

**Central America and Brazil**  
**Regional Operational Plan**  
**ROP 2022**  
**Strategic Direction Summary**  
**May 2022**



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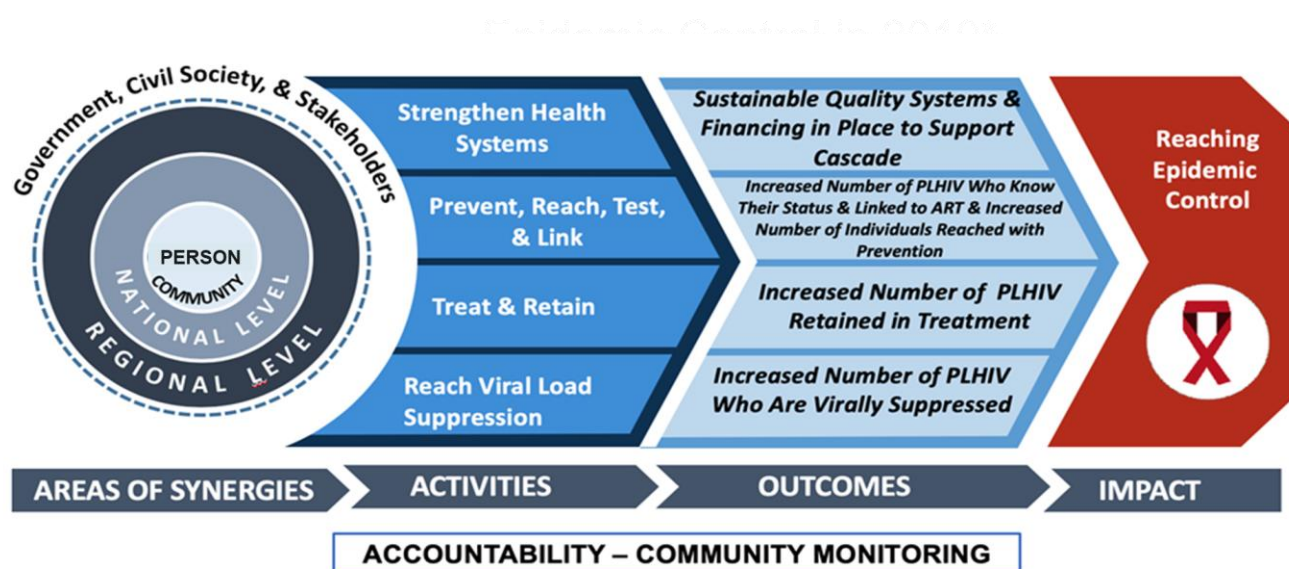
## \*Military PSNU data are non-public

A portion of PEPFAR data relates to foreign military sites, such as bases, barracks, or military hospitals. Data originating at these sites are aggregated to each respective OU's Military priority sub-national unit (PSNU) and are non-public. When developing graphics for the Strategic Direction Summary (SDS), do not include the Military PSNU, which you can find in PSNU dropdowns in Panorama. These services may be funded through a variety of implementing agencies or mechanisms, so the Military PSNU designation is not equivalent to DOD as an implementing agency.

# 1.0 Vision and Goal Statement

The PEPFAR Central America and Brazil program aligns with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR)'s Regional Operational Plan (ROP22) vision by supporting the countries in the region to achieve sustained epidemic control through equitable health services and solutions, enduring national health systems and capabilities, and lasting collaborations. In partnership with governments, civil society, and other key stakeholders, PEPFAR will build on strategies that prioritize site-level interventions and have a direct impact on the clinical cascade for all countries. PEPFAR will continue to support an aggressive scale-up of site-level support to address the gaps in each country around prevention, case finding, immediate linkage to treatment, and achievement of viral load suppression with a targeted approach to strengthen systems essential to epidemic control. The scale-up strategy started in previous ROPs will continue to focus primarily on El Salvador, Guatemala, and Honduras, but will also intensify site-level support in Panama and continue to support innovative, evidence-based interventions in select municipalities in Nicaragua and Brazil.

**Figure 1.1.1 Central America and Brazil Multi-Year PEPFAR Framework**



As seen in Figure 1.1.1, the multi-year PEPFAR Central America and Brazil strategy is person-centered with activities focused on providing the highest quality services for people living with HIV (PLHIV) based on their feedback and preferences. The strategy continues to build on synergies at the national and regional levels with robust engagement and commitment from all stakeholders. The strategy continues to highlight the importance of accountability mechanisms in the community, such as community-led monitoring, as an essential component of reaching epidemic control.

**Strengthening Quality Health Systems to Support the Cascade:** Reliable supply chains, efficient lab networks, robust systems to address equity and human rights, and functioning strategic information systems are all crucial foundations for epidemic control. Intensive policy dialogue is also needed to ensure the political will to adopt the key elements necessary to reach epidemic

control. PEPFAR will strategically target technical assistance to address and resolve identified system barriers to ensure the long-term sustainability and quality of national programs.

Prevention, Case Identification, and Linkage: PEPFAR will continue to support safe and ethical index testing at treatment sites for all newly diagnosed PLHIV, all PLHIV who have been lost to follow-up, and all PLHIV who are not virally suppressed. With index testing, high-yield key population-focused testing strategies, scaling up self-testing, and expanding catchment areas of provided-initiated testing (PITC), the United States Government (USG) plans to support countries to close the gap in the first 95, of PLHIV who do not yet know their status, and address the challenges of late diagnosis in the region. For the ROP22 prevention strategy, the USG will leverage lessons learned from Pre-Exposure Prophylaxis (PrEP) implementation for high-risk key populations (KP) and for serodiscordant partners in Guatemala, Brazil, and Panama to scale-up PrEP in the whole region, including the introduction of Event-Driven PrEP.

Rapid Antiretroviral Therapy (ART) Initiation and Continuity of Treatment: PEPFAR will continue to prioritize rapid ART initiation with immediate linkage of positives identified at the community level to same-day treatment (or within seven days.) PLHIV presenting with HIV advanced disease will be screened and treated for OI's and have intensified follow up. Differentiated service delivery (DSD) models will be offered to stable patients, including multi-month dispensing (MMD), community distribution of antiretrovirals (ARVs), home delivery of ARVs, etc. PEPFAR will increase efforts to return those who have interruptions to treatment and increase adherence with intensified adherence counselling and follow up.

Reaching Viral Load (VL) Suppression: PEPFAR uses a comprehensive and data driven approach to strengthen the HIV VL laboratory systems and aims to leverage existing investments in laboratories to enhance VL testing coverage in Central America. The program is identifying critical barriers and challenges within laboratory networks and building capacity to support VL testing and other PEPFAR diagnostics. As a result of this effort, we expect to optimize performance of the national VL laboratory network to increase VL coverage and, ultimately, suppression as clinicians have access to timely results to guide clinical decision making. Programmatic activities include conducting a comprehensive situational analysis of the current VL network financing structure and stakeholder engagement; implementing a strategy that optimizes the laboratory network system; developing and adapting viral load training materials aligned with national and PEPFAR guidelines; providing ongoing national and regional level technical assistance; and conducting quarterly follow-up meetings to share data and to monitor testing capacities and efficiencies.

Countries in the region are making significant progress but are not yet on track to reach the 95-95-95 goals. With the adoption of aggressive key targets to increase the numbers of PLHIV who know their status, PLHIV on treatment, PLHIV who are virally suppressed, and key policy changes to address high-level barriers, the USG has a unique opportunity to significantly scale up interventions and resources. This would support host country governments to aggressively tackle the gaps in the cascade and in a collaborative effort with all stakeholders, including Civil Society and multilateral partners, to reach epidemic control.

The PEPFAR program recognizes that many structural barriers and social determinants of health including racism, poverty, stigma and discrimination, migration, gender-based violence, and lack of opportunities for employment and education impact PLHIV's ability to engage with prevention, linkage and adherence to treatment in the region. To reach the 95-95-95 targets, our program must include interventions that transform the social determinants associated with HIV. In ROP 22, the USG is focusing on instituting robust interventions to address equity and Human Rights at the site, community, and national levels.

## 2.0 Epidemic, Response, and Program Context

### 2.1 Summary statistics, disease burden and country profile

The Central America and Brazil region continues to have a concentrated epidemic with certain key populations such as men who have sex with men (MSM) and transgender women (TG) with much higher prevalence rates than the general population as illustrated in Table 2.1.1

**Table 2.1.1: Host Country Government Results**

Country	New Infections 2020	PLHIV	Incidence rate /1,000 h	HIV prevalence (%)				New Infection Change from 2010 (%)	HIV deaths Change from 2010 (%)
				15-49 years	FSW	MSM	TG		
Brazil	48,000	930,000	0.23	0.6	5.3	18.6	30.0	21%	1%
El Salvador	<1,000	25,000	0.13	0.5	2.8	13.9	22.3	-46%	90%
Guatemala	<1,000	33,000	0.05	0.2	1.0	9.0	15.3	-51%	-7%
Honduras	<1,000	22,000	0.07	0.2	3.0	10.0	6.4	-6%	-43%
Nicaragua	<1,000	12,000	0.11	0.4	2.2	8.4	9.5	4%	-19%
Panamá	1,800	31,000	0.44	1.0	1.1	13.4	29.8	13%	0%

Source: [www.aids.unaids.org](http://www.aids.unaids.org). For new infections and deaths change: UNAIDS Data 2020.

Source Population: Brazil: [www.ibge.gov.br](http://www.ibge.gov.br). El Salvador: proyecciones de población municipal 2005-2025. DIGESTYC 2014. Guatemala: [www.inec.gob.gt](http://www.inec.gob.gt). Honduras: [www.inec.gob.gt](http://www.inec.gob.gt). Nicaragua: [www.inidec.gob.ni](http://www.inidec.gob.ni). Panama: [www.inec.gob.pa](http://www.inec.gob.pa)

At the same time, a USG analysis of MOH data on active PLHIV showed that most individuals are self-identified heterosexuals (75% in Guatemala and 89% in El Salvador). In the case of Guatemala, the data also demonstrates that individuals are being diagnosed late with 44% of newly diagnosed individuals in 2020 had a CD4 of less than 200. The percentage of late diagnosis was 25% in El Salvador (much lower than the 37% in 2019), 29% for Honduras (higher than the 26% in 2019), 38% in Panama, 22% in Nicaragua and 27% in Brazil (Source: UNAIDS 2021 report).

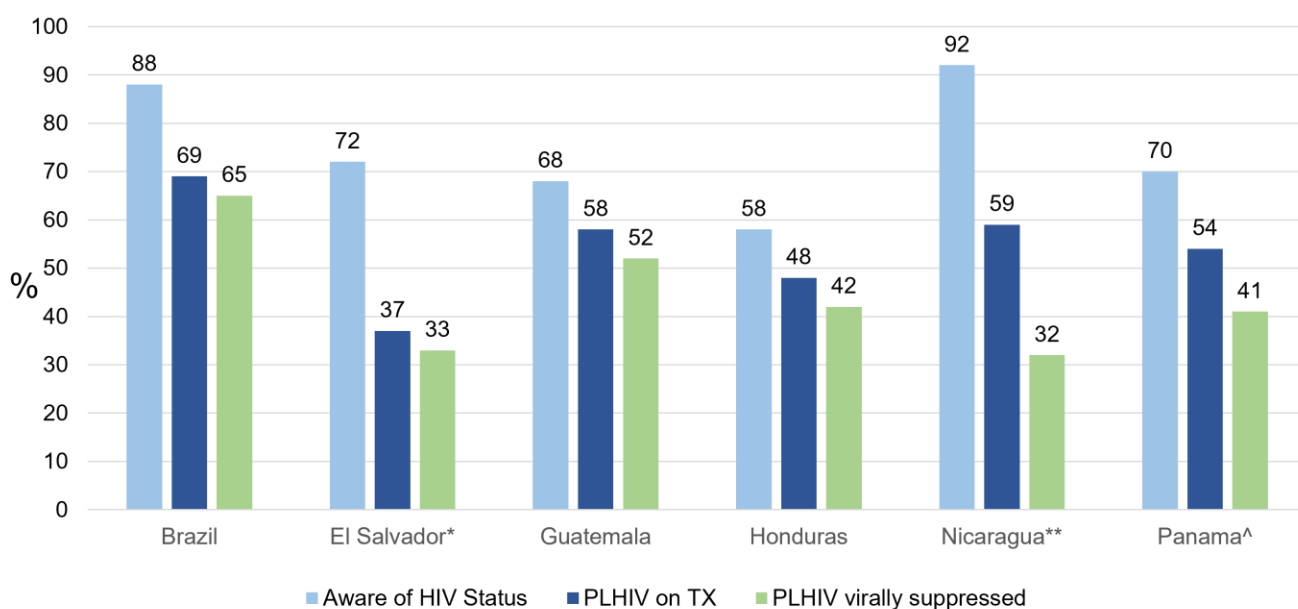
Significant gaps remain in each of the pillars of the continuum of care cascade for each country as seen in Table 2.1.2 and Figure 2.1.1. Except for Nicaragua, all countries show gaps in the estimated number of PLHIV who do not yet know their status. All six countries have significant disparities between diagnosed PLHIV and those on treatment, meaning they have not been linked to treatment after diagnosis, have not initiated treatment, or have had treatment interruption. For those on treatment, the percentage of PLHIV who are virally suppressed is relatively higher across the region, but gaps in diagnosis, linkage and continuity of treatment illustrate that all countries have still need to make significant progress to reach epidemic control.

**Table 2.1.2: 95-95-95 cascade: HIV diagnosis, treatment and viral suppression**

Country	PLHIV	PLHIV who know their status	PLHIV On ARV	PLHIV with Viral Suppression
Brazil	930,000	820,000	666,000	594,000
El Salvador	25,000	19,000	14,000	12,000
Guatemala	33,000	25,000	21,000	19,000
Honduras	22,000	16,000	12,000	8,200
Nicaragua	12,000	9,400	5,800	ND
Panamá	31,000	19,000	16,000	ND

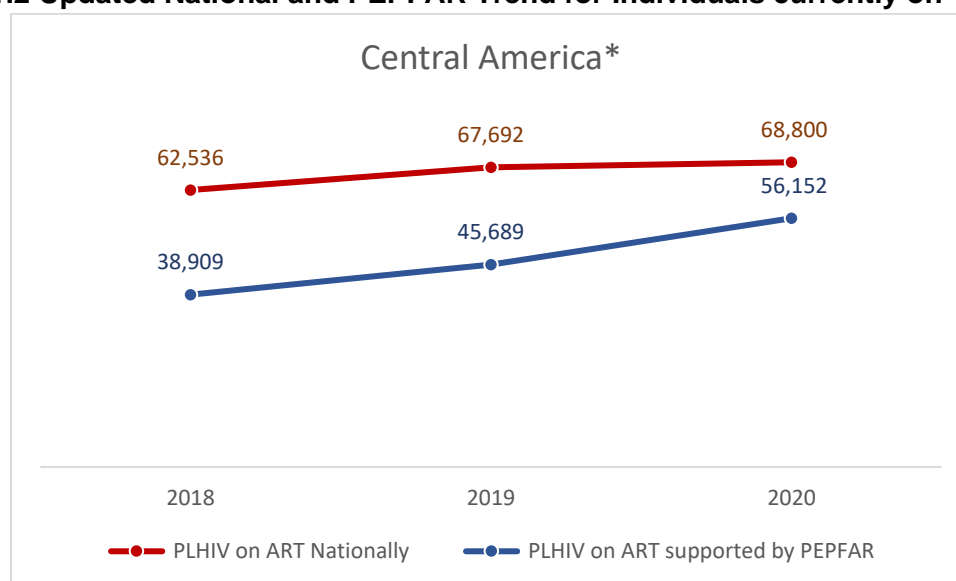
Source: [www.aids.unaids.org](http://www.aids.unaids.org). ND=No data available.

**Figure 2.1.1: 95-95-95 cascade: HIV diagnosis, treatment and viral suppression, 2020**



Source: [www.aids.unaids.org](http://www.aids.unaids.org). 2021

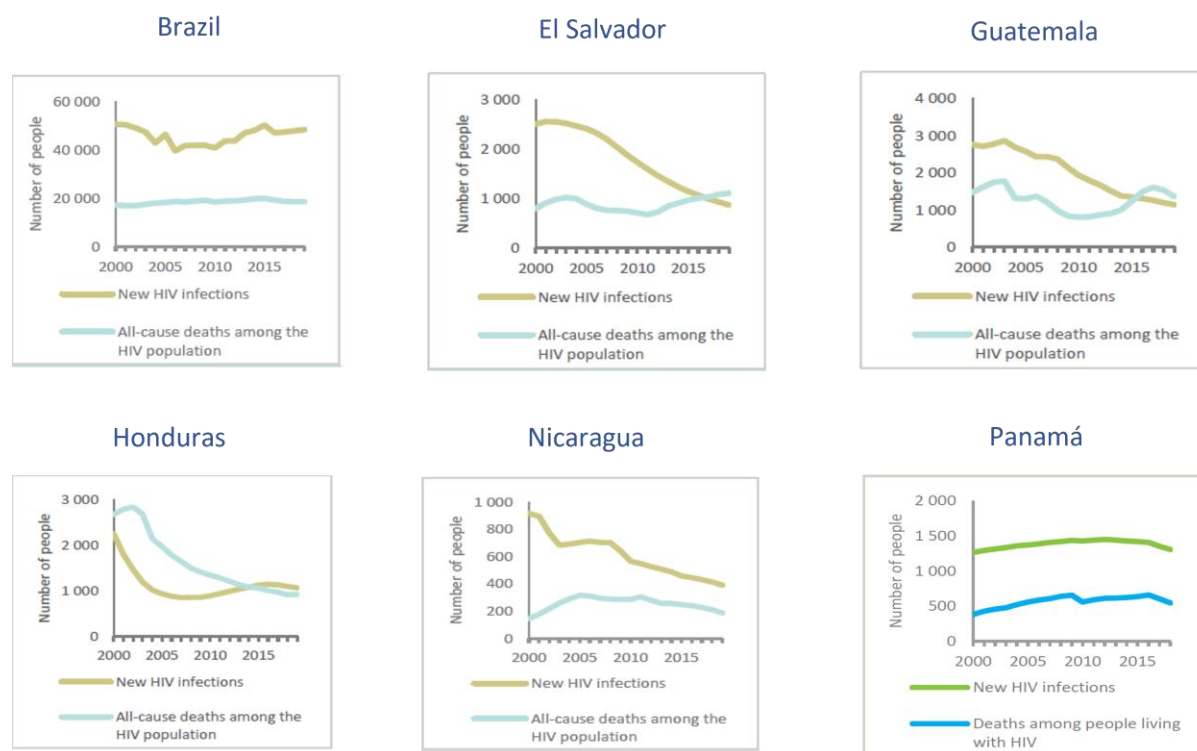
**Figure 2.1.2 Updated National and PEPFAR Trend for Individuals currently on Treatment**



\*El Salvador, Guatemala, Honduras, Nicaragua and Panama.

Source: National PLHIV on Antiretroviral Treatment (ART): [www.aids.unaids.org](http://www.aids.unaids.org), and PLHIV on ART supported by PEPFAR: DATIM (genie file downloaded 2022\_04\_05)

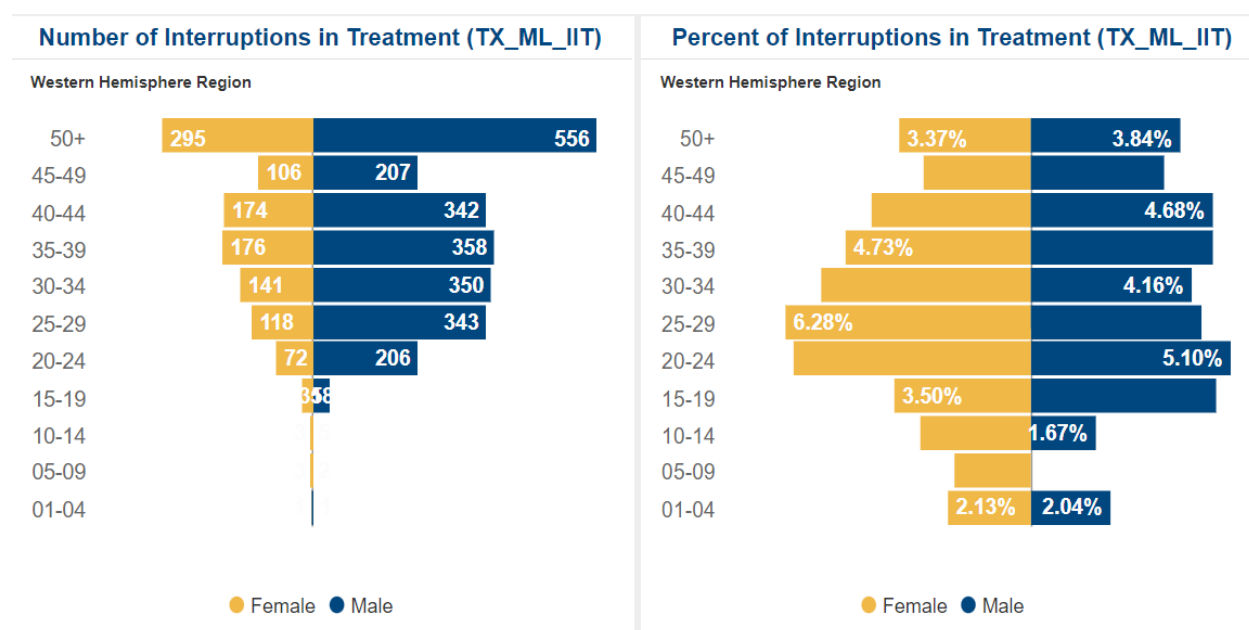
**Figure 2.1.3 Updated Trend of New Infections and All-Cause Mortality Among PLHIV**



Source: UNAIDS Spectrum, 2021

Per Figure 2.1.3, trends in new infections and all-cause mortality vary among countries. Brazil and Panama show little or no progress in the reduction of new infections, while Guatemala, El Salvador, and Nicaragua demonstrate declines since 2010; however, all-cause mortality for Guatemala and El Salvador has increased over the same period. Brazil had a decrease in HIV-related deaths since implementation of the test and treat strategy. Honduras has seen a downward trend for both; however, it has shown a recent uptick in new infections. Only Nicaragua demonstrates a more recent trend of both new infections and all-cause mortality declining, but both are still relatively high as Nicaragua still has a significant gap between those diagnosed and those on treatment as seen in the cascade.

**Figure 2.1.4 Person Gained/Lost from ART by Age/Sex, FY22 Q1 (Brazil, El Salvador, Guatemala, Honduras, Nicaragua, and Panama)**



Source: Panorama (2022\_03\_30)

As seen in Figure 2.1.4, the greatest total number of treatment interruptions are from PLHIV over 50, particularly males. However, the largest percentage of treatment interruptions are from younger PLHIV between 20-34 years, with slightly more interruption among females. The PEPFAR program aims to tailor services to meet the varying needs of PLHIV throughout their lives to ensure continuity of care.

### Implementation of Key Policies to address MPRs

In general, Central America and Brazil have a favorable legal policy framework for implementation of the PEPFAR Minimum Program Requirements (MPRs) and other World Health Organization (WHO) guidelines. The majority of the MPRs and supporting policies are already systematically implemented given the timing required to finalize the technical and administrative processes to formally modify the regulations in each country.



For test and start, ARV optimization, differentiated service delivery (DSD), and index testing, the region has made important progress. All countries completed formal policy approval and those still in the approval process are being implemented in public facilities and PEPFAR supported sites. The program is still finalizing index testing protocols in Panama, but this will be completed soon.

The region at large is advancing self-testing and PrEP, including formative research, product procurement, and guideline development. Three of the five countries (Brazil, Guatemala, and El Salvador) are implementing self-testing, and Brazil, Guatemala, and Panama are already implementing PrEP. All countries have made progress on the regulations necessary for harmonizing these MPRs with national guidelines. All countries will apply lessons learned from project start-up from country to country while they are rolling out PrEP and self-testing. They will continue scaling these interventions and implementing activities to increase demand by September 2022 to set the foundation for ROP22 implementation.

In alignment with new MPR to integrate equity, reduce stigma and discrimination, and promote human rights, the region has already been implementing critical interventions to address these issues at the facility, community, and national levels. In response to recent trends in legislative proposals to restrict the rights of KPs in the region, the program plans to expand human rights-based programming in ROP22 including gender-based violence training and developing a human rights observatory to report cases of stigma, discrimination, and violence against KP and PLHIV. In addition, PEPFAR implementing partners have strong partnerships with the Ombudsmen offices throughout the region and have facilitated courses on human rights of PLHIV and LGBTQIA+ populations in their institutional platform, supporting the reduction of stigma and discrimination among public officials. This is critical because human rights and stigma and discrimination are barriers that have been identified as persistent by UNAIDS to achieve the 95-95-95 Goals.

The Community-led Monitoring (CLM) program-led by the Central American Network of People Living with HIV in Central America (REDCA+) and the Brazilian Interdisciplinary AIDS Association (ABIA) in Brazil, in partnership with civil society organizations, and host country governments, will continued to be implemented and expanded. The results of the first year of data collection are currently being published and will be used to develop improvement plans in partnership with other stakeholders to improve quality of services at the site level as part of a person-centered approach.

Monitoring policies and implementation of minimum program requirements are systematically evaluated through Site Improvement through Monitoring System (SIMS), Sustainability Index and Dashboard (SID), data quality assurance (DQA) processes, and granular supervision visits, which will continue in ROP22.

Please see Appendix D for more details on each Minimum Program Requirements for each country.

### **Major programmatic and system gaps and barriers in achieving epidemic control**

Through data analysis and triangulation, the following gaps to reach epidemic control have been identified in the region:

1<sup>st</sup> 95: PLHIV that know their status

- Lack of subnational PLHIV estimations.
- Provider-initiated HIV testing and counseling (PITC) is implemented without a risk-based approach, leading to missed opportunities to identify new cases in the most vulnerable groups.
- Inaccurate contact information and delays in reporting affect case finding with index testing.
- Delay in formalizing Index Test guidelines inhibits large-scale scaling up (Brazil, Guatemala, Panama).
- Delays in country adoption of self-testing modality for screening results in missed opportunities for case finding.
- The timing for approval of national protocols for PrEP inhibit a robust response for prevention and avoiding new HIV cases.
- Continued requirement for individual-level pre-test counseling in national guidelines.
- Recurrent HIV rapid test stock outs.
- Laws restricting HIV testing to certain cadres, allowing no pathway for certification for other service providers (in some countries).

2<sup>nd</sup> 95: PLHIV on ART

- Not all positives identified outside of clinics have an effective referral system to HIV services.
- Confidentiality protocols impede PITC reporting (Panama).
- Communication gaps with other testing implementers at the community level for referral to HIV services.
- Absence of early warning systems for PLHIV who lose contact to be linked to ART in a timely manner.
- Weak TB/opportunistic infection and HIV cross control.

3<sup>rd</sup> 95: PLHIV Virally Suppressed

- Lack of a strategy to deconcentrate services (first/second level of care/community) and laboratory.
- Weak patient registry at the service level to determine client interruption in treatment or death.
- Shortage of Viral Load reagents at key sites (Honduras).
- Weak sample transportation networks.

Other barriers affecting more than one of the cascade pillars:

- Geographic and economic barriers to PLHIV and KP access HIV services.
- PLHIV fear sharing information about contacts.
- Lack of standardized guidelines, operating procedures and information systems to register and follow-up PLHIV on ART.
- Health system capacity identified as a potential barrier to cohort growth.
- Stigma and discrimination practices in health services (outside of HIV clinics) and in public settings.

- Constraints in Logistics Management Information systems (LMIS) for registration, data use, and monitoring and analysis of inventory levels.
- MOH concerns on legacy ARV stocks and existing regulations on expiration, damaged, or unused drugs, could lead to a slowdown of the cohort's transition to Tenofovir/Lamivudine/Dolutegravir (TLD).
- Lack of integrated systems to HIV services for inventory management information systems for diagnostic tests and laboratory supplies and registration.

In addition, recently there have been changes in the context that can become barriers to implementation:

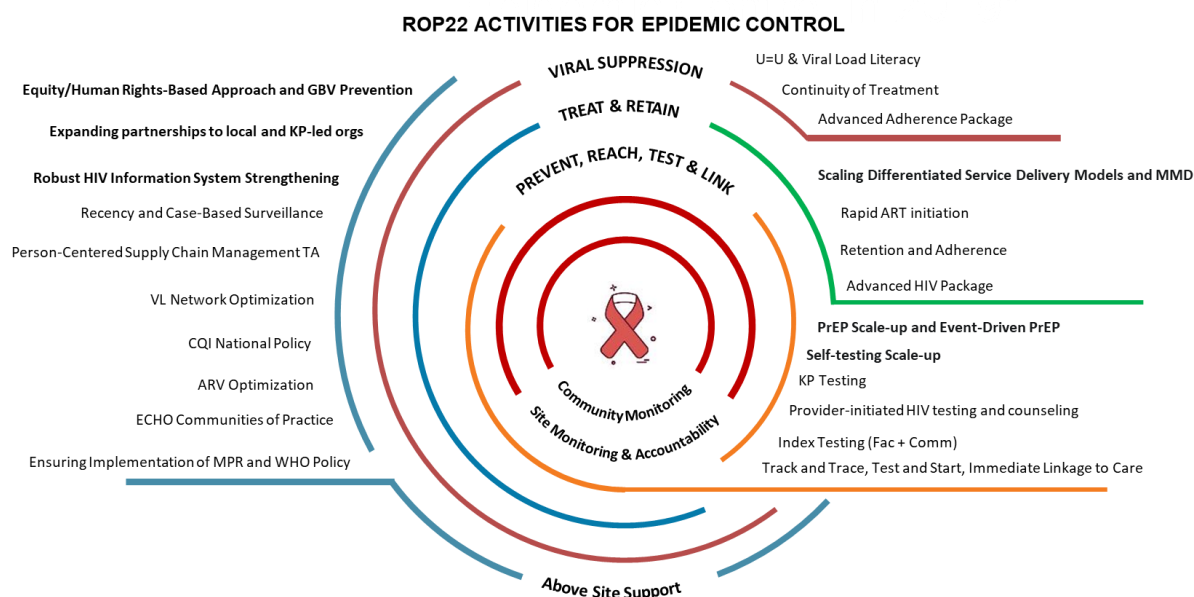
- Laws to control funding received by civil society organizations (CSOs) could delay or halt the local partner transition process (Guatemala, El Salvador, and Nicaragua).
- Potential legislation to restrict rights of KP (Guatemala).
- Governance models, reversals in governance, and elections slow down the decision-making process and affect scaling-up of interventions.

The PEPFAR program is prioritizing the following actions to address these barriers and gaps:

1. PrEP and self-testing scale-up through private and public sector partners, support to public sector in adopting strategies, and diversify delivery models for PrEP.
2. Implementation of key population outreach and testing, social network testing, index testing, and private laboratories testing strategies with direct referral to HIV services.
3. Expanding PITC in public and private settings and coordinating with key actors in testing sites for referral of new cases.
4. Expand service delivery in alignment with host government catchment areas.
5. Enhance HIV recent infection surveillance to identify and respond to concentrations of active transmission.
6. Increase internal and expanded granular analysis to identify and prevent gaps, avoid losses, build opportunities, and create new partnerships, including deep-dive analysis of PEPFAR and host-country programmatic data.
7. Strengthen and build upon existing health information systems (HIS) for PLHIV registration and follow-up; both physical and digital records.
8. Strengthening Supply Chain Management and LMIS including promoting End-To-End visibility; HIV tracer commodities; reporting nominal data; analyses of national and subnational gaps; and supervision at the site level.
9. Improve forecasting and supply planning by updating TLD migration plan optimization, including all HIV tracer commodities, and addressing legacy ARV barriers.
10. Strengthen the VL testing and sample transportation networks.
11. Policy monitoring and operational reforms (including SIMS and SID) to address structural barriers, continuing an enabling environment for key populations, and ensuring high-quality services.
12. Promote stakeholder engagement to support equity, reduction of stigma and discrimination, promotion of human rights of PLHIV and LGBTQI+ throughout the cascade, and mitigation of harmful policies and social norms in different settings.
13. Community-led Monitoring (CLM) and active engagement of civil society partners in the HIV service delivery and policy arena.

## 2.2 New Activities and Areas of Focus for ROP22, Including Focus on Person-Centered ART Continuity

Figure 2.2.1 ROP22 Activities for Epidemic Control



New activities or activities that are scaling in ROP22 are bolded in the above graphic.

To complement to priorities listed in the above section, the PEPFAR Central America and Brazil program will introduce the following new activities in ROP22:

- **Intensifying intervention to address equity and Human Rights:** In ROP22, the program will focus on creating safe spaces in the community, implementing Free of Stigma and Discrimination Certifications and Gender-Based Violence Training at the facility-level, and on developing alliances with Ombudsman's Offices and the Justice Sector to prevent, denounce, investigate, and prosecute hate crimes, an Observatory of HHRR violations with legal advice for KP at the above-site level. The program will also build on formative research started in ROP21 to implement innovations to overcome barriers to services for other vulnerable populations such as mobile populations and indigenous communities.
- **Bringing New Technologies to Scale:** PEPFAR Central America and Brazil will bring new technologies to scale, including Self Testing, PrEP, linkage to care, Rapid ART initiation, Advance HIV OI's rapid diagnosis, management with intensified community follow up and Treatment Optimization, to improve the quality of person-centered care. The program will leverage best practices from current implementation for more efficient scale-up and transition them to routine service delivery (e.g., forecasting, supply planning, training and in place) for sustainable implementation.
- **Expanding Differentiated Service Delivery (DSD) and Improving Access to Services:** To facilitate ART Continuity, PEPFAR Central America is identifying catchment areas around health facilities in large metropolitan areas (aligning with predesignated MOH networks

and natural flows of clients). By making this explicit, staff can work in the surrounding community to expand differentiated service delivery models (multi-month dispensing, community drug delivery, home-delivery, pick-up points, extended hours, etc.); and increase the quality and access to testing, linkage to treatment and adherence support in the community for PLHIV.

- **Expanding Partnerships with Local and KP-led Organizations:** The program plans to expand partnerships through sub-awards to local and KP-led organizations to provide peer-led services, mobilize communities, and help scale PrEP, DSD and other program priorities. The program will also continue to prioritize Community-led Monitoring (CLM) to keep site-level implementation accountable and improve quality of services.
- **Building Robust Data Systems:** PEPFAR Central America will work with host government to plan more robust and comprehensive HIV data systems to improve the quality of surveillance data from end-user to national level in each country.
- **Equity-Based Programming, DSD Expansion, PLHIV care into Primary Health Care services, and Social Networking Strategies in Brazil:** The PEPFAR Brazil program will focus on cross-cutting activities to reduce inequity, stigma and discrimination, including online training in Zero Discrimination, social benefits and rights, and mapping the social security network establishing bidirectional references. They will also expand DSD options for ART and PrEP delivery, and appointment alerts by Virtual Clinic (home delivery/post, primary care clinics, or automatic dispensers/digital lockers). The PACK (Practical Approach to Care Kit) methodology will be implemented, focusing on access and HIV care-sharing in primary health care services for PLHIV and people at high risk of HIV infection. Finally, they will support Social Network Strategies roll-out, with the implementation of different voucher options according to each location and user decision.

## **2.3 Investment Profile**

The governments of Central America and Brazil have been financially leading their national responses since the beginning of the HIV epidemic and have been steadily increasing their budgetary investment over time.

The results of the NASA studies in Figure 2.3.1 show the lead role that national governments continue to play in investing resources including financing commodities, with Global Fund and PEPFAR providing complementary funds. For 2022, the government of Panama is providing 66% of total HIV funding (with PEPFAR providing 4%), the government of Guatemala is providing 65% of funds (with PEPFAR contributing slightly under 11%), the government of Honduras is providing 53% of the total funds (with PEPFAR at 1%), and the government of El Salvador is providing 73% of funds (with PEPFAR at 6%). Four of the five Central American countries have active Global Fund grants. Panama closed out its final grant at the end of 2021 and Brazil does not have a Global Fund grant. PEPFAR's contribution to the HIV response increased during ROP20 in line with the aggressive site-level scale-up strategy and has marginally increased since.

**Table 2.3.1: Budget by Program Area (including commodities) and Funding Source by Country**

Table 2.3.1: Panama - Budget by Program Area (incl. Commodities), 2019-2022								
	Domestic Government		Global Fund		PEPFAR		Other Funders	
	2021	2022	2021	2022	2021	2022	2021	2022
Care and Treatment	\$27,946,699	\$28,679,638	\$174,848	\$179,433	\$675,870	\$693,595	\$2,270	\$2,329
HIV Testing Services	\$2,075,251	\$2,129,678	\$39,210	\$40,238	\$402,861	\$413,427	\$528,244	\$542,098
Prevention	\$2,893,289	\$2,969,169	\$1,146,242	\$1,176,303	\$288,215	\$295,774	\$10,681,073	\$10,961,198
Orphans and Vulnerable Children	\$51,891	\$53,251	\$0	\$0	\$0	\$0	\$250,910	\$257,491
Above Site Programs	\$328,503	\$337,118	\$1,980,726	\$2,032,673	\$796,769	\$817,665	\$287,500	\$295,040
Program Management	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total (incl. Commodities)	\$33,295,632	\$34,168,854	\$3,341,025	\$3,428,648	\$2,163,715	\$2,220,461	\$11,749,997	\$12,058,156
Data Sources and Additional Comments	Note 1) Data for 2018 were generated based on the NASA 2018 database of Panama. 2) For the years 2020, 2021, 2022, 2023, and 2024: a) were estimated annual expenditure reported in 2018 data, readjusted the expenditures by inflation; b) It is assumed that the variation of the annual expenditure in each of the items for the years indicated above, will be equal to the interannual variation of the general CPI registered between 2020 - 2021; c) The website <a href="http://www.secmca.org/simafir.html">http://www.secmca.org/simafir.html</a> was consulted for the data of the Consumer Price Index of Panama.							

Table 2.3.1: Guatemala - Budget by Program Area (incl. Commodities), 2019-2022																		
	Domestic Government				Global Fund				PEPFAR				Other Funders					
	2021	2021 Revised	2023	2023 Revised	2021	2022	2023	2024 (if available)	2022	2022 Revised	2023	2024 (if available)	2021	2021 Revised	2022	2022 Revised	2023	2023 Revised
Care and Treatment	\$31,418,303		\$34,522,454	\$0		\$1,558,668	\$0	\$1,712,665	\$281,249	\$0	\$294,815	\$0	\$309,036	\$1,951,793	\$2,045,941	\$0	\$2,144,631	\$0
HIV Testing Services	\$3,944,758		\$4,334,503	\$0		\$279,353	\$0	\$306,953	\$620,457	\$0	\$650,386	\$0	\$681,758	\$92,078	\$96,520	\$0	\$101,176	\$0
Prevention	\$3,328,877		\$3,657,773	\$0		\$2,338,035	\$0	\$2,589,034	\$1,935,704	\$0	\$2,029,076	\$0	\$2,126,953	\$1,719,845	\$1,802,805	\$0	\$1,889,767	\$0
Orphans and Vulnerable Children	\$70,997		\$78,011	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Above Site Programs	\$115,220		\$126,604	\$0		\$2,676,692	\$0	\$2,941,151	\$1,893,784	\$0	\$1,985,135	\$0	\$2,080,892	\$887,942	\$930,773	\$0	\$975,671	\$0
Program Management	\$412,601		\$453,366	\$0		\$3,978,764	\$0	\$4,371,869	\$2,060,111	\$0	\$2,159,485	\$0	\$2,263,652	\$174,544	\$182,963	\$0	\$191,789	\$0
Total (incl. Commodities)	\$39,290,755		\$43,172,710	\$0		\$10,831,512	\$0	\$11,901,673	\$6,791,304	\$0	\$7,118,896	\$0	\$7,462,290	\$4,826,202	\$5,059,003	\$0	\$5,303,034	\$0
Data Sources and Additional Comments	1) Data for 2015 were generated based on NASA 2015 data from Guatemala. 2) For the years 2020, 2021, 2022, 2023, and 2024: a) were estimated annual expenditure reported in 2015 data, readjusted the expenditures by inflation; b) It is assumed that the variation of the annual expenditure in each of the items for the years indicated above, will be equal to the interannual variation of the general CPI registered between 2019 and 2020; c) The website <a href="http://www.secmca.org/simafir.html">http://www.secmca.org/simafir.html</a> was consulted for data on the Guatemala Consumer Price Index.																	

Table 2.3.1: Honduras - Budget by Program Area (incl. Commodities), 2021-2022								
	Domestic Government		Global Fund		PEPFAR		Other Funders	
	2021	2022	2021	2022	2021	2022	2021	2022
Care and Treatment	\$11,017,596	\$11,603,270	\$2,202,025	\$2,319,080	\$887,218	\$934,381	\$0	\$0
HIV Testing Services	\$2,167,131	\$2,282,332	\$620,063	\$653,025	\$146,777	\$154,580	\$1,000,523	\$1,053,709
Prevention	\$4,719,515	\$4,970,395	\$1,272,713	\$1,340,368	\$558,062	\$587,728	\$7,974,679	\$8,398,598
Orphans and Vulnerable Children	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Above Site Programs	\$1,534,876	\$1,616,467	\$408,780	\$430,510	\$1,900,889	\$2,001,936	\$0	\$0
Program Management	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total (incl. Commodities)	\$19,439,119	\$20,472,464	\$4,503,581	\$4,742,983	\$3,492,946	\$3,678,624	\$8,975,202	\$9,452,307
Data Sources and Additional Comments	Note 1) Data for 2016 and 2019 were generated based on the NASA 2016 database and the NASA 2019 database of Honduras. 2) For the years 2020, 2021, 2022, 2023, and 2024: a) were estimated annual expenditure reported in 2019 data, readjusted the expenditures by inflation; b) It is assumed that the variation of the annual expenditure in each of the items for the years indicated above, will be equal to the interannual variation of the general CPI (base year 2000) registered between 2020 - 2019; c) The website <a href="http://www.secmca.org/simafir.html">http://www.secmca.org/simafir.html</a> was consulted for the data of the Consumer Price Index of Honduras.							

**Table 2.3.1: El Salvador - Budget by Program Area (incl. Commodities), 2019-2022**

	Domestic Government		Global Fund		PEPFAR		Other Funders	
	2021	2022	2021	2022	2021	2022	2021	2022
Care and Treatment	\$26,504,065	\$28,124,545	\$1,648,176	\$1,748,946	\$1,040,697	\$1,104,326	\$402,329	\$426,928
HIV Testing Services	\$5,737,284	\$6,088,066	\$1,058,150	\$1,122,846	\$302,989	\$321,514	\$173,017	\$183,596
Prevention	\$20,730,618	\$21,998,105	\$1,643,083	\$1,743,542	\$25,385	\$26,937	\$5,070,912	\$5,380,952
Orphans and Vulnerable Children	\$1,322,706	\$1,403,578	\$0	\$0	\$0	\$0	\$246,014	\$261,055
Above Site Programs	\$633,549	\$672,285	\$1,967,967	\$2,088,291	\$3,384,003	\$3,590,903	\$2,438,007	\$2,587,069
Program Management	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total (incl. Commodities)	\$54,928,222	\$58,286,578	\$6,317,376	\$6,703,625	\$4,753,074	\$5,043,681	\$8,330,280	\$8,839,600
Data Sources and Additional Comments	1) Data for 2018 were generated based on the NASA 2018 database of El Salvador. <a href="http://www.salud.gob.sv/download/informe-de-medicion-de-gastos-en-sida-ano-2018-el-salvador/">http://www.salud.gob.sv/download/informe-de-medicion-de-gastos-en-sida-ano-2018-el-salvador/</a> 2) Data for 2019 were generated based on the NASA 2019 database for El Salvador. <a href="http://www.salud.gob.sv/download/informe-de-medicion-de-gastos-en-sida-ano-2019-el-salvador/">http://www.salud.gob.sv/download/informe-de-medicion-de-gastos-en-sida-ano-2019-el-salvador/</a> 3) For the years 2020, 2021, 2022, 2023, and 2024: a) were estimated annual expenditure-based in 2019 data, readjusted the expenditures by inflation; b) It is assumed that the variation of the annual expenditure in each of the items for the years indicated above, will be equal to the interannual variation of the general CPI registered between 2020 and 2021; c) The website <a href="http://www.secmca.org/simafic.html">http://www.secmca.org/simafic.html</a> was consulted for the data of the Consumer Price Index of El Salvador.							

Brazil - Budget by Program Area (incl. Commodities), 2021-2022				
	Domestic Government (CY)	PEPFAR (FY)		
	2021	2021	2022	2023
Above Site Program	N/A	\$ 485,463	\$ 93,976	\$ 435,983
Care & Treatment	\$ 353,383,459	\$ 342,726	\$ 1,812,238	\$ 653,187
HIV testing services	\$ 61,454,175	\$ 3,169,881	\$ 644,557	\$ 657,648
Prevention	\$ 6,931,842	\$ 54,412	\$ 130,199	\$ 204,479
Program Management	N/A	\$ 567,356	\$ 199,652	\$ 448,782
TOTAL	\$ 421,769,476	\$ 4,619,838	\$ 2,880,622	\$ 2,400,079

## Procurement Profiles for Key Commodities

As shown in Table 2.3.2, national governments continue to fund the majority of commodities, especially antiretrovirals (ARVs). Rapid test kits and viral load reagents are covered by host countries and the Global Fund, although there are frequent stock outs reported across Honduras and Guatemala. Some PEPFAR funds are utilized for rapid test procurement but are not registered at central systems until NASA processes are completed in each country. Global Fund and host countries purchase condoms which represents approximately 6% of the total key commodities.

As part of the other commodities items, supplies such as Duo Test, Hepatitis B/C, CD4 test, coolers, needles, masks, or other minor lab supplies were registered.

**Table 2.3.2: Commodities Budget by Funding Source by Country**

Table 2.3.2: El Salvador Budget by Commodity Detail, 2019-2022								
	Domestic Government		Global Fund		PEPFAR		Other Funders	
	2021	2022	2021	2022	2021	2022	2021	2022
Antiretroviral Drugs	\$3,008,257	\$3,103,336	\$0	\$0	\$0	\$0	\$346,620	\$357,575
Condoms and Lubricants	\$23,670	\$25,117	\$0	\$0	\$0	\$0	\$2,175,145	\$2,308,135
Rapid Test Kits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Laboratory Supplies and Reagents	\$5,078,027	\$5,388,502	\$1,521,317	\$1,614,332	\$0	\$0	\$320,842	\$340,459
Medicines	\$2,919,936	\$3,098,463	\$62,733	\$66,568	\$0	\$0	\$3,241	\$3,439
Consumables	\$423,188	\$449,062	\$90,464	\$95,996	\$79,064	\$74,509	\$83,090	\$88,170
Health Equipment	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
PSM Costs	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Total Budget, Commodities Only</b>	<b>\$11,453,078</b>	<b>\$12,064,480</b>	<b>\$1,674,514</b>	<b>\$1,776,895</b>	<b>\$79,064</b>	<b>\$74,509</b>	<b>\$2,928,938</b>	<b>\$3,097,778</b>
<p><b>Data Sources and Additional Comments</b></p> <p>1) Data for 2018 were generated based on the NASA 2018 database of El Salvador. <a href="http://www.salud.gob.sv/download/informe-de-medicin-de-gastos-en-sida-ano-2018-el-salvador/">http://www.salud.gob.sv/download/informe-de-medicin-de-gastos-en-sida-ano-2018-el-salvador/</a>  2) Data for 2019 were generated based on the NASA 2019 database for El Salvador. <a href="http://www.salud.gob.sv/download/informe-de-medicin-de-gastos-en-sida-ano-2019-el-salvador/">http://www.salud.gob.sv/download/informe-de-medicin-de-gastos-en-sida-ano-2019-el-salvador/</a>  3) For the years 2020, 2021, 2022, 2023, and 2024: a) were estimated annual expenditure-based in 2019 data, readjusted the expenditures by inflation; b) It is assumed that the variation of the annual expenditure in each of the items for the years indicated above, will be equal to the interannual variation of the general CPI registered between 2020 and 2021; c) The website <a href="http://www.secmca.org/simafir.html">http://www.secmca.org/simafir.html</a> was consulted for the data of the Consumer Price Index of El Salvador.</p>								

Table 2.3.2: Guatemala - Budget by Commodity Detail, 2019-2022								
	Domestic Government		Global Fund		PEPFAR		Other Funders	
	2021	2022	2021	2022	2021	2022	2021	2022
Antiretroviral Drugs	\$8,630,331	\$8,821,699	\$0	\$0	\$0	\$0	\$0	\$0
Condoms and Lubricants	\$243,698	\$255,453	\$672,778	\$705,231	\$199,373	\$208,990	\$1,386,377	\$1,453,251
Rapid Test Kits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Laboratory Supplies and Reagents	\$9,692,923	\$10,160,480	\$0	\$0	\$24,477	\$25,658	\$375,868	\$393,999
Medicines	\$2,559,827	\$2,683,305	\$461,279	\$483,530	\$0	\$0	\$984,861	\$1,032,368
Consumables	\$647,250	\$678,472	\$339,784	\$356,174	\$43,526	\$45,626	\$29,071	\$30,473
Health Equipment	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
PSM Costs	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Total Budget, Commodities Only</b>	<b>\$21,774,029</b>	<b>\$22,599,408</b>	<b>\$1,473,841</b>	<b>\$1,544,934</b>	<b>\$267,377</b>	<b>\$280,274</b>	<b>\$2,776,177</b>	<b>\$2,910,091</b>
<p><b>Data Sources and Additional Comments</b></p> <p>1) Data for 2015 were generated based on NASA 2015 data from Guatemala.  2) For the years 2020, 2021, 2022, 2023, and 2024: a) were estimated annual expenditure reported in 2015 data, readjusted the expenditures by inflation; b) It is assumed that the variation of the annual expenditure in each of the items for the years indicated above, will be equal to the interannual variation of the general CPI registered between 2019 and 2020; c) The website <a href="http://www.secmca.org/simafir.html">http://www.secmca.org/simafir.html</a> was consulted for data on the Guatemalan Consumer Price Index.</p>								

Table 2.3.2: Honduras - Budget by Commodity Detail, 2021-2022								
	Domestic Government		Global Fund		PEPFAR		Other Funders	
	2021	2022	2021	2022	2021	2022	2021	2022
Antiretroviral Drugs	\$2,718,220	\$2,900,884	\$244,539	\$260,972	\$0	\$0	\$1,999	\$2,134
Condoms and Lubricants	\$606,580	\$647,342	\$21,628	\$23,082	\$0	\$0	\$7,914,757	\$8,446,628
Rapid Test Kits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Laboratory Supplies and Reagents	\$1,396,200	\$1,490,025	\$933,533	\$996,266	\$0	\$0	\$79,286	\$84,614
Medicines	\$696,289	\$743,080	\$627,580	\$669,754	\$0	\$0	\$0	\$0
Consumables	\$54,257	\$57,903	\$481,647	\$514,014	\$0	\$0	\$94,554	\$100,908
Health Equipment	\$0	\$0	\$92,748	\$98,980	\$0	\$0	\$0	\$0
PSM Costs	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Total Budget, Commodities Only</b>	<b>\$5,471,545</b>	<b>\$5,839,233</b>	<b>\$2,401,676</b>	<b>\$2,563,069</b>	<b>\$0</b>	<b>\$0</b>	<b>\$8,090,595</b>	<b>\$8,634,283</b>
<p><b>Data Sources and Additional Comments</b></p> <p>Note  1) Data for 2016 and 2019 were generated based on the NASA 2016 database and the NASA 2019 database of Honduras.  2) For the years 2020, 2021, 2022, 2023, and 2024: a) were estimated annual expenditure reported in 2019 data, readjusted the expenditures by inflation; b) It is assumed that the variation of the annual expenditure in each of the items for the years indicated above, will be equal to the interannual variation of the general CPI (base year 2000) registered between 2020 - 2019; c) The website <a href="http://www.secmca.org/simafir.html">http://www.secmca.org/simafir.html</a> was consulted for the data of the Consumer Price Index of Honduras.</p>								



Table 2.3.2: Panama Budget by Commodity Detail, 2019-2022								
	Domestic Government		Global Fund		PEPFAR		Other Funders	
	2021	2022	2021	2022	2021	2022	2021	2022
Antiretroviral Drugs	\$18,195,432	\$18,297,330	\$0	\$0	\$0	\$0	\$150,410	\$151,252
Condoms and Lubricants	\$72,144	\$74,036	\$40,442	\$41,503	\$0	\$0	\$0	\$0
Rapid Test Kits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Laboratory Supplies and Reagents	\$1,868,962	\$1,917,978	\$2,925	\$3,001	\$78,156	\$80,206	\$0	\$0
Medicines	\$268,074	\$275,105	\$0	\$0	\$0	\$0	\$0	\$0
Consumables	\$293,336	\$301,029	\$64,606	\$66,300	\$0	\$0	\$91,984	\$94,396
Health Equipment	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
PSM Costs	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total Budget, Commodities Only	\$20,697,948	\$20,865,478	\$107,972	\$110,804	\$78,156	\$80,206	\$242,394	\$245,649
Data Sources and Additional Comments	Note							
	1) Data for 2018 were generated based on the NASA 2018 database of Panama. 2) For the years 2020, 2021, 2022, 2023, and 2024: a) were estimated annual expenditure reported in 2018 data, readjusted the expenditures by inflation; b) It is assumed that the variation of the annual expenditure in each of the items for the years indicated above, will be equal to the interannual variation of the general CPI registered between 2020 - 2021; c) The website <a href="http://www.secmca.org/simafir.html">http://www.secmca.org/simafir.html</a> was consulted for the data of the Consumer Price Index of Panama.							

Brazil - Budget by Commodity Minor Category, 2021-2022			
	PEPFAR		
	2021	2022	2023
CD4 Reagents and Consumables	\$ 23,868	\$ 47,250	\$ 25,337
Other Pharma Product	\$ 15,470	\$ -	\$ 277,813
Other Tests	\$ 19,448	\$ 5,702	\$ 13,971
Recency Testing	\$ 351,120	\$ -	\$ -
Self Testing	\$ 5,562	\$ -	\$ 41,381
TB Reagents and Consumables	\$ 5,460	\$ 1,620	\$ 2,221
VL Reagents and Consumables	\$ 338,000	\$ 183,600	\$ 101,397
<b>TOTAL</b>	<b>\$ 758,928</b>	<b>\$ 238,172</b>	<b>\$ 462,119</b>

**Table 2.3.3: Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration**

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration		
Funding Source	Total USG Non-PEPFAR Resources*	Objectives
USAID MCH	3,000,000	Improve the health of pregnant women and children, reducing malnutrition and improving maternal and childcare.
USAID Family Planning	5,500,000	Contribute to reducing the unsatisfied demand for family planning methods and improving the reproductive health of the population.
USAID Nutrition	4,500,000	Reduce chronic malnutrition in selected geographic areas.
<b>Total</b>	<b>13,000,000</b>	

\* Funds only in Guatemala

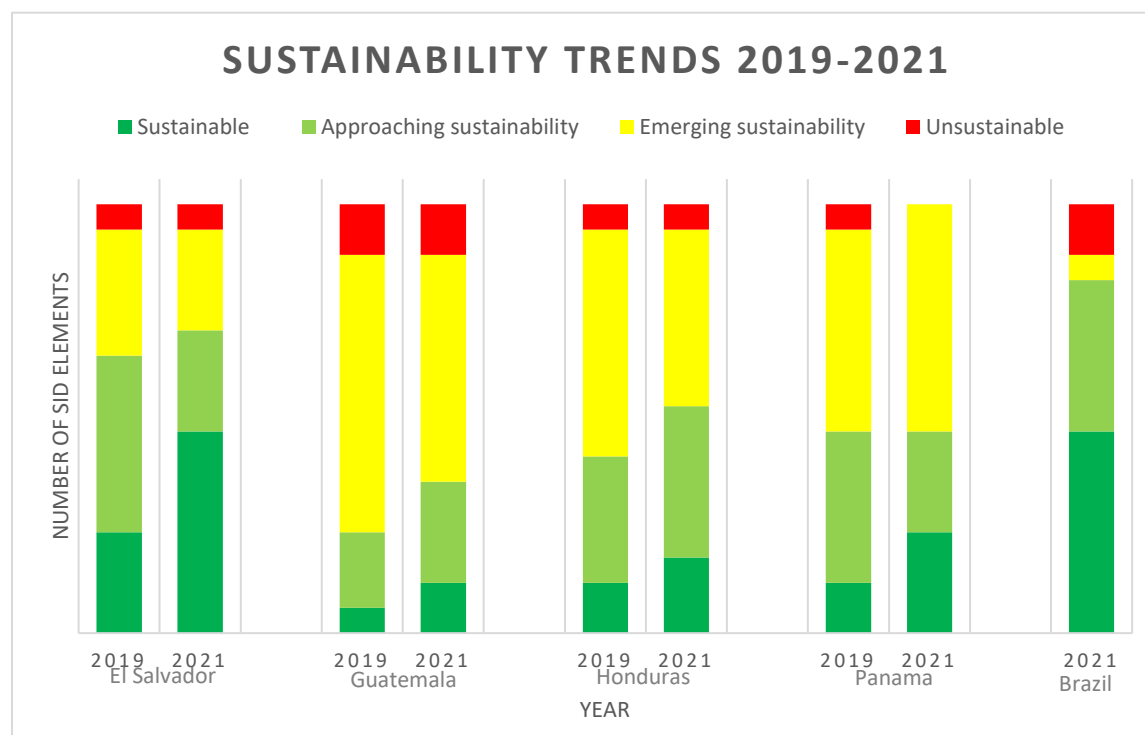
## 2.4 National Sustainability Profile Update

### Progress addressing sustainability strengths and vulnerabilities identified through the Sustainability Index Dashboard (SID):

During the last three years, the Central America and Brazil region has continued to successfully address the sustainability gaps identified in the Sustainability Index Dashboard (SID). Although there is variation between countries, the five countries show an increase in the number of

sustainable elements. Brazil conducted their first SID assessment in 2021. Nicaragua did not undergo a SID assessment in 2021 and is therefore not included in this analysis.

**Figure 2.4.1 Sustainability Trends 2019-2021**



The results of SID 2021 show that the Planning and Coordination element is at sustainable levels across all countries. The most relevant positive changes towards sustainability identified in the last SID are as follows:

- In El Salvador, four elements advanced to the area of sustainability including Service Delivery, Health Workforce, Quality Management, Technical and Allocative Efficiencies and Commodity Security and Supply Chain
- In Guatemala, Public Access to Information and Epidemiological and Health Data advanced to sustainable levels
- in Honduras, Service Delivery, Health Workforce, Epidemiological and Health Data and Financial/Expenditure Data advances to sustainable levels
- In Panama, Technical and Allocative Efficiencies advanced to sustainable levels

**Figure 2.4.2 2021 Sustainability Index Dashboard Matrix**

SID Dashboard 2021	El Salvador	Guatemala	Honduras	Panama	Brazil	Number of countries with vulnerability
<b>Governance, Leadership, and Accountability</b>						
1. Planning and Coordination						0
2. Policies and Governance						1
3. Civil Society Engagement						4
4. Private Sector Engagement						5
5. Public Access to Information						2
<b>National Health System and Service Delivery</b>						
6. Service Delivery						1
7. Human Resources for Health						1
8. Commodity Security and Supply Chain						2
9. Quality Management						4
10. Laboratory						4
<b>Strategic Financing and Market Openness</b>						
11. Domestic Resource Mobilization						3
12. Technical and Allocative Efficiencies						1
13. Market Openness						0
<b>Strategic Information</b>						
14. Epidemiological and Health Data						0
15. Financial/Expenditure Data						3
16. Performance Data						3
17. Data for Decision-Making Ecosystem						2

### **SID Elements to be Prioritized in ROP22:**

Several elements of the SID are already being addressed to improve levels of sustainability. For ROP22 the following elements have been identified as priorities to improve performance: Civil Society engagement, Private sector engagement, Quality Management, Laboratory, Commodity Security and Supply Chain.

### **Changes in Investments:**

All countries have maintained their level of funding and resources (primarily from the Global Fund and PEPFAR), with exception of Panama where the Global Fund ended implementation in December 2021.

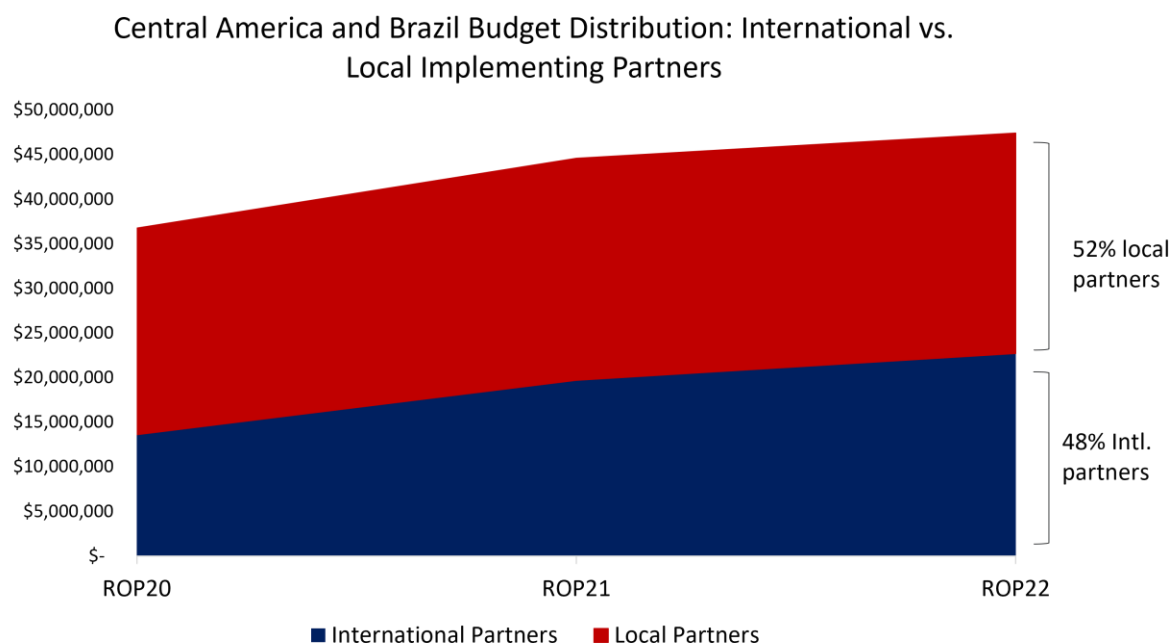
To avoid duplication and optimize interventions, the PEPFAR teams are in continuous communication with the Global Fund while planning and implementing activities to support national sustainability strategies. The PEPFAR teams have periodic virtual meetings with each of the portfolio managers and the Global Fund coordinator for Latin America and Caribbean (LAC) is also engaged in activities at the regional level. An example of this joint coordination has been in improving HIV information systems, where the GF has provided financing and PEPFAR has provided the related technical expertise.

At the field level, meetings with the Principal Recipients and implementing organizations are routinely organized to maintain coordination and communication. In cases where there is

overlapping geographic focus, the teams perform a deduplication exercise for each reporting period.

### Transition to Local Partners:

**Figure 2.4.3 Central America and Brazil Budget Distribution: International vs. Local Implementing Partners**



In recent years, significant progress has been made transitioning from international implementing partners to local partners, with 52% of total PEPFAR funding budgeted to local partners for ROP22. Important activities such as treatment service delivery and prevention services are implemented across the region by local partners. Additionally, local partners are strengthening the policy environment, human rights, sustainability, combined prevention, and the governance of civil society organizations to conduct information analysis.

## 2.5 Alignment of PEPFAR investments geographically to disease burden

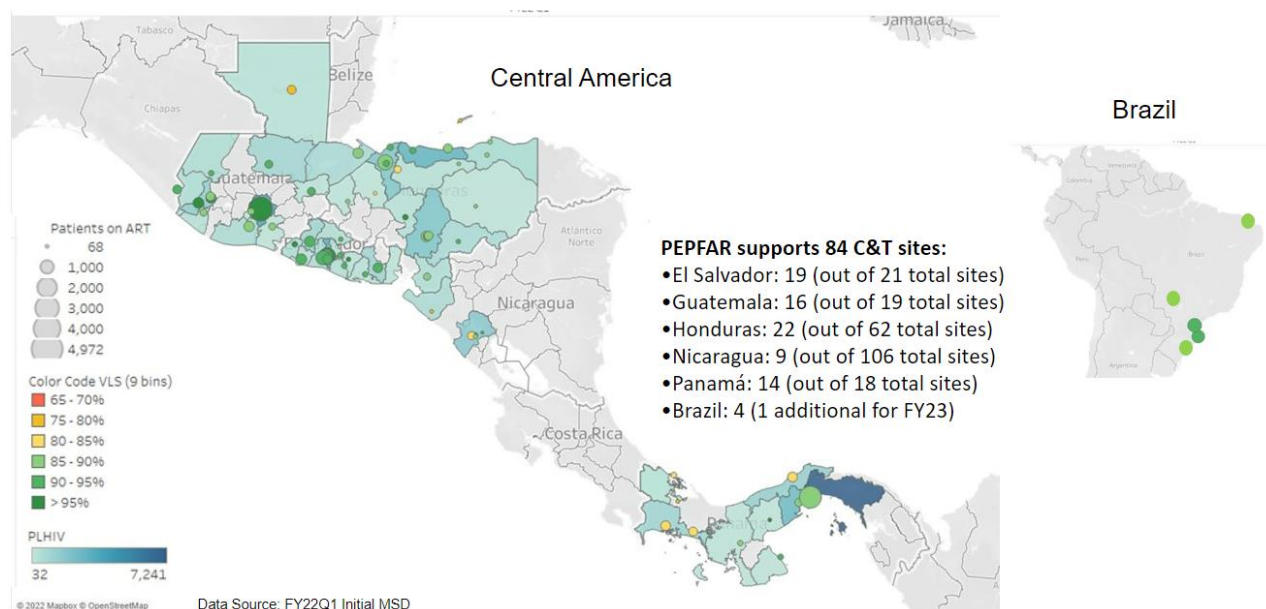
Before ROP19, the Central America PEPFAR program had traditionally completed a regional SNU-based analysis and selected municipalities with the highest burden as priority SNUs for PEPFAR interventions. However, after a more extensive analysis, results revealed that treatment sites in major cities had clients from all over the country, as PLHIV were willing to travel long distances to seek services at their preferred site. In response to better meet the needs of PLHIV, the PEPFAR program underwent a massive scale-up in ROP20 to directly support the majority of sites in alignment with host government catchment areas. This distribution, which will continue in ROP22, covers the entire cohort in Guatemala, El Salvador, and Panama, and the majority of PLHIV in Honduras and Nicaragua. While PEPFAR is not in every site in El Salvador, Guatemala, and Panama, the program covers the cohort through referral networks.

**Table 2.5.1: Coverage of PEPFAR Program in Central America and Brazil**

Table 2.5.1: Coverage of PEPFAR Program in Central America and Brazil				
Country	PLHIV	PEPFAR Coverage	% Coverage	# of PEPFAR Supported Sites
El Salvador	25,000	25,000	100%	19
Guatemala	33,000	33,000	100%	16
Honduras	22,000	17,600	80%	22
Nicaragua	12,000	10,200	85%	9
Panama	31,000	31,000	100%	14
Brazil	85,311	28,246	33%	21

Efforts in Nicaragua and Panama will focus on high burden sites within the existing priority SNUs. Brazil will continue intensive support in the four priority SNUs (Campo Grande, Curitiba, Florianópolis, and Porto Alegre) and will add a fifth SNU (Fortaleza) based on trends of increasing incidence. Initial activities will be introduced in the Amazon region to address gaps in the provision of HIV services to the general population, as well as vulnerable migrants and indigenous peoples.

**Figure 2.5.1: Map of Geographic Coverage of PEPFAR program**



## 2.6 Stakeholder Engagement

PEPFAR Central America/Brazil continuously engages with key stakeholders at the regional, national, and local levels to ensure USG activities are constantly being improved and refined to maximize support towards sustainable epidemic control. In Central America, the PEPFAR team leverages the influence of the regional entities (COMISCA and the Regional Coordinating

Mechanism), to influence policy and guidelines in all countries. As COMISCA is made up of the Ministers of Health for all countries from the Central American region, resolutions and commitments made by COMISCA at the regional level can then be leveraged to inform national policy and implementation.

At the national level, PEPFAR Central America/Brazil engages with both host governments and civil society organizations regularly through above-site activities. The USG has also historically partnered with national chambers of commerce equivalents and is currently exploring new ways to engage with the private sector, especially private sector laboratories as options for clients to seek testing. The program will seek to establish HIV policies in the workplace, to facilitate prevention, treatment, and promotion of human rights related to HIV and the most affected populations.

As referenced in the previous section, PEPFAR Central America works closely with the Global Fund and other multilateral stakeholders such as PAHO and UNAIDS. Together they have developed a formal plan for program implementation with a framework to avoid duplication and ensure coordination and monitoring of key indicators. PEPFAR will continue building on this plan to align policy advocacy and operational functions for greater regional collaboration. Brazil also coordinates closely with the National AIDS program to engage stakeholders, which include PAHO, UNAIDS, and local civil society as recommended by the Ministry of Health, in such a way as to leverage sector-based expertise and buy-in by these stakeholders.

The PEPFAR team engages stakeholders throughout the ROP planning process through country-level stakeholder meetings before the ROP to solicit input into the strategy, during the ROP to participate in decision-making and after the ROP to disseminate the finalized strategy.

## **2.7 Stigma and Discrimination**

Stigma and discrimination against KPs remain a major barrier to uptake of critical health services outside of the HIV clinics. Based on models of person-centered care, the program will continue to provide training on stigma and discrimination for all clinic and health facility staff to ensure stigma free service delivery to key populations.

The trainings will also include broader support staff from different departments such as the emergency room, outpatient clinics, and other operational support services that have direct contact with PLHIV as doormen, cleaning staff, etc. In addition, the program is implementing an S&D program for public servants in different government agencies to facilitate access to services other than health.

## **3.0 Geographic and Population Prioritization**

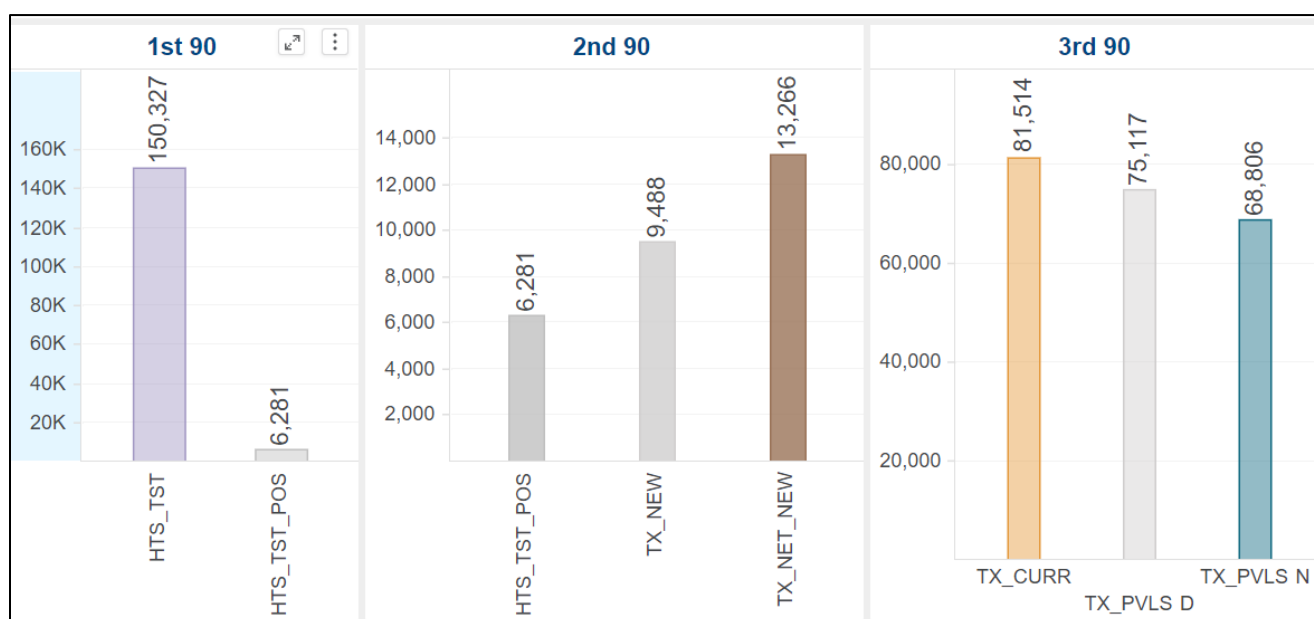
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The aggressive scale-up strategy for El Salvador, Guatemala, Honduras, and Panama requires a national approach and as noted previously, due to the relatively small size of the countries and preference of persons to seek services in SNUs that are not necessarily where they reside. Therefore, the focus for geographic prioritization in those four countries is treatment sites per Table and Figure 2.5.1 in the previous section. All PEPFAR SNUs are classified as scale-up aggressive.

Overall, the PEPFAR program will prioritize all PLHIV and will continue to also focus support on the most affected key populations in the region (men who have sex with men, sex-workers and transgender women.) The USG will also support the military populations in El Salvador, Guatemala, and Honduras in close collaboration with the host country's military health systems.

## 4.0 Person-Centered Program Activities for Epidemic Control

**Figure 4.0.1 Overview of 95/95/95 Cascade, FY21 (Brazil, El Salvador, Guatemala, Honduras, Nicaragua, and Panama)**



Source: Panorama (2022\_03\_30)

### 4.1 Finding people with undiagnosed HIV and getting them started on treatment

The Central America and Brazil region has continued to innovate their testing strategy, developing and implementing approaches to increase the access to HIV tests for populations with the highest prevalence and positive yields.

The PEPFAR team recognizes the existing testing gaps that need to be addressed to reach epidemic control, particularly in reaching men. To address these gaps, the program will build on and adapt the following mix of case finding modalities in both public and private facilities:

- Safe and Ethical Index Testing for Newly Diagnosed & Non-Virally Suppressed PLHIV
- Key Population Testing & Peer Linkage at Highest Volume Facilities & Online Outreach Programs
- Social Network Testing
- Optimized Provider Initiated Testing & Counseling (PITC) by Utilizing Geographic Catchment Areas
- Self-testing Scale-Up
- HIV Recency Testing

## **Index Testing**

The Central America and Brazil PEPFAR program has been scaling-up safe and ethical index testing, prioritizing all newly diagnosed individuals and all non-virally suppressed PLHIV including all those who have had treatment interruption and are re-engaged in treatment. To increase uptake of index testing, partners of index cases are given various options to seek testing at the treatment site, at other public clinics, at private labs, via cyber-educators, self-tests, etc. The USG team supports linkages to different testing options and then to treatment for all those who test positive. The USG works to ensure appropriate monitoring of index case partners who are tested, no matter where they decide to seek testing services.

Index testing contributes to the highest positive yield out of our testing modalities at 15% in facilities and 11% in the community (see Figure 4.1.1), but the volume achieved needs to be improved. To address this issue, the PEPFAR program aims to increase coordination among both facility and community-based implementing partners to share the list of contacts that have not yet been reached. The PEPFAR team will continue strengthening healthcare worker capacity to implement this strategy, including customized SIMS CEEs on index testing, on-site mentoring, and specialized training on advanced skills for index testing.

## **KP Testing & Linkage**

The USG will continue to identify new cases through the VICITS strategy (Sexually Transmitted Infection and HIV Surveillance, Prevention and Control Strategy, commonly known as VICITS by its Spanish acronym), and through the online outreach program as both interventions continue to identify high numbers of KP PLHIV efficiently. All individuals identified through these interventions will be immediately linked to treatment and offered index testing for their partners. A unique partnership with private laboratories provides more access to testing for KPs and PEPFAR partners support accompaniment to public treatment sites for all who test positive.

## **Social Networking Strategy**

The PEPFAR program plans to expand Social Network Strategies due to the emerging patterns of positivity and hot spots within social networks. Cyber educator teams and other health workers will have systems in place to track different social networks, understand the dynamic of each network, and identify the best approach to use. The overall strategy is to enlist HIV-positive and high-risk, HIV-negative persons to recruit individuals from their social and sexual networks for HIV testing services. Once tested, network members become recruiters and refer members of their networks for testing. This process continues, creating chains of recruitment that can penetrate hidden networks. This is guided by the principle that people in the same social network are more likely to trust each other and respond positively to HIV testing messages from people they know and trust. The recruiters will direct them to KP-friendly clinics where they can safely receive HIV services in a welcoming environment.

## **Optimized Provider Initiated Testing & Counseling (PITC)**

In ROP22, the PEPFAR program will expand PITC strategies by utilizing existing geographic catchment areas around treatment sites and facilities reporting to hospitals in metropolitan areas. This will increase the opportunities to reach men, who have different health-seeking behavior



patterns. This strategy will include mentorship to assure compliance with national testing guidelines, especially among clients with TB and STIs, as well as strategies to identify clients at higher risk of infection (as determined by behavioral or signs/symptoms-based criteria) presenting to facilities for other health reasons.

### **Self-testing Scale-Up**

PEPFAR has introduced self-testing in Brazil, Guatemala, El Salvador, Honduras, and Panama and has started scaling-up distribution in ROP21. In ROP22, the program will continue to leverage lessons learned from across the region to scale-up, institutionalize self-testing in the national health systems, and to focus on reaching men and other vulnerable populations through the differentiated distribution models.

### **Recency Testing**

Central America was the first PEPFAR operating unit to implement the rapid recency test and PEPFAR will continue to support this activity at reference laboratories. The USG has been working to build the capacity of national laboratories to collect and analyze data results. In ROP22, the program will emphasize integrating recency testing data into routine surveillance data systems, analysis, and use recency results for public health action (including targeted prevention and testing interventions.) The PEPFAR team will establish recent infection surveillance across Central America and Brazil to monitor and respond to the HIV epidemic, specifically focusing on recent infections among newly diagnosed PLHIV. This will allow countries to identify and respond to concentrations of ongoing transmission. Recent infection surveillance systems can more rapidly identify trends of the epidemic and allow countries to implement the right interventions, for the right populations, at the right time. The team will monitor trends using the recent infection testing algorithm (RITA) among newly diagnosed PLHIV by select demographic and HIV risk variables to inform HIV prevention and active case finding interventions in geographic locations associated with elevated recency results.

### **Safeguarding Client Confidentiality**

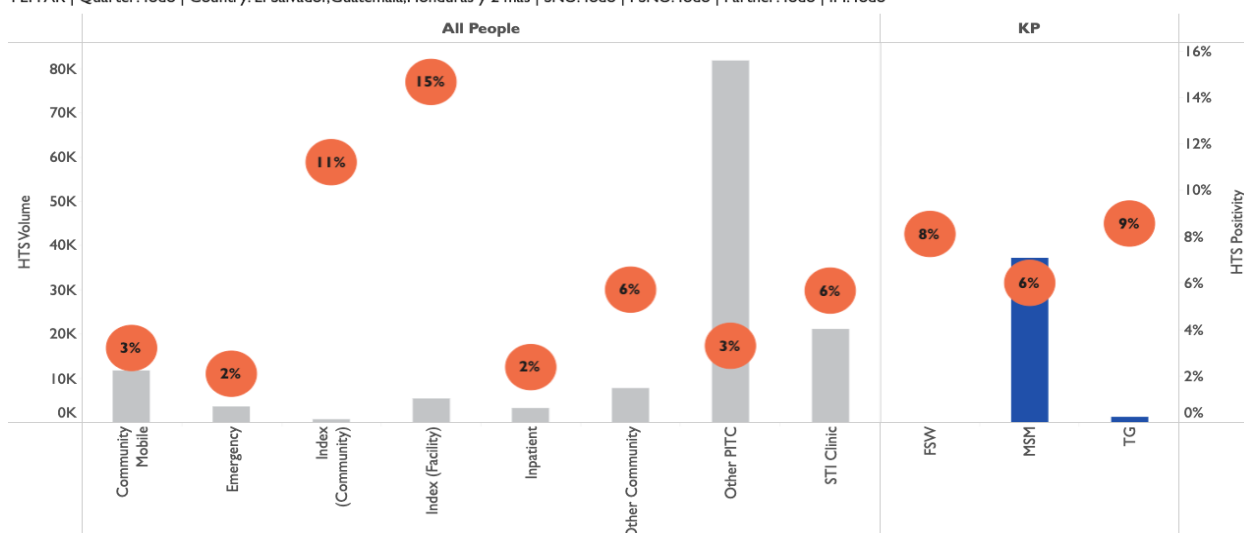
To safeguard client confidentiality throughout the testing process, the use of Unique Identifier Codes is already institutionalized within the program's protocols. In addition, very strict access to all personal information is part of the permanent measures taken by implementing partners; documents are filed on cabinets with no public access; and the electronic files do not have public access and are encrypted to increase their safety.

The USG will also support these case finding strategies with military populations, including index testing and optimized PITC for military personnel with STIs.

**Figure 4.1.1 Testing Volume and Yield by Modality and KP, FY21**

#### HTS Volume and Positivity by Modality\* & Key Population during FY21

PEPFAR | Quarter: Todo | Country: El Salvador, Guatemala, Honduras y 2 más | SNU: Todo | PSNU: Todo | Partner: Todo | IM: Todo

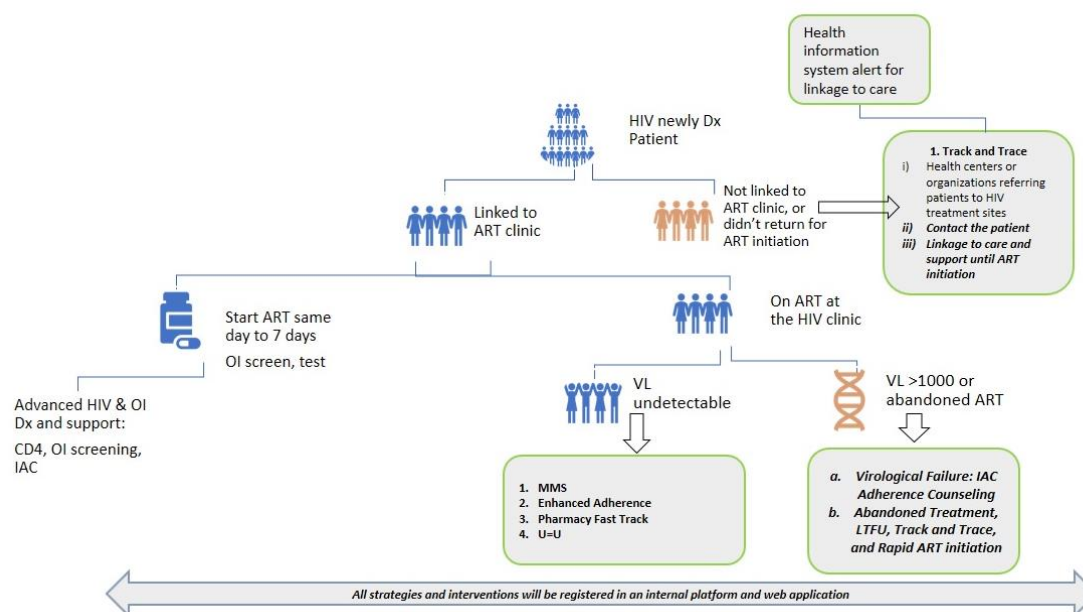


Source: DATIM, Dec 2021

## 4.2 Ensuring Viral Suppression and ART Continuity

In ROP22, the PEPFAR Central America and Brazil program will continue to build support of intensive direct service delivery at treatment sites across the region to ensure PLHIV are retained in treatment and viral suppression is reached.

**Figure 4.2.1 PEPFAR Treatment Site Strategy for Retaining & Ensuring Viral Suppression**



The components of this treatment strategy include the following:

- Linkage to Care & Registry to Verify Referrals of Newly Diagnosed, community and reengage of the pre-ART that are LTFU at site level/Track and Trace Pre-ART
- Early Antiretroviral Treatment Initiation
- Advanced HIV Package: screen, test, treat and prevent opportunistic infections (OI), including TB
- Advanced HIV community intensified follow up
- Scaling Differentiated Service Delivery Models (DSD) such as after-hours Clinics, Community Drug Distribution, Home Delivery, Pharmacy Fast Track and Multi-month Scripting/Dispensing
- Advanced Adherence Package and Reengagement of PLHIV Lost to Follow Up
- Track and Trace (PLHIV Diagnosed but never linked or initiated on ART)
- Undetectable=Untransmissible (U=U)
- High Viral Load Tracking & Management
- Tele-mentoring ECHO program
- Address structural and contextual factors associated with adherence, linkage, and viral load suppression, such as migratory status, sexual orientation, gender-based violence, etc.

### **Linkage to Care & Registry to Verify Referrals of Newly Diagnosed PLHIV / Track and Trace Pre-ART**

PEPFAR supports efforts to ensure all newly diagnosed PLHIV are immediately linked to treatment no matter where the client decides to seek both testing and treatment services. PLHIV that had one or more visits but did not return to start ART will be tracked and returned to the clinic to begin ART immediately. In Central America/Brazil, PLHIV have expressed preferences for treatment at sites that are not necessarily close to where they reside or where they were tested, PEPFAR is supporting a linkage alert as part of the HIV surveillance national system in the Central America region to ensure that all clients diagnosed in the country are linked to care and that can be verified. Linkage to care is implemented through health navigators, linkage liaisons, or similar figures, both funded by PEPFAR and Global Fund projects. With such support, more than 90% accept this service and are linked in a median of 3 days. For sites that are not receiving this support, PEPFAR has implemented track and trace activities, to improve linkage to care and to detect people aware of their HIV positive status but never linked. A detailed list of the multiple barriers faced by PLHIV with a recent diagnosis will allow for the development of a more effective set of actions that contributes to an improvement of linkage to care actions.

### **Early Antiretroviral Treatment Initiation**

PEPFAR will continue supporting same-day Rapid Antiretroviral Treatment initiation (or within seven days of diagnosis), for PLHIV without severe Opportunistic Infections and are otherwise considered stable. The USG provides support for site-level protocols, opportunistic infection diagnosis, and human resources where necessary to support early treatment. PLHIV have shown a clear preference for receiving care at their established treatment site. An understanding of consumer preferences for packaging, clinic visit frequency, as well as an understanding of the social

support network, partners reaction, nutritional status, economic stability, is needed for broader effectiveness of the early treatment initiation. In PEPFAR supported sites, Rapid ART initiation is offered to 80% of clients, with plans to expand this intervention to PLHIV coinfected with TB so they can start both treatments for TB and HIV within seven days.

### **Advanced HIV Package: Screen, Test, Treat and Prevent Opportunistic Infections (OI), including TB**

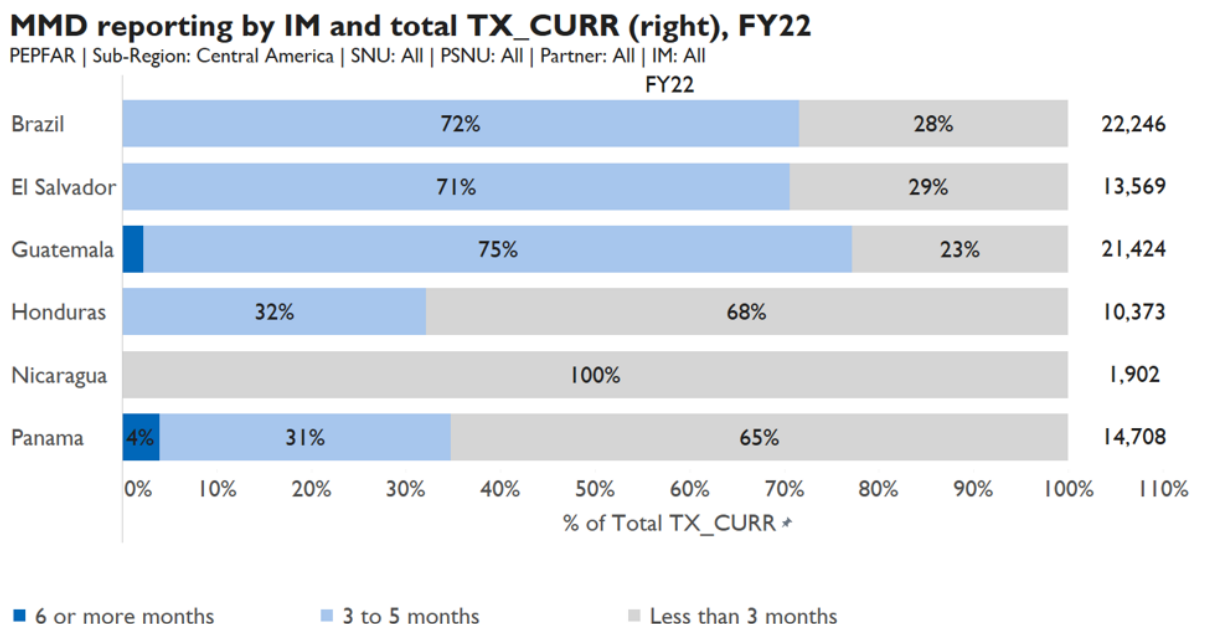
Recent data suggest that the probability of presenting with Advanced HIV Disease and OIs is between 30 to 50% in Central America. Therefore, the USG will ensure that all sites have the tools and protocols according to WHO guidelines in place to ensure the rapid diagnosis of OIs and treatment, intensified counseling, and community follow-up for these patients. TB screening at all visits, rapid testing for TB and fungal infections, OI treatment, and TB prevention treatment (TPT) will also be provided to address these challenges in Central America. PEPFAR is training clinicians to ensure implementation of TPT, as all countries' TB/HIV co-infection guidelines include this practice. Based on 2018 WHO country reports, only El Salvador's TPT coverage is relatively high, whereas in Brazil, Guatemala, Nicaragua, and Panama major gaps persist to assure the standard of care. Local follow-up in the implementation of infection control plans (TBIC) is also carried out, assuring that risk for patient infection at ART clinics and hospitals remains low. Gaps have been identified in screening for TB in PLHIV with advanced HIV disease, OI rapid testing, and completion of TPT. Through close monitoring, training, on-site competency evaluations, and tele-mentoring case-based sessions via the TB ECHO Regional program the program aims to close these gaps.

### **Differentiated Service Delivery Models (DSD) including Multi- Month Scripting/Dispensing (MMD) and Pharmacy Fast Track**

Differentiated service delivery (DSD) is a person-centered approach to HIV care and treatment that tailors services to different groups of people living with HIV depending on their evolving needs, while maintaining the basis of the public health approach: simple, standardized, and evidence based. For stable patients, the PEPFAR program will continue to support the implementation of multi-month scripting and dispensing, pharmacy fast-track and home delivery of ARVs to enable PLHIV to visit the clinic less frequently and free up existing human resources to attend more clients.

Through the rapid roll-out of MMD in the context of COVID-19 emergency measures, the PEPFAR program has illustrated how MMD can improve the quality of services and reduce the level of work for health providers who gain more time to focus on non-adherent, non-virologically suppressed PLHIV. The PEPFAR program is working closely with national governments to ensure that MMD policies are incorporated into official treatment guidelines and standard operational procedures outside of COVID emergency protocols. The PEPFAR program is also working with governments to provide supply chain technical assistance to prevent stock-outs within the context of MMD roll-out. The USG will work to implement MMD at the site level at PEPFAR supported sites while continuing to push for policy change at the above site level.

**Figure 4.2.3 Number and Percent Contribution of Persons Receiving MMD by Country, Q1 FY22**



Source: DATIM, January 2022

### Advanced Adherence Package & Reengagement of PLHIV Lost to Follow Up

The USG will prioritize re-engaging clients that have interrupted treatment. These PLHIV will have individual case management services including advanced disease screening with CD4 count, and if it is less than 200, they will have rapid OI's screening and treatment, ARV re-initiation and intensified follow up. PEPFAR will provide support for personnel at treatment sites and in communities to locate and bring back those positives. PLHIV who are at risk of abandoning treatment, identified through missed appointments, will be contacted by clinic promoters via phone (voice or SMS) to provide reminders of appointments, reschedule missed appointments, and mitigate any other barriers to attendance. The use of SMS, such as the AlerTAR platform developed by PEPFAR Central America, has been shown to improve adherence to ART when used to remind PLHIV of appointments, medications, or both. Clients had a higher percentage of viral suppression than their peers who did not receive the messages. For patients at risk of abandoning treatment, the use of community liaison and clinical health promoters will be used as a strategy. PEPFAR is also implementing other models to reengage PLHIV such as providing extended clinic hours and ART delivery close to home.

Other models specific to certain populations or country contexts will also be supported, such as adherence clubs for Venezuelan migrants in Panama, adherence clubs for indigenous populations in their languages, and providing documents for clients to obtain permission from work to attend medical appointments. In military populations, the USG will support an adherence program geared toward active-duty personnel adapted to their unique situation and using military health navigators.

## **Track and Trace**

For persons who were diagnosed but never linked or initiated on ART, the USG will use the Track and Trace strategy which includes identifying and following up with unlinked individuals through phone and home contacts and ensure their linkage to treatment, and in cases where their treatment has been confirmed in another setting, it will be documented. The USG will actively carry out track and trace and at the same time work to support the institutionalization of processes and procedures for tracking all those who are diagnosed. Understanding the barriers, threats, and fears faced by PLHIV with a recent diagnosis and the accompaniment provided through a constant, respectful, and friendly environment will be key for the effectiveness of the track and trace strategy. In addition, a private provider network is being promoted in some countries, which, working collaboratively with the programs of the Ministry of Health, can give follow-up to those HIV cases that want to be linked to treatment in the private sector.

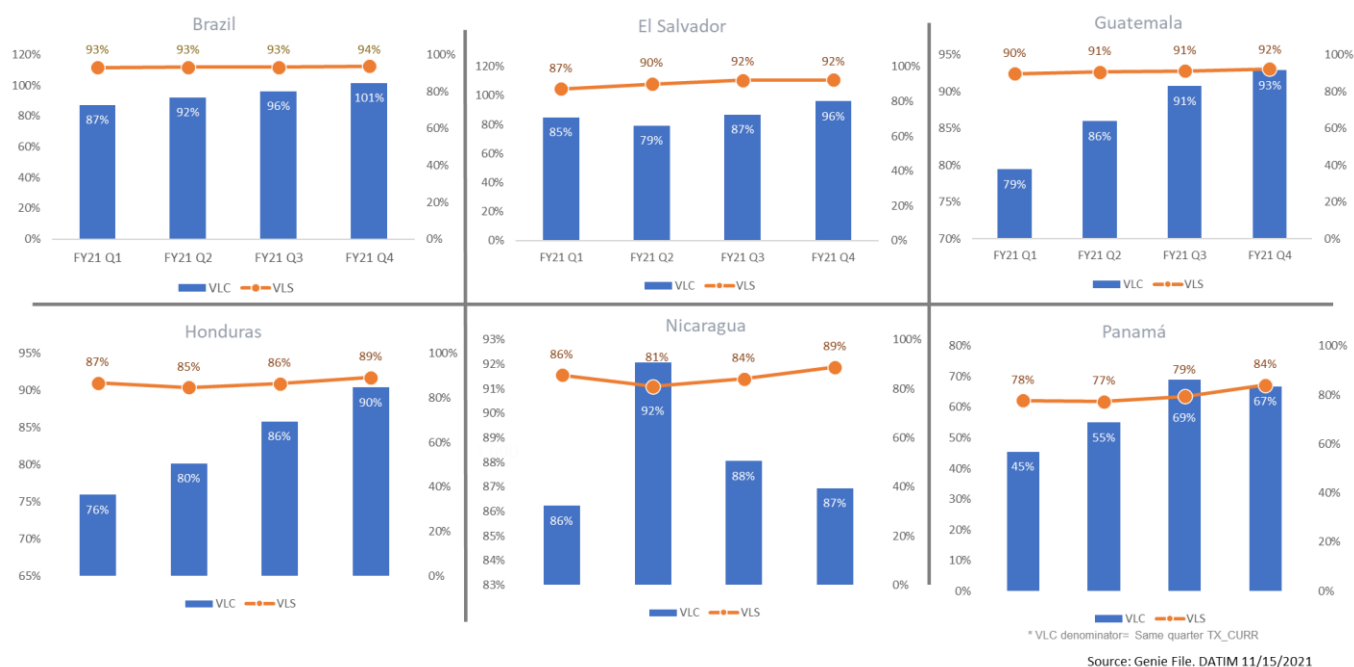
## **U=U**

The PEPFAR program has been incorporating U=U messaging and viral load literacy into all work at treatment sites to ensure PLHIV are aware of the importance of adherence to treatment. It is currently being expanded in a variety of contexts, including translation into several indigenous languages. The PEPFAR program will follow up with a comprehensive review to understand the effectiveness of the campaign across different contexts and languages.

## **High Viral Load Tracking & Management**

To ensure continued viral load suppression, regular viral load monitoring is essential. The USG is supporting the development of systems at treatment sites to monitor and manage viral loads for all PLHIV receiving treatment. To address the high rates of drug resistance in Central America, the PEPFAR program is implementing the Cyclical Acquired HIV Drug Resistance (CADRE) patient monitoring to systematically conduct genotype testing to generate representative HIV drug resistance estimates.

**Figure 4.2.2 Viral Load Outcomes, FY21**



### 4.3 Prevention

The USG will continue to implement targeted combination prevention activities tailored to key populations, including the promotion of safe behaviors such as condom use, PrEP, testing, and subsequent linkage to HIV care and treatment services for diagnosed PLHIV. It is a comprehensive package that employs a broad risk assessment including mental health, substance use, and gender-based violence. PEPFAR aims to reach PLHIV who are experiencing no adverse health effects and are not currently seeking services. Interventions will be tailored to each country and for each group of KP as appropriate. PEPFAR develops specific interventions to reach ‘hidden MSM’ that may not be found at traditional hot spots.

The USG uses partnerships with the public sector, civil society, and the private sector to explore new evidence-based models for reaching specific KP groups (e.g., the use of new technologies, building on previous successful experiences with social media, site interventions, and other biomedical interventions such as self-testing). PEPFAR also works to strengthen the immediate linkage to public sector care and treatment for any individual diagnosed through non-public sector service providers. Individuals from the key and priority populations are engaged throughout every step of the activity to provide ongoing feedback on interventions and to offer suggestions for improvement through our Community-Led Monitoring initiative and engagement with CSOs. Their insight and perspective can be invaluable especially when trying to address site-level barriers to accessing services.

The PEPFAR program also recognizes the structural aspects that must be addressed as part of the comprehensive prevention package, including the use of alcohol and drugs, internalized homophobia, stigma and discrimination, lack of social support network, etc.

The PEPFAR program's key prevention strategies are as follows:

### **Testing**

The goal for prevention programming is to ensure at-risk KP are enrolled into a holistic prevention program that is centered around HIV testing. As mentioned in the previous section, the Central America/Brazil program will continue systematic efforts to implement the Index Testing strategy, targeting all the recently diagnosed cases as well as cases being recovered for treatment or with non-viral load suppression. Furthermore, PEPFAR will expand self-testing, social networking strategies and expand PITC to second level of health facility networks to increase the early detection of new cases in the region.

### **Cyber-Educators**

At community level, the prevention services will use face to face and social media interactions to reach KP. Social media use and cyber-educators will reach and link hidden KP populations to HIV services and explore ways to bring prevention services to vulnerable groups, to ensure early diagnosis of HIV and a link to treatment services. PEPFAR covers the costs of all technological equipment to implement the activity, cyber-educators, training, materials, monitoring of virtual interactions, site mentoring, the development and financing of a private lab network for testing accessibility, counseling, and follow-up with PLHIV to link them to care services.

### **VICITS**

The PEPFAR program will also continue to support the provision of a prevention package for key populations through the Sexually Transmitted Infection (STI) and HIV Surveillance, Prevention and Control Strategy, commonly known as VICITS by its Spanish acronym. VICITS is a combination prevention strategy for key populations that offers HIV testing, improved STI diagnosis and treatment, tailored counseling, condom and lubricant distribution, peer promotion, peer navigation to HIV treatment services, and an information system to monitor trends. More recently, PrEP has also been added to the prevention package available at VICITS sites, and PEPFAR will support increased access to PrEP at these facilities.

### **Preventing Transmission within Sero-discordant Couples**

Sero-discordant couples are offered a package of services including disclosure support, conception counseling, PrEP, and HIV testing. The partner who is HIV negative in a sero-discordant couple will be encouraged to be tested at least annually (or more often if warranted by risk assessment) and promptly linked to appropriate prevention or treatment services.

### **PrEP**

Pre-Exposure Prophylaxis (PrEP) enrollment requires an HIV test to ensure HIV negative status. Once enrolled in the PrEP program, clients are tested every three months for HIV. As part of the person-centered approach, PEPFAR will promote the use of self-testing in specific cases. If HIV seroconversion is detected among an individual taking PrEP, the individual is immediately linked to treatment services.

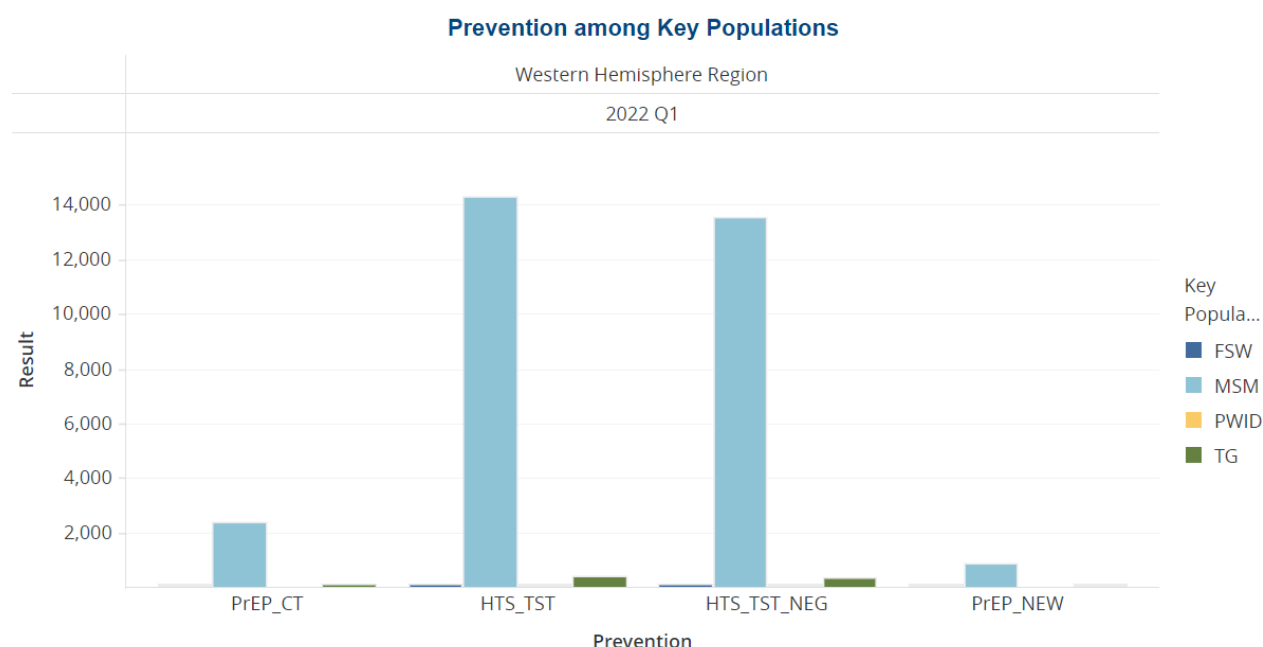


Currently, PEPFAR Central America/Brazil PrEP promotion is implemented in Brazil, Guatemala, and Panama, and will begin in Honduras and El Salvador during ROP21. PEPFAR is supporting direct service delivery to expand access to PrEP (communication and outreach, medications, laboratory and clinical supplies, capacity building of human resources, condoms provision, adherence support, etc.), as well as technical assistance for optimal implementation (policy shifts, training, quality management, data monitoring, demand creation, information systems, etc.). PEPFAR coordinates with all key partners in each country to expand access and integrate PrEP into existing combination prevention packages for both key populations and sero-discordant couples identified through index testing.

Brazil adopted PrEP as part of the national HIV/AIDS policy in late 2017 for populations at increased risk of exposure to HIV, e.g., discordant couples, MSM, and sex workers. PEPFAR/Brazil provides PrEP screening to determine eligibility, blood tests including creatinine, PrEP dispensation, and follow-up visits and exams. The program offers PrEP through differentiated service models including extended hours, walk-in assistance, and PrEP counseling for MSM, transgender-persons, sex-workers, sero-discordant couples (and soon teenagers (>15yo), and all people at high risk of HIV infection).

In ROP22, the Central America and Brazil program will focus on scaling-up PrEP in all countries with more ambitious targets, introducing Event-Driven PrEP, and transitioning PrEP to routine service delivery (with forecasting, supply planning and training) for sustainable implementation.

**Figure 4.3.2 Prevention Continuum by Key Population Group**



Source: Panorama (2022\_03\_30)

## 4.4 Commodities

While the national governments in Central America procure most of the antiretroviral medicines and other commodities, PEPFAR provides technical assistance in strengthening the supply chain for key commodities to help countries to achieve the 95-95-95 targets. PEPFAR has strengthened countries' response capacity (policies, master plans, tools, SOPs, training human resources) to generate and track ARV stock levels at the central warehouse and service delivery points (HIV clinics).

PAHO's Strategic Fund pooled procurement mechanism is the main procurement mechanism for antiretrovirals in all countries. Global Fund grants, which on average procure 25% of HIV commodities (mainly lab commodities), use their procurement mechanism (the Wambo platform); in specific cases, it procures through PAHO's Strategic Fund. Ministries of Health in El Salvador, Guatemala, and Honduras use local providers as an "emergency" procurement option, in cases of imminent risk of stock-out, or during stock-outs. Due to legal limitations, Panama's procurement mechanism has traditionally been through local providers. However, with PEPFAR support, the law was modified to allow access to more procurement mechanism options, like the Strategic Fund are now an option.

COMISCA's joint procurement process was created in 2009 to provide countries with an alternative procurement option, considering economies of scale and sustainability of national health interventions. This presents several benefits compared to other options, including payment at reception instead of advance payment, prices set at purchasing country, not a manufacturing country, economies of scale related to better prices, and fixed prices for three-year periods. Health Ministries and Social Security Institutes in different countries in Central America use COMISCA's mechanisms for diverse health commodities. However, only Costa Rica has purchased ARVs with this mechanism. PEPFAR's support to strengthen COMISCA's joint price negotiation and procurement, as a feasible option for HIV tracer commodities, includes developing cost analysis of available procurement options, facilitating the update and alignment of HIV commodities national lists, disseminating this mechanism, developing a collaborative approach between COMISCA and the Ministries of Health and National AIDS Programs, simplifying processes to register potential providers through the development of automated modules and increasing the list of available commodities and their technical specifications. Currently, there are ongoing country efforts, particularly in Guatemala and Honduras, to diversify the procurement for HIV tracer commodities, through COMISCA, in efforts to mitigate supply chain disruptions from COVID.

As illustrated in the chart below, there are funding gaps and budget restraints in El Salvador and Guatemala, and in Panama there are still issues with the procurement mechanism approval. The multiannual forecasting exercises for 2022 and 2023 are still not available, but the only projected commodity shortages are related to viral load supplies in Honduras, El Salvador and Panama. To account for these shortages, the PEPFAR program has allocated emergency funding for those commodities within our ROP22 budget.

**Chart 4.4.1 2021 Commodities Summary for El Salvador, Honduras Guatemala and Panama**

2021 Annual Commodity Procurement Summary for El Salvador, Honduras, Guatemala and Panama						
Annual Procurement Profile for Key Commodities						
Commodity Category	Total Current Year USD\$	% Domestic Government t	% Global Fund	% PEPFAR	% Other	Trend 2018-2021
Antiretroviral Drugs	5,795,173.71	96%	1%	3%	0%	Slight change in Domestic Government investment, from 98% in 2018 to 96% in 2021.
Condoms and Lubricants	1,369,282.05	92%	8%	0%	0%	Domestic Government investment has increased from 63% in 2018 to 92% in 2021.
Rapid test kits	1,027,499.73	63%	37%	0%	0%	Domestic Government investment has reduced from 77% in 2018 to 63% in 2021.
Laboratory Supplies and Reagents	2,144,777.90	48%	52%	0%	0%	No significant change in Domestic Government investment, maintained below 50%
Medicines	413,971.39	64%	36%	0%	0%	
Consumables	653,781.50	18%	82%	0%	0%	
Health Equipment	76,069.59	0%	100%	0%	0%	
<b>Total</b>	<b>11,480,555.88</b>	<b>77%</b>	<b>21%</b>	<b>1%</b>	<b>0%</b>	

## 4.5 Collaboration, Integration and Monitoring

The USG interagency team is dedicated to a united approach to achieving epidemic control. The ROP22 vision reflects what all IPs (regardless of agency) will offer at the PEPFAR site-level package as described previously. Close coordination with all stakeholders will also be essential for this scale-up strategy to be successfully realized.

PEPFAR has a long history of working closely with all key stakeholders. The USG works in close coordination with national governments to achieve a sustainable HIV response, through increased domestic funding, strategic alliances, and effective use of available resources. PEPFAR works to support government commitments to reaching epidemic control. The development of the annual cascade reports is an example of multi-sectoral collaboration, led by Ministries of Health and supported by WHO, GF, UNAIDS, PEPFAR, and NGOs involved in the national HIV response. Support for major policy changes such as the transition to TLD is established by including leading clinicians with the engagement of health authorities and promoted by experts such as WHO, UNAIDS, and USG agencies who provide technical support to update norms and protocols and guidelines.

PEPFAR agencies make detailed agreements and provide clear guidance to each implementing partner (IP) to avoid duplication and ensure targets are met. PEPFAR agencies work with their IPs to leverage synergies, share best practices from other countries, establish clear targets, and provide technical guidelines, as well as monitoring, supervising, and coaching IPs to ensure they are meeting the established targets and having the expected impact. With the scale-up strategy, all selected sites will each be supported by one USG agency to ensure no duplication of efforts. PEPFAR agencies are also strengthening their partner oversight strategies. This includes the use of the Accountability, Connectivity, and Transparency (ACT) strategy, Granular Site Management (GSM), and High-Frequency Reporting and Data Quality Assessments methodologies to monitor progress toward target achievement and to verify compliance with national guidelines and PEPFAR minimum program requirements. These initiatives will complement additional quality assurance and clinical mentoring initiatives at PEPFAR-supported sites, such as the Site Improvement Management System (SIMS), continuous quality improvement (CQI), national supervision processes, and joint improvement plan development as part of the Community-led Monitoring initiative.

The PEPFAR team recognizes the impact of the COVID-19 pandemic in the implementation of this ROP. PEPFAR operates in partnership with host governments, and under the Chief of Mission authority. The team is diligently working with Ministries of Health and implementing partners to allow uninterrupted essential HIV services to clients while carefully observing national and PEPFAR recommendations for COVID-19 prevention, management, and control. In addition, WHO recommendations on COVID-19 infection prevention and control (IPC) for healthcare workers (HCW) are being shared on time via the HIV ECHO sessions to lower the risk of infection in PLHIV and HCW supporting them.

## 4.6 Targets by population

**Table 4.6.1**

<b>Table 4.6.1 ART Targets by Prioritization for Epidemic Control in Central America</b>						
<b>Prioritization Area</b>	<b>Total PLHIV</b>	<b>Expected current on ART (APR FY22)</b>	<b>Additional patients required for 80% ART coverage</b>	<b>Target current on ART (APR FY23) TX_CURR</b>	<b>Newly initiated (APR FY23) TX_NEW</b>	<b>ART Coverage (APR 23)</b>
Attained						
Scale-Up Saturation						
Scale-Up Aggressive	123,000	73,878	24,562	115,800	15,029	71%
Sustained						
Central Support						
Commodities (if not included in previous categories)						
<b>Total</b>	123,000	73,878	24,562	115,800	15,029	71%

Table 4.6.2 ART Targets by Prioritization for Epidemic Control in Brazil						
Prioritization Area	Total PLHIV*	Expected current on ART (APR FY22)	Additional patients required for 80% ART coverage	Target current on ART (APR FY23) TX_CURR	Newly initiated (APR FY23) TX_NEW	ART Coverage (APR 23)
Attained						
Scale-Up Saturation						
Scale-Up Aggressive	85,311	26,414	59,000	28,246	2,437	33%
Sustained						
Central Support						
Commodities (if not included in previous categories)						
<b>Total</b>	85,311	26,414	59,000	28,246	2,437	33%

\*In PEPFAR supported SNUs

**Table 4.6.3**

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate* (SNUs)	Disease Burden*	FY23 Target
<b>El Salvador:</b> Target Populations: MSM, TG and FSW	MSM: 54,000 TG: 1,800 FSW: 45,000	Prevalence: MSM: 13.9% TG: 22.3 % FSW: 1.8%	KP_PREV: 13,445
<b>Guatemala</b> Target Populations: MSM, TG and FSW	MSM: 116,000 TG: 4,300 FSW: 84,000	Prevalence: MSM: 9% TG: 15.3 % FSW: 1.0%	KP_PREV: 12,967
<b>Honduras</b> Target Populations: MSM, TG and FSW	MSM: 40,900 TG: 2,700 FSW: 22,800	Prevalence: MSM: 10% TG: 6.4 % FSW: 3.0%	KP_PREV: 7,461
<b>Nicaragua</b> Target Populations: MSM, TG and FSW	MSM: 34,900 TG: 6,600 FSW: 14,800	Prevalence: MSM: 8.8% TG: 9.5 % FSW: 2.2%	KP_PREV: 4,294
<b>Panama</b> Target Populations: MSM, TG and FSW	MSM: 29,600 TG: 2,000 FSW: 8,600	Prevalence: MSM: 13.4% TG: 29.8 % FSW: 1.1%	KP_PREV: 6,999
<b>TOTAL</b>	MSM: 275,400 TG: 15,400 FSW: 175,200		45,166

## 4.7 Cervical Cancer Program Plans

Cervical cancer screening has not historically been integrated into the PEPFAR program in Central America and Brazil. PEPFAR did conduct a landscape analysis in 2021 to understand current national cervical cancer programming, which found that a comprehensive approach to Cervical Cancer was not incorporated into the services provided by HIV clinics in Guatemala, El Salvador and Honduras. Results for Panama are not yet available.

The nine services that participated in the study had the following results:

**Table 4.7.1 Summary Results from Cervical Cancer Study**

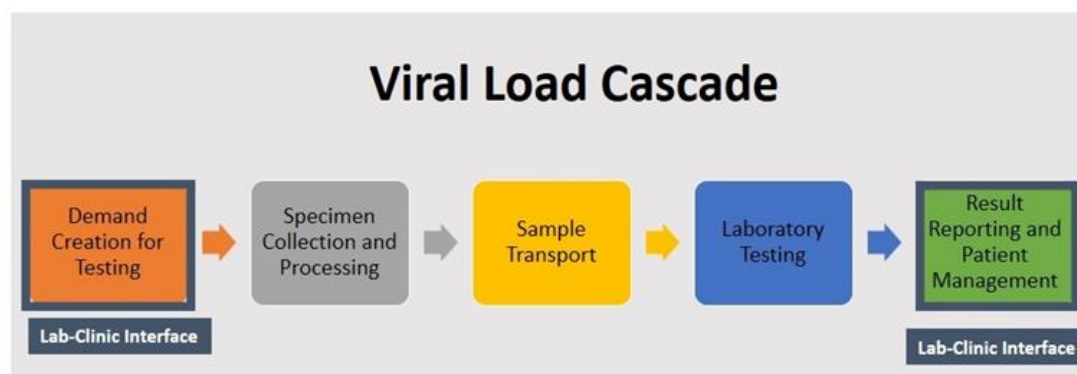
Country	Prevention	Detection in the center	Referral to another center for detection	Follow-up for link to treatment	Treatment
Guatemala (3 centers)	No HPV vaccination strategy	No	3/3	3/3	3/3 (in reference centers)
El Salvador (3 centers)		3/3	0	3/3	1/3
Honduras (3 centers)		2/3	1/3	2/3	3/3 (in reference centers)
<b>Total</b>	<b>0/9</b>	<b>5/9</b>	<b>4/9</b>	<b>8/9</b>	<b>7/9</b>

Guatemala, El Salvador, and Honduras have regulatory, programmatic, and operational frameworks that must be updated in coordination with the national HIV and sexual and reproductive health programs. ROP22 will include activities to update guidelines and protocols, including references to early diagnosis, and treatment options for HIV-positive women diagnosed with invasive cervical cancer.

#### 4.8 Viral Load

Access to viral load testing and utilization of results for patient management with adherence counseling is key for Central American countries to achieve the UNAIDS target of 95% viral suppression of patients on ART. In ROP22, PEPFAR will continue to work to improve access and equity of viral load testing for HIV treatment monitoring in Central America and Brazil, across the VL cascade.

**Figure 4.8.1 Viral Load Cascade**



Network optimization is essential for creating efficient and effective diagnostic networks and is best achieved using a stepwise approach. The first step in network optimization is to assess the current network structure, capacity, and efficiency to identify gaps in the current network. The diagnostic network exercise was done in Panama, Honduras, and El Salvador, the findings help the program identify gaps in the HIV viral load testing and where to focus our improvement plans. During ROP21 the PEPFAR program will continue the diagnostic network optimization exercise in Nicaragua and Guatemala and use those results to inform programming for ROP22.

Recent data analyses reveal that there are still gaps in HIV viral load (VL) testing coverage in Central America. The laboratory network supporting VL testing faces significant systemic challenges that contribute to the low VL coverage. Decentralization efforts in Panama exacerbated systemic network barriers and decentralized laboratories have not been able to provide timely VL services. PEPFAR is supporting the national program to implement a new strategy of testing, centralizing the VL testing for monitoring using all-inclusive pricing, and decentralizing prioritized VL testing using POC instruments. To provide timely and accurate services to PLHIV, countries must reduce their high-VL sample rejection rate, increase their skilled workforce, and modernize infrastructure at the decentralized VL laboratories.

### **Proposed Objectives and Key Activities**

The PEPFAR program aims to leverage existing investments in laboratories to enhance VL testing coverage in Central American countries. Through this programming, the PEPFAR team proposes to identify critical challenges to the laboratory network and capacity to support VL testing and other PEPFAR diagnostics. As a result of this analysis, the program expects to optimize the performance of the national VL laboratory networks, contributing to increased VL coverage and suppression as clinicians have access to timely results to guide clinical decision-making. In close coordination with the MoH and other critical stakeholders (PEPFAR agencies and partners, UNAIDS, PAHO, and others), PEPFAR Central America/Brazil developed robust plans for strengthening laboratory testing and sample referral network for increased coverage of HIV VL specimens across all testing sites based on these results of these studies. Furthermore, laboratories will track testing capacities, efficiency, turnaround around time, and specimen rejection rate for routine assessment and improvement of the network. The next steps include:

1. Implementing partners are developing a National Strategic Plan for the HIV Viral Load Laboratory Network in Panama, including associated guidance, to strengthen and scale up the implementation of the WHO guidelines for viral load testing.
2. The USG is providing technical assistance to laboratory technicians in Central American countries through training and mentorship to sustain quality-assured testing through laboratories.

## 5.0 Program Support Necessary to Achieve Sustained Epidemic Control

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For ROP22, PEPFAR will continue to prioritize above-site investments that contribute directly to the Minimum Program Requirements and to the barriers highlighted by the SID exercise (see Section 2.4). The USG will focus on systems strengthening interventions including support to advance human rights and address stigma and discrimination. These interventions complement and enhance the site-level investments and are critical to improving access of people vulnerable to and living with HIV to prevention, testing, treatment, and laboratory services. Every year, the regional team works with in-country stakeholders to document the progress of systems investments against the sustainability index. Based on the index and ongoing dialogue with the countries, the following system's investments have been prioritized (many of which have been highlighted in other sections): strengthening health information systems, laboratory networks, and person-centered supply chain management; addressing GBV, stigma and discrimination; select survey, surveillance, research and evaluation activities including participatory action research and recency surveillance; human resources for health capacity building through the ECHO program and beyond; and Continuous Quality Improvement (CQI) activities.

PEPFAR is working in coordination with the Global Fund to strengthen HIV HIS to effectively monitor the cascade and improvements in capacity are already being seen. It will continue working with HIV-HIS at Ministries of Health in Guatemala Honduras, El Salvador, Panama and Brazil especially in those areas related to the interconnectivity of the system, data quality, routine monitoring, and developing CoC cascades at the local level, disaggregated by key populations.

PEPFAR will continue working with CSOs in Guatemala Honduras, El Salvador, Nicaragua, Panama and Brazil to improve HIV knowledge management at the organizational level, increasing the quality of their participation in the national response. The CSOs have learned how to analyze secondary data using the social determinants of the health framework and uses it to prioritize areas for advocacy. The CSOs that are implementing HIV applied research using the community intervention model, will contribute directly to increase the linkage of HIV patients to treatment, reengage those lost to follow, and increase adherence to reaching viral suppression. PEPFAR will continue using the HIV Knowledge Management Platform to train CSOs leaders in its virtual campus, foster communities of practice, sharing knowledge among stakeholders, CSOs leaders, and HIV patients.

The USG is also working with military health programs to improve the availability and use of strategic information for decision-making. Furthermore, PEPFAR programs strengthen existing



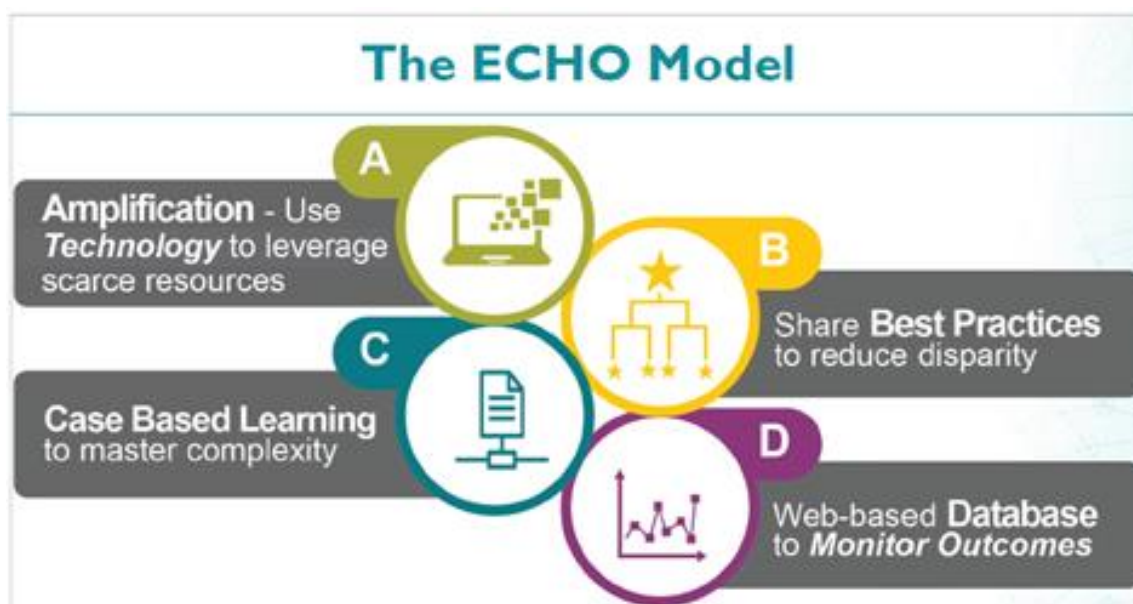
systems to monitor new interventions such as PrEP, Recency Surveillance, Track and Trace, and leverage existing platforms such as ECHO to build capacity.

PEPFAR continues to strengthen the use of data to improve the availability of HIV medicines and supplies. In ROP22, Central America and Brazil program will increase its footprint at the site level to ensure timely remediation of supply chain challenges, improve storage of medicines, and provide support for multi-month dispensing and transition to new and better HIV regimens. In addition, a comprehensive approach for viral load implementation will be used to improve access to viral load testing and results reporting. In ROP22, the focus will be on optimizing the network, improving quality management, providing technical assistance to laboratorians, and improving the laboratory information system.

PEPFAR will support the implementation of continuous quality improvement (CQI) approaches in laboratories and at clinical sites to improve the quality-of-service delivery. The CQI approach will ensure a more rigorous and frequent review of data, implementation of real-time solutions, and monitoring of their impact for scale-up to additional sites.

To improve advanced clinical care, PEPFAR will support Ministries of Health throughout the region to improve TB prevention and treatment, improve prevention and infection control, and improve clinical guidelines to better treat opportunistic infections and advanced clinical care. REDCA+ has been awarded a sub-grant to implement community-led monitoring throughout Central America. Findings and recommendations from the community-led monitoring will be critical as PEPFAR strives to continuously improve the quality of sites.

**Figure 5.1.1 Tele-Mentoring ECHO Program**



The USG will continue training health care providers on care & treatment guidelines through the tele-mentoring case-based HIV ECHO programs in the region, creating a virtual community of practice where a local pool of experts will be created to share best practices and improve the quality of care for PLHIV. The ECHO platform will be used to ensure health care providers at PEPFAR supported treatment sites have the latest technical information to implement all key strategies and global best practices. ECHO may also be used in the context of COVID19 to equip treatment sites

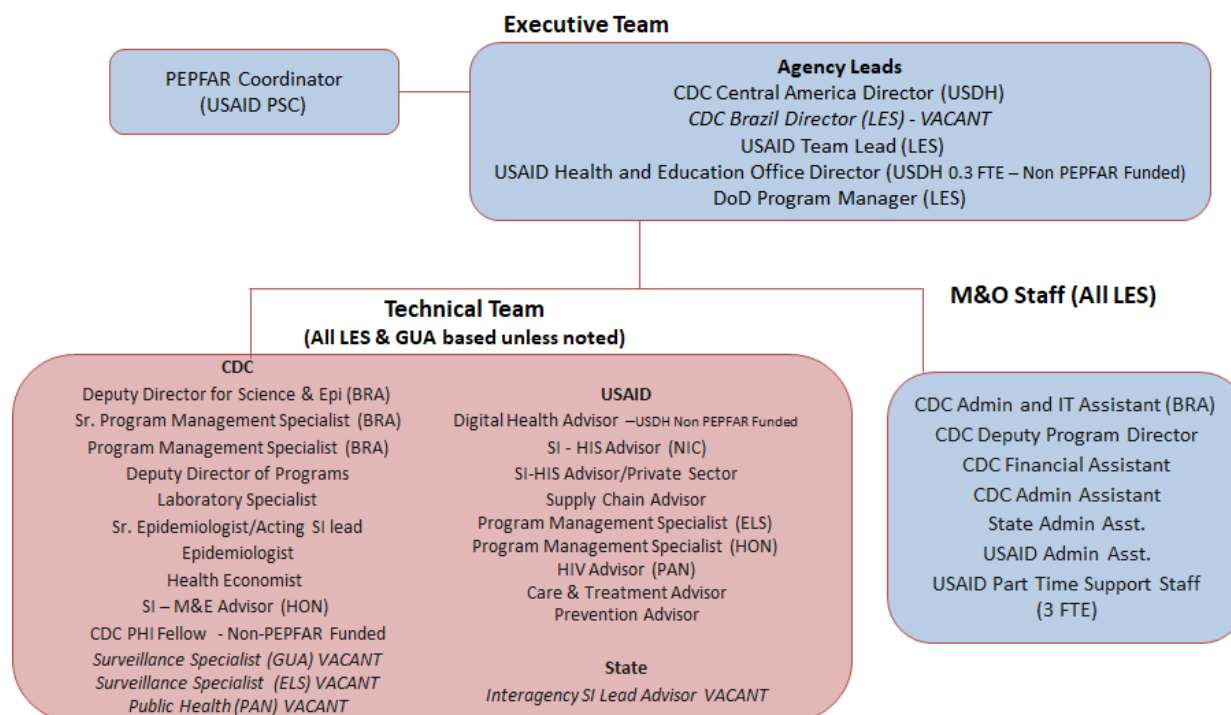
with tools needed to adapt their services to ensure the continuation of care and treatment for their clients. USG will continue training health care providers on care & treatment guidelines through the tele-mentoring case-based HIV ECHO programs in the region, creating a virtual community of practice where a local pool of experts will be created to share best practices and improve the quality of care for PLHIV. The ECHO platform will be used to ensure health care providers at PEPFAR supported treatment sites have the latest technical information to implement all key strategies and global best practices.

To date, the USG has established five recurring Project ECHO programs that draw participants from countries throughout the Western Hemisphere. These programs include ECHO HIV, ECHO Mental Health, ECHO Laboratory, ECHO Prevention, and the Information Systems ECHO. Each of these ECHOs caters to a target audience that play critical roles in the PEPFAR supported treatment sites. Each ECHO program draws upon expertise from the region and relies on the community of practice throughout PEPFAR programming to learn best practices and share resources throughout the region. The ECHO Prevention program draws healthcare workers involved in HIV prevention and testing programs at all levels of implementation, from the site level up to the various ministries of health. The Prevention ECHO has received positive reception, reaching an average of 112 participants in the weekly sessions. ECHO Prevention has included different blocks on HIV combination prevention and testing thematic areas, including Index Testing, PrEP, STI, PEP, HIV services for Key Populations, Addressing Stigma and Discrimination, social media use for demand creation, Active HIV Case Finding, PITC, Self-Test, and others. The ECHO Laboratory team has received praise throughout the region for connecting laboratory technicians and providing a source for continual education with reliable resources. Upcoming ECHO lab sessions material are based on SLMTA Program materials, all related to Quality Management Systems, which will greatly benefit laboratory processes throughout the region. The Information System ECHO has provided a space for data practitioners to develop analytical skills and work through tailored projects meant to build regional capacity. Future curriculum will focus on programs such as R and other statistical analysis programs. ECHO Mental Health has proven to be an invaluable opportunity for health practitioners from all areas of HIV services to learn important techniques to build resilience and maintain balanced lives despite facing challenges. The ECHO HIV program has quickly become a pillar within the Central America PEPFAR community, hosting weekly sessions that provide valuable information sessions followed by a case study by a practitioner in the region. Future programming will include emphasis on advanced HIV treatment, pediatric and adolescent care, and the execution of CQI projects to improve services.

Please see Appendix C for more details on Above-Site activities.

## 6.0 USG Operations and Staffing Plan to Achieve Stated Goals

Figure 6.1.1 PEPFAR Central America/Brazil Operational Staffing Chart



### Vacant Positions

There are five vacant approved positions and one vacant proposed position. The State department vacancy is the Interagency Strategic Information Specialist based in Guatemala and there are four vacancies from CDC based in Guatemala, El Salvador Panama and Brazil. All positions are expected to be filled shortly.

In addition, there is one LES USAID position proposed for Guatemala to support of PEPFAR's continued transition of HIV services to local partners, approved by S/GAC in 2018.

### Changes to CODB

The Cost of Doing Business has marginally increased due to anticipated staffing transitions (notably the PEPFAR Coordinator to a Limited Non-Career Appointment). Staff travel and administrative costs have remained stable.



### Table A.1 Prioritization Matrix by Country and SNU

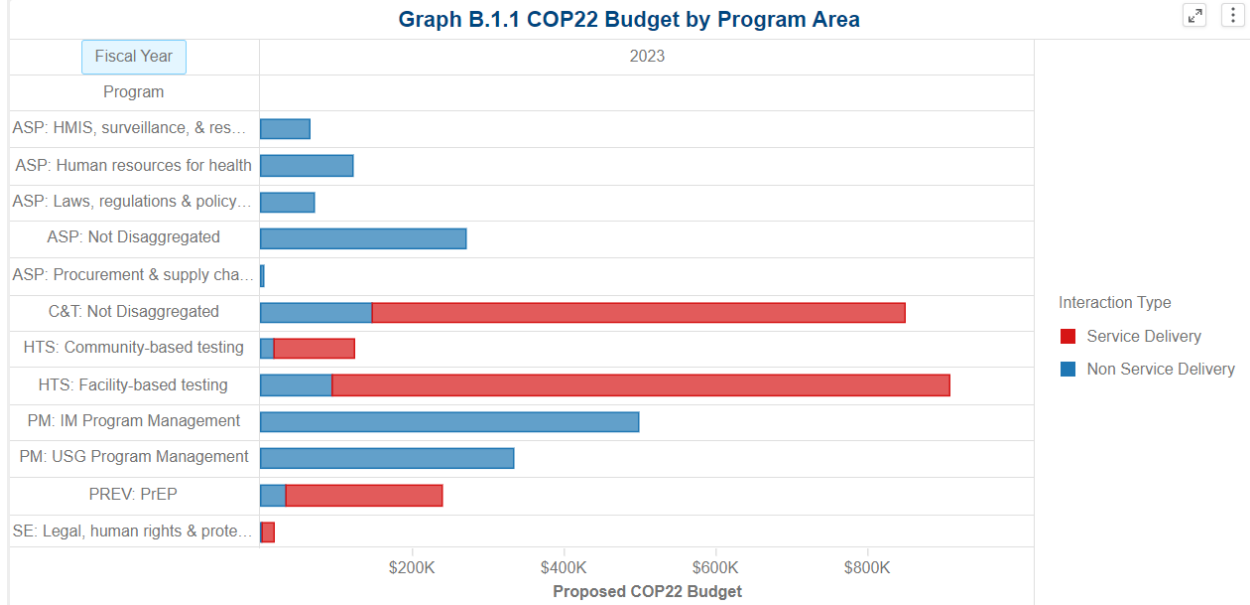
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# APPENDIX B – Budget Profile and Resource Projections

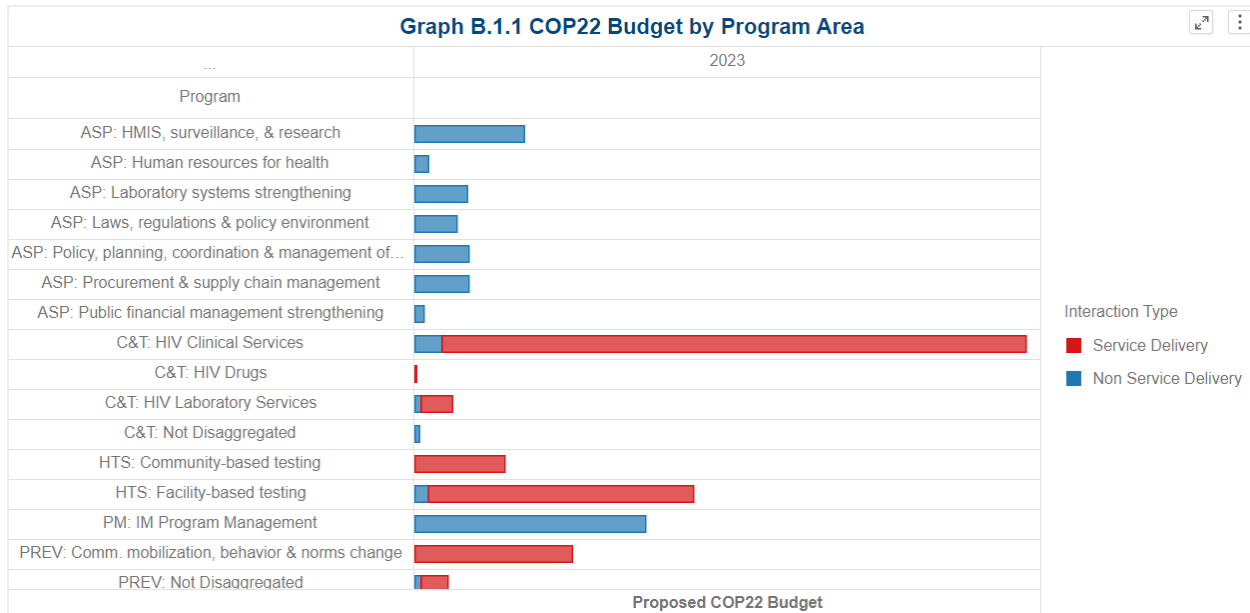
## B1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

### Brazil

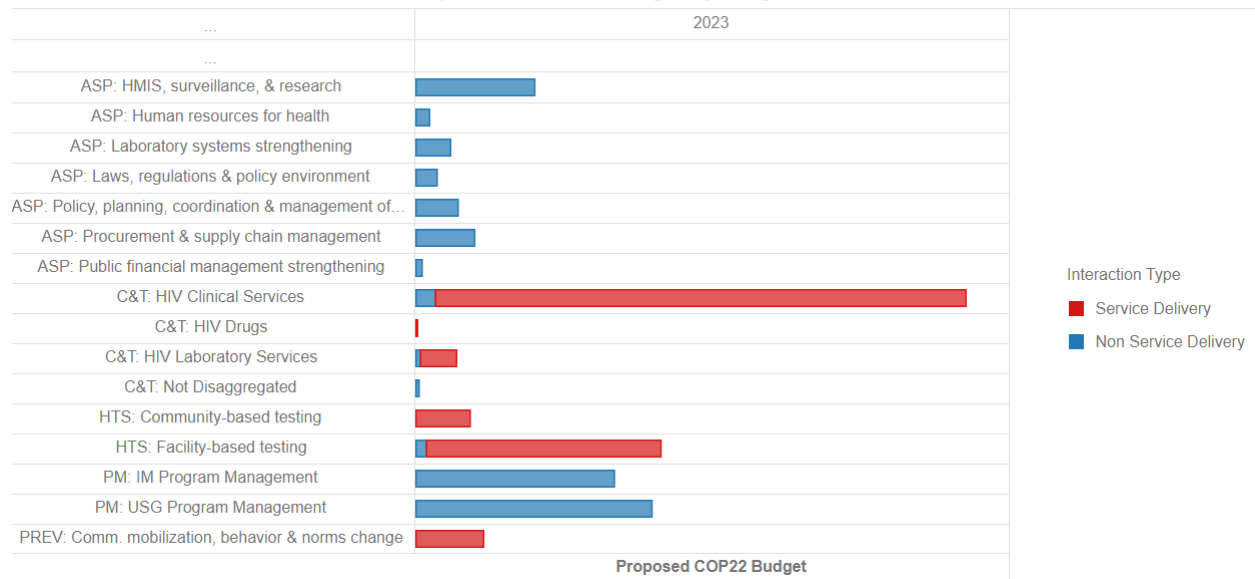


### El Salvador



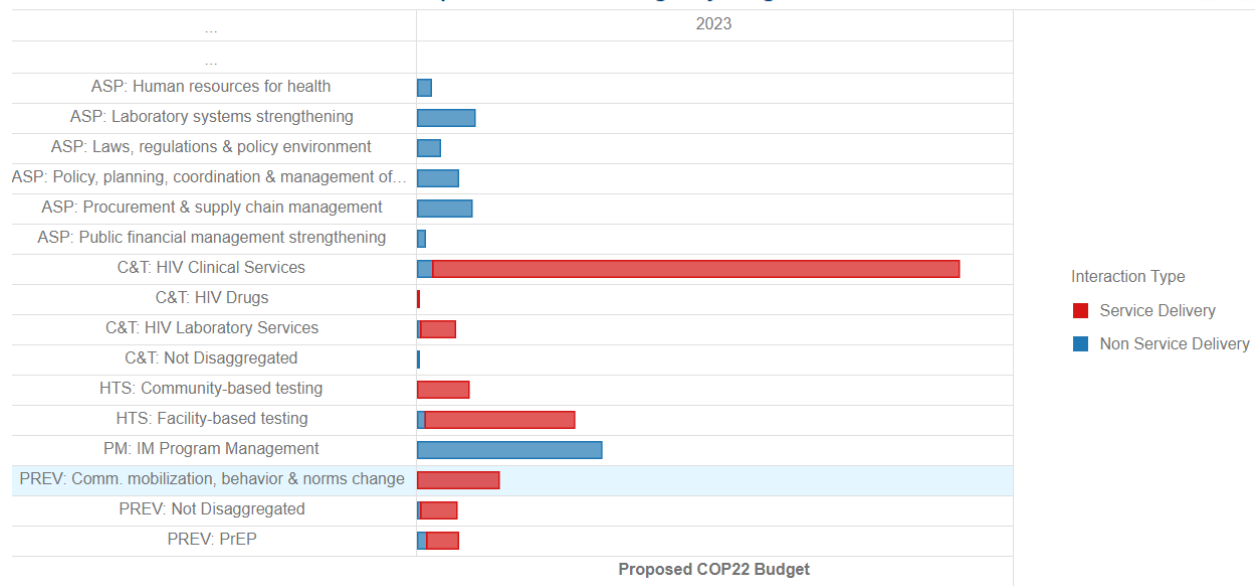
## Guatemala

Graph B.1.1 COP22 Budget by Program Area



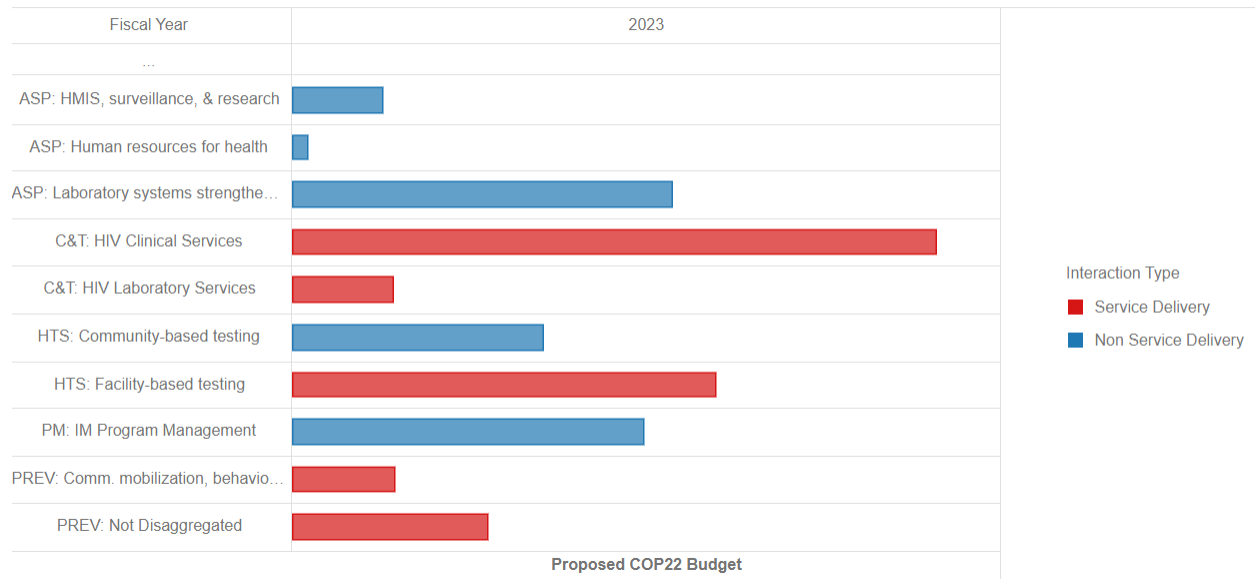
## Honduras

Graph B.1.1 COP22 Budget by Program Area



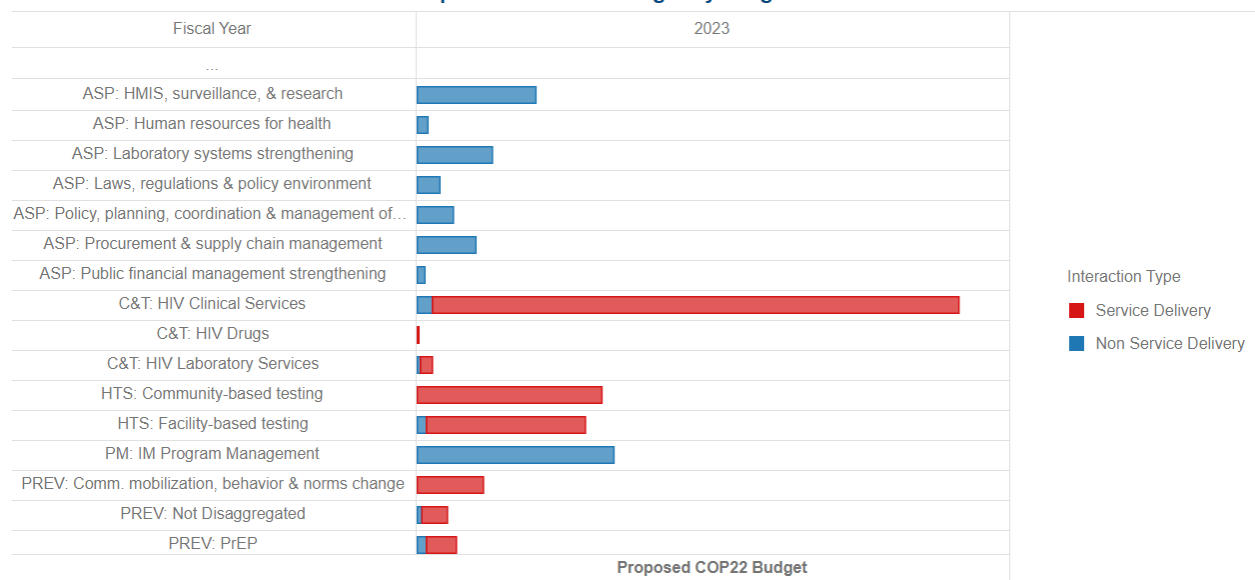
## Nicaragua

Graph B.1.1 COP22 Budget by Program Area



## Panama

Graph B.1.1 COP22 Budget by Program Area



**Table B.1.2 COP22 Budget by Program Area**

**Brazil**

Table B.1.2 COP22 Budget by Program Area							
Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$1,659,539	\$1,840,461	\$3,500,000	47%	53%	100%
C&T	Total	\$146,310	\$703,436	\$849,746	17%	83%	100%
	Not Disaggregated	\$146,310	\$703,436	\$849,746	17%	83%	100%
HTS	Total	\$113,299	\$917,648	\$1,030,947	11%	89%	100%
	Community-based testing	\$18,259	\$105,230	\$123,489	15%	85%	100%
	Facility-based testing	\$95,040	\$812,418	\$907,458	10%	90%	100%
PREV	Total	\$34,273	\$204,479	\$238,752	14%	86%	100%
	PrEP	\$34,273	\$204,479	\$238,752	14%	86%	100%
SE	Total	\$2,548	\$14,898	\$17,446	15%	85%	100%
	Legal, human rights & protection	\$2,548	\$14,898	\$17,446	15%	85%	100%
ASP	Total	\$530,836		\$530,836	100%		100%
	HMIS, surveillance, & research	\$65,034		\$65,034	100%		100%
	Human resources for health	\$121,373		\$121,373	100%		100%
	Laws, regulations & policy environment	\$69,878		\$69,878	100%		100%
	Not Disaggregated	\$270,000		\$270,000	100%		100%
	Procurement & supply chain management	\$4,551		\$4,551	100%		100%
PM	Total	\$832,273		\$832,273	100%		100%
	IM Program Management	\$498,782		\$498,782	100%		100%
	USG Program Management	\$333,491		\$333,491	100%		100%



## El Salvador

**Table B.1.2 COP22 Budget by Program Area**

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$3,586,451	\$6,989,312	\$10,575,763	34%	66%	100%
C&T	Total	\$211,733	\$3,569,656	\$3,781,389	6%	94%	100%
	HIV Clinical Services	\$155,030	\$3,385,713	\$3,540,743	4%	96%	100%
	HIV Drugs		\$1,900	\$1,900		100%	100%
	HIV Laboratory Services	\$33,703	\$182,043	\$215,746	16%	84%	100%
	Not Disaggregated	\$23,000		\$23,000	100%		100%
HTS	Total	\$81,430	\$2,053,081	\$2,134,511	4%	96%	100%
	Community-based testing		\$524,332	\$524,332		100%	100%
	Facility-based testing	\$81,430	\$1,528,749	\$1,610,179	5%	95%	100%
PREV	Total	\$34,898	\$1,366,575	\$1,401,473	2%	98%	100%
	Comm. mobilization, behavior & norms change		\$913,744	\$913,744		100%	100%
	Not Disaggregated	\$34,898	\$154,170	\$189,068	18%	82%	100%
	PrEP		\$298,661	\$298,661		100%	100%
ASP	Total	\$1,925,736		\$1,925,736	100%		100%
	HMIS, surveillance, & research	\$629,229		\$629,229	100%		100%
	Human resources for health	\$80,276		\$80,276	100%		100%
	Laboratory systems strengthening	\$300,500		\$300,500	100%		100%
	Laws, regulations & policy environment	\$242,789		\$242,789	100%		100%
	Policy, planning, coordination & management of disease control	\$308,130		\$308,130	100%		100%

## Guatemala

**Table B.1.2 COP22 Budget by Program Area**

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$10,069,921	\$7,745,928	\$17,815,849	57%	43%	100%
C&T	Total	\$1,604,885	\$4,410,528	\$6,015,413	27%	73%	100%
	HIV Clinical Services	\$1,546,182	\$4,122,359	\$5,668,541	27%	73%	100%
	HIV Drugs		\$1,900	\$1,900		100%	100%
	HIV Laboratory Services	\$33,703	\$286,269	\$319,972	11%	89%	100%
	Not Disaggregated	\$25,000		\$25,000	100%		100%
HTS	Total	\$81,429	\$2,275,518	\$2,356,947	3%	97%	100%
	Community-based testing		\$419,910	\$419,910		100%	100%
	Facility-based testing	\$81,429	\$1,855,608	\$1,937,037	4%	96%	100%
PREV	Total	\$39,676	\$1,059,882	\$1,099,558	4%	96%	100%
	Comm. mobilization, behavior & norms change		\$523,320	\$523,320		100%	100%
	Not Disaggregated	\$39,676	\$221,630	\$261,306	15%	85%	100%
	PrEP		\$314,932	\$314,932		100%	100%
ASP	Total	\$2,284,723		\$2,284,723	100%		100%
	HMIS, surveillance, & research	\$921,696		\$921,696	100%		100%
	Human resources for health	\$106,019		\$106,019	100%		100%
	Laboratory systems strengthening	\$265,500		\$265,500	100%		100%
	Laws, regulations & policy environment	\$168,637		\$168,637	100%		100%
	Policy, planning, coordination & management of	\$324,160		\$324,160	100%		100%

## Honduras

**Table B.1.2 COP22 Budget by Program Area**

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$3,201,064	\$5,483,148	\$8,684,212	37%	63%	100%
C&T	Total	\$119,109	\$3,385,233	\$3,504,342	3%	97%	100%
	HIV Clinical Services	\$88,281	\$3,172,389	\$3,260,670	3%	97%	100%
	HIV Drugs		\$950	\$950		100%	100%
	HIV Laboratory Services	\$18,328	\$211,894	\$230,222	8%	92%	100%
	Not Disaggregated	\$12,500		\$12,500	100%		100%
HTS	Total	\$46,167	\$1,205,285	\$1,251,452	4%	96%	100%
	Community-based testing		\$308,091	\$308,091		100%	100%
	Facility-based testing	\$46,167	\$897,194	\$943,361	5%	95%	100%
PREV	Total	\$76,036	\$892,630	\$968,666	8%	92%	100%
	Comm. mobilization, behavior & norms change		\$491,165	\$491,165		100%	100%
	Not Disaggregated	\$19,786	\$214,469	\$234,255	8%	92%	100%
	PrEP	\$56,250	\$186,996	\$243,246	23%	77%	100%
ASP	Total	\$1,853,143		\$1,853,143	100%		100%
	HMIS, surveillance, & research	\$663,588		\$663,588	100%		100%
	Human resources for health	\$81,124		\$81,124	100%		100%
	Laboratory systems strengthening	\$348,000		\$348,000	100%		100%
	Laws, regulations & policy environment	\$139,818		\$139,818	100%		100%
	Policy, planning, coordination & management of disease control	\$244,298		\$244,298	100%		100%

## Nicaragua

**Table B.1.2 COP22 Budget by Program Area**

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$939,523	\$1,269,053	\$2,208,576	43%	57%	100%
C&T	Total		\$644,508	\$644,508		100%	100%
	HIV Clinical Services		\$557,756	\$557,756		100%	100%
	HIV Laboratory Services		\$86,752	\$86,752		100%	100%
HTS	Total	\$216,669	\$366,825	\$583,494	37%	63%	100%
	Community-based testing	\$216,669		\$216,669	100%		100%
	Facility-based testing		\$366,825	\$366,825		100%	100%
PREV	Total		\$257,720	\$257,720		100%	100%
	Comm. mobilization, behavior & norms change		\$88,424	\$88,424		100%	100%
	Not Disaggregated		\$169,296	\$169,296		100%	100%
ASP	Total	\$418,700		\$418,700	100%		100%
	HMIS, surveillance, & research	\$77,700		\$77,700	100%		100%
	Human resources for health	\$13,000		\$13,000	100%		100%
	Laboratory systems strengthening	\$328,000		\$328,000	100%		100%
PM	Total	\$304,154		\$304,154	100%		100%
	IM Program Management	\$304,154		\$304,154	100%		100%

## Panama

Table B.1.2 COP22 Budget by Program Area							
Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$4,420,812	\$7,800,788	\$12,221,600	36%	64%	100%
C&T	Total	\$144,702	\$4,184,044	\$4,328,746	3%	97%	100%
	HIV Clinical Services	\$121,093	\$4,092,878	\$4,213,971	3%	97%	100%
	HIV Drugs		\$950	\$950		100%	100%
	HIV Laboratory Services	\$23,609	\$90,216	\$113,825	21%	79%	100%
HTS	Total	\$75,238	\$2,677,018	\$2,752,256	3%	97%	100%
	Community-based testing		\$1,441,181	\$1,441,181		100%	100%
	Facility-based testing	\$75,238	\$1,235,837	\$1,311,075	6%	94%	100%
PREV	Total	\$112,468	\$939,726	\$1,052,194	11%	89%	100%
	Comm. mobilization, behavior & norms change		\$516,685	\$516,685		100%	100%
	Not Disaggregated	\$37,468	\$198,380	\$235,848	16%	84%	100%
	PrEP	\$75,000	\$224,661	\$299,661	25%	75%	100%
ASP	Total	\$2,559,528		\$2,559,528	100%		100%
	HMIS, surveillance, & research	\$926,058		\$926,058	100%		100%
	Human resources for health	\$79,582		\$79,582	100%		100%
	Laboratory systems strengthening	\$584,841		\$584,841	100%		100%
	Laws, regulations & policy environment	\$177,808		\$177,808	100%		100%
	Policy, planning, coordination & management of disease control programs	\$278,578		\$278,578	100%		100%

**Table B.1.3 COP22 Total Planning Level**

Table B.1.3 COP22 Total Planning Level			
	Proposed COP22 Budget		
Country	Applied Pipeline	New	Total
Brazil	\$ 3,500,000		\$ 3,500,000
El Salvador	\$ 323,411	\$ 10,252,352	\$ 10,575,763
Guatemala	\$ 3,632,947	\$ 14,182,902	\$ 17,815,849
Honduras	\$ 1,177,795	\$ 7,506,417	\$ 8,684,212
Nicaragua	\$ 284,499	\$ 1,960,077	\$ 2,208,576
Panama	\$ 939,764	\$ 11,281,836	\$ 12,221,600
<b>Total</b>	\$ 9,858,416	\$ 45,183,584	\$ 55,006,000

**Table B.1.4 COP22 Resource Allocation by Program and Beneficiary**

## Brazil

Metrics	Proposed COP22 Budget							Percent to Total						
Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Total	\$849,746	\$1,030,947	\$238,752	\$17,446	\$530,836	\$832,273	\$3,500,000	100%	100%	100%	100%	100%	100%	100%
Key Pops		\$123,489	\$238,752		\$71,500		\$433,741		12%	100%		13%		12%
Non-Targeted Pop	\$604,098	\$907,458			\$459,336	\$832,273	\$2,803,165	71%	88%			87%	100%	80%
Priority Pops	\$245,648			\$17,446			\$263,094	29%			100%			8%

## El Salvador

Metrics	Proposed COP22 Budget						Percent to Total					
Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Total	\$3,781,389	\$2,134,511	\$1,401,473	\$1,925,736	\$1,332,654	\$10,575,763	100%	100%	100%	100%	100%	100%
Key Pops	\$417,666	\$1,130,681	\$1,401,473	\$345,944		\$3,295,764	11%	53%	100%	18%		31%
Non-Targeted Pop	\$3,299,723	\$975,830		\$1,551,292	\$1,332,654	\$7,159,499	87%	46%		81%	100%	68%
Priority Pops	\$64,000	\$28,000		\$28,500		\$120,500	2%	1%		1%		1%

## Guatemala

Metrics	Proposed COP22 Budget						Percent to Total					
Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Total	\$6,015,413	\$2,356,947	\$1,099,558	\$2,284,723	\$6,059,208	\$17,815,849	100%	100%	100%	100%	100%	100%
Key Pops	\$540,856	\$1,293,190	\$1,099,558	\$397,027		\$3,330,631	9%	55%	100%	17%		19%
Non-Targeted Pop	\$5,406,557	\$1,033,757		\$1,861,696	\$5,524,899	\$13,826,909	90%	44%		81%	91%	78%
Not Specified					\$410,309	\$410,309					7%	2%
Priority Pops	\$68,000	\$30,000		\$26,000	\$124,000	\$248,000	1%	1%		1%	2%	1%

## Honduras

Metrics	Proposed COP22 Budget						Percent to Total					
Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Total	\$3,504,342	\$1,251,452	\$968,666	\$1,853,143	\$1,106,609	\$8,684,212	100%	100%	100%	100%	100%	100%
Key Pops	\$263,122	\$760,647	\$968,666	\$276,480		\$2,268,915	8%	61%	100%	15%		26%
Non-Targeted Pop	\$3,202,720	\$470,805		\$1,556,663	\$1,106,609	\$6,336,797	91%	38%		84%	100%	73%
Priority Pops	\$38,500	\$20,000		\$20,000		\$78,500	1%	2%		1%		1%

## Nicaragua

Metrics	Proposed COP22 Budget						Percent to Total					
Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Total	\$644,508	\$583,494	\$257,720	\$418,700	\$304,154	\$2,208,576	100%	100%	100%	100%	100%	100%
Key Pops		\$216,669	\$257,720	\$63,700		\$538,089		37%	100%	15%		24%
Non-Targeted Pop	\$644,508	\$366,825		\$355,000	\$304,154	\$1,670,487	100%	63%		85%	100%	76%

## Panama

Metrics	Proposed COP22 Budget						Percent to Total					
Beneficiary	C&T	HTS	PREV	ASP	PM	Total	C&T	HTS	PREV	ASP	PM	Total
Total	\$4,328,746	\$2,752,256	\$1,052,194	\$2,559,528	\$1,528,876	\$12,221,600	100%	100%	100%	100%	100%	100%
Key Pops	\$1,016,427	\$1,866,800	\$1,052,194	\$362,440		\$4,297,861	23%	68%	100%	14%		35%
Non-Targeted Pop	\$3,312,319	\$885,456		\$2,197,088	\$1,528,876	\$7,923,739	77%	32%		86%	100%	65%

## **B.2 Resource Projections**

The USG team undertook a detailed costing exercise to develop the budget for the integrated site level package by analyzing the costs for each component based on previous related expenditures and levels of effort. The team then considered the size of each proposed site and adjusted the cost estimate accordingly to come up with an estimated budget per country. Above-site activities were first analyzed to ensure only activities critical to epidemic control continue and budgets were developed based on expenditure reports from the previous year.

## APPENDIX C – Tables and Systems Investments for Section 6.0

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## APPENDIX D– Minimum Program Requirements

### Guatemala

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	Test and Start is included in the National Guidelines on the same day of diagnosis if there are no contraindications or within the first seven days after the diagnosis. Additional complementary guidelines were issued in 2021, including ART recommendations for pregnant women and children, and non-occupational PEP.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are >4 weeks of age and weigh >3 kg, and removal of all NVP- and EFV-based ART regimens.	<p>The National ARV Guidelines and complementary guidelines include recommendations for prescribing TLD and retiring the NVP-based regimens. The PEPFAR program developed an optimization plan for TLD with key stakeholders which aims to have 63% of the cohort on TLD by December 21. Preliminary monitoring data indicates that the 76% of progress has been made to reach that goal.</p> <p>The program plans to update this goal and expand the cohort to migrate.</p>
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	<p>The National ARV Guidelines indicate that the health services providers can offer a variety of differentiated service delivery models, including:</p> <ol style="list-style-type: none"> <li>1. Multi-month dispensing from of 3 to 6 months for less frequent visits to the clinic.</li> <li>2. Due to the COVID 19 pandemic, delivery options for multiple months of ARVs was established. The program is advocating for this to be a permanent policy beyond the COVID.</li> </ol>

<p>4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p>Currently, there is a 'Manual for the intensive search for Tuberculosis in PLHIV in Guatemala.' The guide includes prophylaxis for TB with TMP / SMX.</p> <p>In practice, the Comprehensive Care Units perform symptom screening for TB at each follow-up appointment. If any symptom is found, the client is referred for screening. Prophylaxis is offered when an active infection is ruled out.</p>
<p>5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other co-infections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within four weeks.</p>	<p>For early childhood diagnosis, the National HIV and AIDS Program has started implementing the elimination of mother-to-child transmission (EMTCT) strategy in 2021. This has included the expansion of the laboratory network for diagnosis at the first and second levels of care. The strategy includes HIV, Syphilis, and Hepatitis B, but not Tuberculosis. The National ARV Guidelines includes detection by PRC of plasma RNA (viral load) for newborns. However, only 68% of exposed newborns received a test before two months of life. For follow-up at 12 and 24 months, the standard is to use a rapid test or ELISA.</p>
<p>Case Finding</p>	
<p>6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected, and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.</p>	<p>The National Guidelines for Index Testing is in the approval process by the Ministry of Health.</p> <p>For self-testing, there is a validation study planned under the leadership of the National Laboratory. In the next months, a protocol for the study will be developed.</p> <p>Currently, the pilot studies are based on article 3 of the HIV Law. Some organizations such as PASMO, CAS, and OTRANS-RN have implemented self-testing</p>
<p>Prevention and OVC</p>	

7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) .	National guidelines for PrEP implementation are being developed.
8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	NA
<b>Policy &amp; Public Health Systems Support</b>	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward the advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	The Ombudsman Office implemented "Virtual Trainer of Trainers in Human Rights of PLHIV and LGBTIQ+ to Reduce Stigma and Discrimination" course, which aims to strengthen institutional competencies, through training of trainers in the public sector. As of December 2021, the PDH has also incorporated the virtual course training 32 people from the Social Security sector resulting in an improvement in stigma and discrimination index of 20.6%.

10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP, and routine clinical services affecting access to HIV testing and treatment and prevention.	According to Guatemalan law, all health services are free for the population.
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	The National Health Quality Policy launched in 2019; however, its operational implementation is still limited. With support from USAID partners, efforts are being made to establish standards and instruments for HIV services implemented in seven units of the MOH.
12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils, and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	In the framework of strengthening prevention actions for health personnel, it does, but in coordination with the support of cooperants, being the issue of diversity and stigma and discrimination cross-cutting but not specific.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to the community-, KP- and women-led responses	Significant progress has been made to transition to local partners. For ROP22, 52% of PEPFAR funds will go to local partners. PEPFAR also partners with several KP and Indigenous-led organizations. The program plans to continue this transition through future awards.

14) Evidence of partner government assuming greater responsibility of the HIV response, including demonstrable evidence of year after year increased resources expended	The National budget allocated to HIV increased by 15% between 2018 and 2019 and an additional 5% for 2020. In the year 2021, there was no increase. The budget execution for 2021 was 85.73%.
15) Monitoring and reporting of morbidity and mortality outcomes, including infectious and non-infectious morbidity.	The National AIDS Program (NAP) updates the MOH web page and the HIV dashboard periodically. In the case of mortality, the data shown is for the year 2020. Cases of sexually transmitted infections by age are also monitored, but the data is not nominal. Non-infectious morbidity is not reported. <a href="https://vihcovidgt.wixsite.com/2020/salas-situacionales">https://vihcovidgt.wixsite.com/2020/salas-situacionales</a>
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	The NAP is structuring a new information system that incorporates unique identifiers of patients. The system has been conceptual designed, but is pending development. The expectation is that the system will be implemented in two years.

## EL SALVADOR

Care and Treatment	
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<p>1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and direct and immediate (&gt;95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.</p>	<p>The Clinical Guidelines for Comprehensive Care for People with HIV includes all the treatments regimens for VIH in different population groups.</p> <p>An addendum for Test and Start (in no more than seven days after testing positive) was added in December 2021. However, the guidelines do not indicate that ART should not be started on the same day if there are contraindications.</p>
<p>2) Rapid optimization of ART by offering TLD to all PLHIV weighing &gt;30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are &gt;4 weeks of age and weigh &gt;3 kg, and removal of all NVP- and EFV-based ART regimens.</p>	<p>The transition Plan to TLD 2020 – 2021 was already approved. As of March 2022, 10,810 patients are using TLD, (93% of the cohort.)</p>
<p>3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.</p>	<p>The technical guidelines for home delivery of medicines in the national hospital network was approved in October 2021.</p>
<p>4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.</p>	<p>The Clinical Guidelines for Comprehensive HIV Care includes access to tuberculosis care. There are also a technical guidelines for the prevention and control of tuberculosis, updated in 2020. Treatment is free for patients and includes preventive treatment with TMP/SMX.</p>

5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other co-infections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within four weeks.	All VL/EID/ TB and other co-infection tests are available. The Central Laboratory has several Standard Operating Processes (SOPs) and is currently developing manuals for VL.
Case Finding	
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected, and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	<p>The guidelines for index testing implementation was approved in October 2020. Subsequently, an addendum was approved in April 2021 to guarantee the application of the guidelines in the Social Security system.</p> <p>Currently the guide for self-testing is being developed. The National Strategic Plan 2022-2026, indicate that in 2024 the strategy will be fully implemented after conducting and evaluating self-testing pilots.</p>
Prevention and OVC	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	<p>In December 2021, the Technical Guidelines for Pre-Exposure Prophylaxis (PrEP) was approved and is currently being negotiated for its implementation within the private sector.</p> <p>Currently, the is MOH conducting PrEP feasibility studies in coordination with Global Fund and PEPFAR, and it is expected in develop regulations for provision of PrEP in public health services in 2022.</p>

8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14-year-old girls and boys regarding primary prevention of sexual violence and HIV.	NA
<b>Policy &amp; Public Health Systems Support</b>	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward the advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	The Ombudsman Office of El Salvador implemented the "Virtual Trainer of Trainers in Human Rights of PLHIV and LGBTIQ+ to Reduce Stigma and Discrimination" course, which aims to strengthen institutional competencies, through training of trainers in the public sector. Currently this training is being adapted to an in-person course to accelerate access and reach more people.
10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP, and routine clinical services affecting access to HIV testing and treatment and prevention.	All HIV services in El Salvador are free per the National HIV law.



<p>11) OUs assure program and site standards, including infection prevention &amp; control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>In the National Strategic Plan for HIV 2022-2026 (which is currently being validated), includes Continuous Prevention and Care and Quality Assurance provisions , however the institutionalization of the strategy is pending.</p>
<p>12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils, and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.</p>	<p>With the support of PEPFAR, the National Program developed U=U materials for health providers to deliver to PLHIV, along with strategies and protocols for client follow-up.</p>
<p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations supporting Global AIDS Strategy targets related to the community, KP, and women-led responses.</p>	<p>Significant progress has been made to transition to local partners. For ROP22, 52% of PEPFAR funds will go to local partners. PEPFAR also partners with several KP and Indigenous-led organizations. The program plans to continue this transition through future awards.</p>
<p>14) Evidence of partner government assuming greater responsibility of the HIV response, including demonstrable evidence of year after year increased resources expended</p>	<p>Public financing of the HIV response remained above 70% between 2016 - 2019 but decreased by 10% in 2020, largely because of the decrease in care provided at local levels due to the COVID-19 pandemic. There was a subsequent increase in international contributions (PEPFAR and the GF), which reached 31% of the national contribution (NASA 2020).</p>

15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	MINSA implements the National Information System SUMEVE y SIMMOW, which is continuously updated. This tool provides annual information about mortality rates, but still need to improve in the causality analysis.
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## HONDURAS

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	The Manual on Comprehensive HIV Care for Adults and Adolescents includes flowcharts and eligibility criteria for early initiation within the first seven days of diagnosis, prioritizing same-day initiation.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing $\geq 30$ kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are $\geq 4$ weeks of age and weigh $\geq 3$ kg, and removal of all NVP- and EFV-based ART regimens.	The Manual on Comprehensive Care for Adults and Adolescents with HIV includes the transition to TLD aligning with the PEPFAR-supported Optimization Plan.
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	The Manual on Comprehensive Care for Adults and Adolescents with HIV includes recommendations for three-months prescription of ARVs and recommendations that consultation visits should be spaced out every 3 to 6 months.

4) All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	The Manual on Comprehensive HIV Care for Adults and Adolescents stipulates that preventive treatment with cotrimoxazole (TMP/SMX) should be administered to all people with HIV and suspected DR-TB free of payment.
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other co-infections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within four weeks.	All VL/EID/ TB and other co-infection tests are available. The manual for the comprehensive HIV care for children establishes testing check-points at 3, 6, and 12 months in the first year of the diagnosis.
<b>Case Finding</b>	
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected, and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	<p>Index Testing Guidelines is in place.</p> <p>The guidance for Self-testing will be developed after a PEPFAR-supported field evaluation of three hospitals.</p>
<b>Prevention and OVC</b>	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	Feasibility studies for PrEP have been developed. Provision for PrEP in public services is expected in 2022.

8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14-year-old girls and boys regarding primary prevention of sexual violence and HIV.	NA
<b>Policy &amp; Public Health Systems Support</b>	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	With the support of PEPFAR, the Ombudsman Office of Honduras implemented the "Virtual Trainer of Trainers in Human Rights of PLHIV and LGBTIQ+ to Reduce Stigma and Discrimination" course, which aims to strengthen institutional competencies through training of trainers in the public sector. Currently this training is being adapted to an in-person course to accelerate access and reach more people.
10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	All the HIV services in Honduras are free
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	With PEPFAR support, the MOH has implemented a quality management unit and uses of specific instruments to measure performance quality standards in health facilities.

12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils, and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	With the support of PEPFAR, U=U materials were developed for health providers to deliver and follow-up with PLHIV. The MOH trains health personnel, but due to COVID-19, this training has been virtual. There is also an additional training with CSOs, to identify and address stigma and encourage treatment and prevention services for key populations.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations supporting Global AIDS Strategy targets related to the community-, KP- and women-led responses.	Significant progress has been made to transition to local partners. For ROP22, 52% of PEPFAR funds will go to local partners. PEPFAR also engages with several KP and Indigenous-led organizations. The program plans to continue this transition through future awards.
14) Evidence of partner government assuming greater responsibility of the HIV response, including demonstrable evidence of year after year increased resources expended	According to NASA studies, the public sector increased its HIV national expenses to 53% in 2019.
15) Monitoring and reporting of morbidity and mortality outcomes, including infectious and non-infectious morbidity.	Basic mortality and morbidity information is reported by the National Health Information System. PEPFAR is preparing the implementation of formal studies.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	PEPFAR is supporting several initiatives to strengthen the existing information systems, including where the PID is used as a unique identifier.

## Panama

<b>Care and Treatment</b>	
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1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	Rapid initiation of ART in all people diagnosed with HIV infection is being incorporated into the Therapeutic Management Guidelines and is in the final approval process.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing $\geq 30$ kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are $\geq 4$ weeks of age and weigh $\geq 3$ kg, and removal of all NVP- and EFV-based ART regimens.	Transition to TLD regimens have been established in all services, although the guidance is still pending approval. The country has just issued an amendment to Law 1, which allows purchases of medicines at risk of shortages, including ARVs.
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	Under a COVID-19 emergency resolution, MMD is being implemented throughout the country. The National HIV/AIDS Program is completing the approval of the ministerial resolution that incorporates ARV multi-month dispensing to ensure it's a continued strategy.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	TB Preventive Therapy (PTT) and Cotrimoxazole are available within the package of free services regulated by MoH for adults and children.
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other co-infections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within four weeks.	<p>Currently, Panama has the capacity to perform to perform VL/EID and TB tests.</p> <p>Panama follows WHO guidelines and protocols for clinical screening of TB for PLHIV.</p> <p>Panama also follows the 2021 WHO Guidance for diagnosis of other co-infections of interest. For Cryptococcosis and Histoplasmosis, MINSA has an established protocol for therapeutic management. PEPFAR has promoted surveillance in each ART clinic by donating</p>

	kits for diagnosis and capture at the level of tools such as AlerTAR. PEPFAR is strengthening OI's surveillance regulations through the PNS, a clinical management guide for PV.
<b>Case Finding</b>	
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Both strategies are being implemented and the guidelines are in the approval process.
<b>Prevention and OVC</b>	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	The PrEP Management Protocol in Panama is under review for approval at the MOH. While the revision is being carried out, the procedure manual is being tested in three health centers with the PEPFAR support.
8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	NA
<b>Policy &amp; Public Health Systems Support</b>	

<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward the advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p>The Ombudsman's office in Panama has implemented the "Virtual Trainer of Trainers in Human Rights of PLHIV and LGBTIQ+ to Reduce Stigma and Discrimination" course, which aims to strengthen institutional competencies through training of trainers in the public sector. Currently this training is being adapted to an in-person course to accelerate access and reach more people.</p>
<p>10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP, and routine clinical services affecting access to HIV testing and treatment and prevention.</p>	<p>According to Panama law, all diagnosis and treatment services for HIV are free.</p>
<p>11) OUs assure program and site standards, including infection prevention &amp; control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>MINSA has a designated unit to monitor and improve the provision and quality of health services.</p>
<p>12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention</p>	<p>PEPFAR's manuals and training on the topics of Assisted Contact Notification (NAC), Routine Counseling, Intensified Adherence Counseling (CIA) and other recovery strategies are aligned to strengthen the U=U message and the E&amp;D approach. The project continues to expand the scope to create awareness and integration within the basic service delivery packages at the national level. PEPFAR also supported the implementation of a U=U campaign in 2021 through influencer</p>



	videos, doctor testimonials, WhatsApp posts and flyers.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses.	Significant progress has been made to transition to local partners. For ROP22, 52% of PEPFAR funds will go to local partners. PEPFAR also engages with several KP and Indigenous-led organizations. The program plans to continue this transition through future awards.
14) Evidence of partner government assuming greater responsibility of the HIV response, including demonstrable evidence of year after year increased resources expended	At the public level, the budget allocated to HIV increased by 15% between 2018 and 2019 and an additional 5% in 2020. In 2021, there was no increase. The budget execution in 2021 was 85.73%.
15) Monitoring and reporting of morbidity and mortality outcomes, including infectious and non-infectious morbidity.	Panama does not have a process of monitoring morbidity and mortality in PLVIH. Currently, PEPFAR consults the national electoral registry to verify if people who have interrupted treatment are deceased and registers it in AlerTAR. A specific study supported by PEPFAR is in process to document morbidity related to advanced disease and mortality due to HIV.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	Panama uses an ID number as the unique identifier of the patients.

## BRAZIL

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	<p>The national HIV guideline incorporated Test &amp; Treat strategy in December 2013.</p> <p>PEPFAR supported sites have 89% of Test &amp; Treat and 71% of Test and Start.</p>
2) Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are >4 weeks of age and weigh >3 kg, and removal of all NVP- and EFV-based ART regimens.	<p>DTG-based regimen is first, second, and third-line treatment, including adolescents, children above 6 years old and pregnant women. 89% of new cases and 55% of all cohort are in DTG-based regimens.</p> <p>The MoH is planning to implement DTG for children &gt;4 weeks of age.</p> <p>NVP is in phase out for adults and newborn prophylaxis but is kept as an alternative for under 2 years old. 0.1% of new cases and 0.6% of all cohort are in NVP-based regimens.</p> <p>Fixed combination with dolutegravir (TLD) is not used in Brazil.</p>
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	<p>There has been a considerable increase in dispensing from 30 days to three-month MMD.</p> <p>DSD models in PEPFAR supported sites that are currently being implemented or planned, include extended opening hours, men's clinic, home delivery for self-testing, automatic dispensers, peer navigators for 6 months, health facility of choice, Virtual Clinic/ARV home delivery.</p>
Case Finding	

6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected, and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	<p>Index testing has been a national policy since July 2021. National implementation is in progress.</p> <p>Self-testing has been a national policy since October 2018, and self-tests are distributed free-of-charge in ARV pharmacies, through PrEP services and through extramural activities. PEPFAR supported sites also offer automatic dispensers and home delivery of self-tests.</p>
<b>Prevention and OVC</b>	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) .	<p>PrEP has been a national policy since January 2018. It is offered for contacts of index cases that tested negative, KP and persons with high-risk practices.</p> <p>The MoH is processing a PrEP Guideline update to offer PrEP to teenagers above 15 years old.</p>
<b>Policy &amp; Public Health Systems Support</b>	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward the advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	Partnership with National Social Care System (SUAS) and UNAIDS are progressing toward the advancement of equity, reduction of S&D, and promotion of Human Rights (HCWs training and stakeholders' mobilization).
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is	CQI training was conducted in FY21, with implementation underway (FY22) in PEPFAR supported sites. Due to a lack of experience, there is a need to improve CQI practices into site and program management routine.

supported by IP work plans, Agency agreements, and national policy.	
12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils, and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	With the support of PEPFAR, communication strategies on U=U literacy were developed aimed at PLHIV, but also to HCWs and the general population at supported sites.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to the community-, KP- and women-led responses	88% of PEPFAR funding in Brazil is allocated to local implementing partners. The program plans to further include KP-led and women-led organizations.
14) Evidence of partner government assuming greater responsibility of the HIV response, including demonstrable evidence of year after year increased resources expended	The Brazilian Government is responsible for 99% of resources used in the HIV response. There has been an increase of 9,4% in the past 5 years.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	The country uses the National Social Security Number (CPF) as a patient unique identifier.

# APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

## 1. Misalignments between Investments and Outcomes

Moving towards long-term sustainability requires that investments in the HIV response contribute to improvements in the systems and capacities that are critical to achieving and maintaining epidemic control. Investment levels in the Central America and Brazil region have remained relatively stable in the past three years from national governments, PEPFAR, Global Fund, and other donors. The SID results show positive changes in most of the selected health system areas, but there are still gaps to reach sustainability and misalignment between investments and outcomes. For example, the laboratory systems across all four example countries have a higher percentage of national government investment (ranging from 50-80%) but still have lower sustainability scores on the SID (ranging from 4.11 to 6.74). As reflected in the SID, many lab networks have human resource gaps and issues with infrastructure, among other challenges. To address this, the PEPFAR program aims to strengthen national lab systems through a variety of interventions (as outlined in section 4.8 Viral Load) for eventual transition.

**Figure E.1.1. Central America Investment Profile and Sustainability Index Dashboard (SID) Scores**

	El Salvador					Guatemala				
Health System Areas	Expenditure			SID		Expenditure			SID	
	2019	2021 (e)	Domestic responsibility	2019	2021	2019 (e)	2021 (e)	Domestic responsibility	2019	2021
Health Management Information Systems 1/	\$ 1,186,079	\$ 1,331,066	3.5%	7.01	8.23	\$ 617,539	\$ 685,059	1.3%	5.61	7.17
Laboratory Systems 2/	\$ 269,080	\$ 301,973	78.9%	6.78	6.68	\$ 538,683	\$ 597,581	80.6%	4.54	6.74
Supply Chain 3/	\$ 70,216	\$ 78,799	85.8%	5.63	7.43	\$ 243,335	\$ 269,940	83.1%	5.47	5.61
Human Resources for Health 4/	\$ 41,424	\$ 46,488	9.1%	5.34	9.33	\$ 489,907	\$ 543,472	0.0%	4.27	5.89
Policy 5/	\$ 966,466	\$ 1,084,608	16.8%	7.67	7.39	\$ 180,810	\$ 200,579	6.1%	7.44	7.55
Planning and Financing Management 6/	\$ -	\$ -	-	5.62	6.83	\$ -	\$ -	-	7.53	8.05

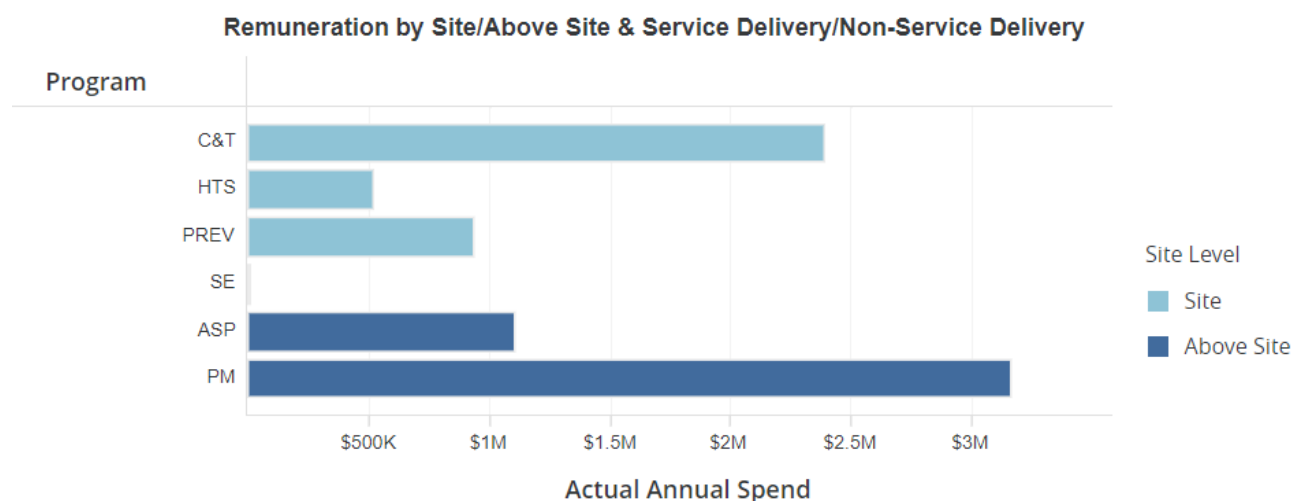
  

	Honduras					Panama				
Health System Areas	Expenditure			SID		Expenditure			SID	
	2019	2021 (e)	Domestic responsibility	2019	2021	2019 (e)	2021 (e)	Domestic responsibility	2019	2021
Health Management	\$ 742,836	\$ 827,711	51.9%	5.82	7.57	\$ 437,351	\$ 475,543	12%	7.26	8.16

Information Systems 1/										
Laboratory Systems 2/	\$ 132,334	\$ 147,454	55.1%	6.11	4.11	\$ 382,533	\$ 415,938	68%	6.24	6.31
Supply Chain 3/	\$ -	\$ -	34.1%	5.35	6.77	\$ 9,741,704	\$ 10,592,411	67%	7.04	7.9
Human Resources for Health 4/	\$ -	\$ -	-	6.53	8.23	\$ 23,898	\$ 25,985	1%	7.92	7.12
Policy 5/	\$ 282,401	\$ 314,678	27.0%	7.69	7.66	\$ 121,908	\$ 132,554	0%	6.65	6.55
Planning and Financing Management 6/	\$ -	\$ -	-	7.57	6.94	\$ -	\$ -	-	4.96	6.79

Another aspect of alignment to consider is where PEPFAR invests in its staff and by program area. Figure E.1.2, illustrates where PEPFAR is investing in staff by examining expenditures of staff remuneration by program area. With the exception of Program Management (PM), the PEPFAR Central America and Brazil focuses most of staff on site-levels program areas, with the highest expenditures in Care and Treatment (C&T), followed by prevention, the above-site, then testing (HTS). This aligns with the PEPFAR program shift towards intensive site-level support for direct service delivery.

**Figure E.1.2. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery for Brazil, El Salvador, Guatemala, Honduras, Nicaragua, and Panama**



## 2. Areas for Transition

Efforts for greater domestic responsibility will require a strategic, multi-year, staged approach in partnership with local governments and institutions. The timeline for domestic responsibility of different elements of the response will vary, with some requiring continued donor investment over an extended period. Others, however, may present opportunities for exploring potential transfer of responsibility mechanisms within a shorter time frame.

**Figure E.2.1 SID Dashboard 2021**

SID Dashboard 2021	El Salvador	Guatemala	Honduras	Panama	Brazil	Number of countries with vulnerability
<b>Governance, Leadership, and Accountability</b>						
1. Planning and Coordination						0
2. Policies and Governance						1
3. Civil Society Engagement						4
4. Private Sector Engagement						5
5. Public Access to Information						2
<b>National Health System and Service Delivery</b>						
6. Service Delivery						1
7. Human Resources for Health						1
8. Commodity Security and Supply Chain						2
9. Quality Management						4
10. Laboratory						4
<b>Strategic Financing and Market Openness</b>						
11. Domestic Resource Mobilization						3
12. Technical and Allocative Efficiencies						1
13. Market Openness						0
<b>Strategic Information</b>						
14. Epidemiological and Health Data						0
15. Financial/Expenditure Data						3
16. Performance Data						3
17. Data for Decision-Making Ecosystem						2

Three areas where the PEPFAR Central America and Brazil program see opportunities for partner country governments to take on greater responsibility in the short-term include Quality Management, private sector partnerships with Market Openness, and in Epidemiological data. For Quality Management, while the SID scores are not as high, all countries have an established CQI plan in place and are poised to begin implementation. For Market Openness, the region doesn't have many restrictions for private sector and there are good market conditions for private sector expansion in PrEP, self-tests, private lab networks and supply chain. PEPFAR will continue to work to strengthen these opportunities throughout ROP22 to facilitate the transition to the government. Finally, Epidemiological Data has consistently high SID scores across all the countries. While countries are currently receiving support from Global Fund and PEPFAR partners to strengthen epidemiological data collection, the program continues to work to transition these activities.

### **3. Engagement with Partner Country Governments in ROP22 to Ensure Sustainability of Core Elements of the HIV Response**

Close collaboration with partner country governments and local partners is essential to developing a clear pathway to full country ownership of a sustainable HIV response. As previously mentioned, PEPFAR Central America/Brazil continuously engages with key stakeholders at the regional, national, and local levels to ensure USG activities are constantly being improved and refined to maximize support towards sustainable epidemic control. In Central America, the PEPFAR team leverages the influence of the regional entities (COMISCA and the Regional Coordinating Mechanism), to influence policy and guidelines in all countries. As COMISCA is made up of the Ministers of Health for all countries from the Central American region, resolutions and

commitments made by COMISCA at the regional level can then be leveraged to inform national policy and implementation.

At the national level, PEPFAR Central America/Brazil engages with both host governments and civil society organizations regularly through above-site activities. As outlined in the ROP22 priorities, the PEPFAR program will work closely with partner government on strengthening HIS systems, lab networks, on human rights/equity programming. The PEPFAR program is also prioritizing partnerships with KP-led and local organizations as outlined in the ROP22 priorities.

The country teams will continue to focus efforts on closing gaps identified in the 2021 SID. To track progress towards sustainability, each country has a multi-year Sustainability Strategy that is supported and monitored by PEPFAR partners. In the area of public policies and financing, financial planning and advocacy will be strengthened to manage resources for budget modifications, avoid the elimination of budget items, and to optimize spending. The team will enhance the joint monitoring of the implementation of the MPRs through the triangulation of SIMS, SID, granular site visits and the analysis of the MER indicators to monitor progress towards sustainable epidemic control.