and topics. (R)	Support interventions pertaining to gender norms within the context of HIV among health personnel and groups that are influential to the epidemic. (R)	
PROGRAM/ SYSTEM SUPPORT			
Policy, advocacy, guidelines (OHSS)	1. Develop and implement policy and advocacy (legislation, policies and regulations) focused on Test and Start, benefiting KP, PLHIV focusing on S&D and GBV prevention, including other relevant stakeholders. (R) 2. Provide TA to improve KP CSOs to participation in the national response. (R) 3. Technical assistance for the National AIDS Spending Assessment, NASA. (R) 4. Support and defend the rights of HIV-infected and affected- individuals, MSM, transgender population, including providing legal & advocacy assistance in issues related to S&D and the HIV/AIDS cascade & TA for development of a policy regarding beneficiary rights and stigma discrimination at community level . (R) 5. Support the Sustainability Plan being implemented by the Regional Coordination Mechanism harmonized with the HIV cascade priorities. (R) 6. Technical assistance for the development of	1. Provide support to Global Fund programs and activities, and donor coordination. (R) 2. Promote the COMISCA mechanism to support regional revision and harmonization of national guidelines in care and treatment. (R) 3. Support the development or updating of national guidelines for serving key populations (MSM, transgender) in the health sector. Avoiding the gaps in the HIV/AIDS continuum of care and prevention. (R) 4. Support the sharing of methods, tools, and other useful information, and share best practices and lessons learned focus in the HIV cascade to monitor HIV epidemic. (R) 5. Technical assistance to develop	1. Provide TA to National Aids Commissions and other national stakeholders to develop, implement and evaluate national HIV plans. (R)

	mechanisms for resource mobilization and cost reduction for the purchase of ARVs, commodities and reagents for diagnosis and monitoring of HIV. (R) 7. Technical assistance to increase the involvement of non-health public sectors in the HIV response in support of the continuum of care and prevention in HIV with Finance ministries. (R) 8. Technical assistance and support to strengthen information systems for monitoring HIV cascade. (R)	and implement HIV/AIDS monitoring and evaluation (M&E) plans, responding to the HIV cascade information needs, to properly monitor the epidemic and its response, including use of information from studies. (R)	
Quality Improvement (OHSS)	1. Implement QI/QA plans at KP-focused clinics and HIV care and treatment centers to increase quality and access of cascade services to KP, Garifuna, and TB patients. (R) 2. Provide TA to each intervention point for the monitoring of its expenditures through systems that meet financial management criteria at the operational level. (R) 3. Provide in-service trainings for individuals serving KP in CoC activities, including gender, stigma and discrimination and topics related. (R)	1. Support development of guidelines related to the HIV continuum of care and treatment. (E,G,P, N) 2. Provide TA for capacity building of CSOs linked to the HS. (E,G,P) 3. Technical assistance for strengthening community governance in the framework of the continuum of care to improve the HIV cascade outputs. (E,G,N,P) 4. Technical assistance and support for citizen monitoring for HIV/AIDS accessible services for the continuum of care and prevention for HIV-infected and affected- individuals and key populations. (E,G,N,P) 5. Develop curriculum for pre & in-service trainings focused on comprehensive HIV services for KP. (R) 6. Technical Assistance for Surveillance, M&E and Data for Decision making trainings, among Military Populations (G,E,H)	
Logistics (OHSS)	1. Provide TA to HIV-related supply chain systems supporting KP core services. (E,G,P) 2. Provide TA for training and development of cadres with supply chain competencies for KP core services. (E,G,N,P) 3. Support procurement process of HIV+ monitoring commodities (CD4, VL). (E,G,H,P)	1. Conduct pre-service training for logistics supporting KP core services. (E,G,P)	1. Provide TA for procurement of supplies. (H) 2. Remodel facilities, including warehouses. (H)
Laboratory (HLAB)	1. Provide laboratory capacity to support HIV, STI and TB testing and clinical monitoring at each stage of the continuum for KP and PLHIV. (R) 2. Provide in-service trainings in QA/QI and diagnostic techniques used for HIV services (R)	Provide in-service trainings in Continuous Quality Improvement, biosafety, and mentoring. (R)	RTQI (G,H)
SI capacity building (HVSI)	1. Build capacity for and ensure the implementation of the collection, analysis, use, and dissemination of HIV behavioral and biological surveillance and other surveys targeting KP, Garifuna, and PLHIV. (R) 2. Strengthen systematic review of HIV epidemic among KP; identify SNUs where HIV programs are most needed, and monitor services and quality of services provided to KP at the	1. Provide TA to support for the national M&E system planning and development to monitor care and treatment services and policies (MEGAS, GARPR, MoT, etc.) including the Basic Indicator Package Report. (R) 2. Technical assistance for the data collection and processing to	1. Population size estimations (N,H,P)

facility-level. (R)
3. Estimate population size of KP, develop HIV prevalence estimates and number of KP living with HIV, estimate distribution of new infections among KP, and estimate programmatic coverage. (E, G)
4. Generate evidence about the epidemic: prevalence, behavior change, adherence, socio-economic and anthropologic studies among Garifuna, & CoC cascade study & Users satisfaction survey in HIV clinic. . (R)
5. Strengthen HIV-case based surveillance system to improve analysis of HIV burden. (R)
6. Technical and financial support for the Survey data collection and processing of the Stigma & Discrimination Index. (E,G,N,P)
7. Support in SI in adherence across cascade. (R)
8. Technical assistance for data collection and processing to build the HIV/AIDS investment case and modeling the results of cost-effective interventions in the reduction of new HIV infections and the decrease of morbidity-mortality rates. (E,G,P)
9. Dissemination of findings, information and analysis among stakeholders, government officials, key populations and people with HIV/AIDS highlighting on the continuum of care. (E,G,N, P)

build the Model of HIV Modes of Transmission. (E,G,N,P).
3. Technical assistance for implementation of a Strategic Information Forum to disseminate studies and analysis under the framework of the HIV Cascade and continuum of care in HIV/AIDS. (E,G,N)
4. Technical Assistance to Military partners for HIV strategic planning, monitoring and evaluation.
5. Technical Assistance to train Military Personnel in Surveillance, Data Analysis and Data Quality Assurance in HIV.

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$640,825 US	**$20,973,175 US**	**$21,614,000 US**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
HVOP	Other Sexual Prevention	$5,456,575
HVCT	Counseling and Testing	$1,506,247
HBHC	Adult Care and Support	$4,161,022
HTXS	Adult Treatment	$4,332,132
HVTB	TB/HIV Care	$760,359
HLAB	Lab	$635,777
HVSI	Strategic Information	$1,270,097
OHSS	Health Systems Strengthening	$1,042,336
HVMS	Management and Operations	$1,808,630
TOTAL		**$20,973,175**

B.2 Resource Projections

The team utilized the findings from the Expenditure Analysis (EA) exercise done in 2015 as the foundation to use to calculate the amount of necessary resources for ROP16. The team used the EA data as the source for the majority of the unit costs that corresponded to each proposed target. Some of these costs were modified at the SNU level and they were adjusted to make them as real and accurate as possible. The modifications were made based on an analysis of additional information provided by implementing mechanisms or by using similar activities in other countries as reference points. This was discussed and agreed by the EA advisor.

To cost out the activities that are not directly related to targets and for which it was not possible to establish unit expenditure, the team used the overall cost for similar activities that were found in the Expenditure Analysis or an estimated cost with a detailed breakdown for these activities were requested from the IMs.

All of the proposed costs were analyzed and calculated using the PBAC tools, which then were used to calculate the budgets for each country. The PBAC information then served as the source for completing the COP16 FINANCIAL SUPPLEMENT WORKSHEET, where all the detailed budget information can be found.

APPENDIX C

C.1 Acronym List

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral therapy
CCM	Country Coordinating Mechanism
CD4	Cluster of Differentiation 4 (a type of white blood cell)
CDC	Centers for Disease Control and Prevention (USG)
COMISCA	Council of Ministries of Health from Central America (Spanish acronym)
CoPCT	Continuum of Prevention to Care to Treatment
EA	Expenditure Analysis
FSW	Female sex worker
FY	Fiscal year
G2G	Government to government (funding)
GF	Global Fund
HSS	Health systems strengthening
HIV	Human immunodeficiency virus
KP	Key Population
M&E	Monitoring and evaluation
M&O	Management and Operations
MOH	Ministry of Health
MSM	Men who have sex with men
NASA	National AIDS Spending Assessment
NGO	Non-governmental organization
NHA	National Health Accounts
OI	Opportunistic Infection
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PP	Priority Population
RCM	Regional Coordinating Mechanism
ROP	Regional Operational Plan
S/GAC	Office of the Global AIDS Coordinator & Health Diplomacy (Department of State)
SI	Strategic Information
SID	Sustainability Index
SNU	Sub-national Unit
STI	Sexually transmitted infections
TA	Technical Assistance
TB	Tuberculosis
TBD	To be determined
TGW	Trans-gender women
UIC	unique identifier code
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
USG	United States Government
VL	Viral Load