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EVALUATION

Evaluation of the United States Government Central America Regional Partnership Framework

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EVALUATION OF THE UNITED STATES GOVERNMENT CENTRAL AMERICA REGIONAL PARTNERSHIP FRAMEWORK:

A Qualitative Mid-Term Assessment of the Progress of the Regional Program of the President's Emergency Plan for AIDS Relief

OCTOBER 2013

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CONTENTS

ACRONYMS

ARV	Anti-retrovirals
ART	Anti-retroviral Therapy
BCC	Behavior Change Communication
BSS	Behavioral Surveillance Survey
CA	Central America
CAI	Centro de Atención Integral/Comprehensive Care Center
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
COMISCA	Consejo de Ministros de Salud de Centroamérica / Central American Council of Ministers of Health
COSEP	Consejo Superior de la Empresa Privada en Nicaragua/The Superior Council on Private Enterprise in Nicaragua
CSO	Civil Society Organization
DOD	Department of Defense
FSW	Female Sex Worker
GF	Global Fund to Fight AIDS, TB, and Malaria
GH Tech	Global Health Technical Assistance Project
HIV	Human Immunodeficiency Virus
HSS	Health system strengthening
IGSS	Instituto Guatemalteco de Seguridad Social/ Guatemalan Social Security Institute
KAP	Knowledge, Attitude and Practices
KPs/KP	Key Populations
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MEGAS	Medición de Gastos de Sida/ National AIDS Spending Assessment
MOH	Ministry of Health
MSM	Men who have sex with men
MSW	Male Sex Worker
NAC	National AIDS Council
NGO	Nongovernmental Organization
NSP	National Strategic Plan

PASCA	Program for Strengthening the Central American Response to HIV
PC	Peace Corps
PF	Partnership Framework
PEPFAR	President's Emergency Plan For AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RCM	Regional Coordinating Mechanism
SI	Strategic Information
STI	Sexually Transmitted Infection
SW	Sex Workers (Female and Male)
TRANS	Transgender individuals
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling And Testing

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The Central America Partnership Framework (PF) represents a five-year strategic plan to guide efforts in the regional response to the HIV epidemic, and is implemented by the United States Government together with the governments of Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama. The Partnership Framework provides direction to the work of the President's Emergency Plan for AIDS Relief (PEPFAR) in the region in close coordination and collaboration with regional stakeholders. In May of 2013, USAID's GH Tech Bridge 3 was contracted to field an evaluation team to conduct a Mid-Term Assessment of the Central America Partnership Framework, covering the activities of the four USG agencies (USAID, CDC, DOD and Peace Corps) in the seven countries of the region. The broad goal of this evaluation was to assess how well the regional Partnership Framework is contributing to the sustainability of national HIV/AIDS program efforts focused on targeted key populations (KPs), and to identify challenges and gaps to inform future PEPFAR programming. The evaluation focuses on the following three questions: (1) to what extent has the PF been implemented across the four technical areas; (2) how are contextual factors affecting PF outcomes; and (3) what is the level of sustainability reached by USG supported interventions.

EVALUATION DESIGN, METHODS AND LIMITATIONS

Based on consultation with the expanded regional PEPFAR team at the beginning of the assignment, the team proposed a methodology combining document reviews, in depth individual and group interviews, and an online survey to reach an expanded key informant pool in all seven countries. Site visits to four countries (Nicaragua, Honduras, Belize and Guatemala) were complemented by phone interviews to key respondents in the remaining countries (Costa Rica, Panama and El Salvador) to complete the regional perspective on the strengths and challenges of the regional PEPFAR strategy. The interview protocols and online survey instruments were designed based on an analysis of PEPFAR documentation related to the definition and measurement of the two core concepts of *sustainability* and *country ownership,* which are dominant overarching mandates for PEPFAR programs, but do not have explicit metrics associated within the formal set of indicators from either the global or regional frameworks. The document review process identified six core elements, which together are seen as an inter-related and reinforcing set of dimensions: *financial, social, political, capacity, efficiency and accountability*. These six elements formed the core of the instruments used to gather data and insights from the key informants throughout the fieldwork for the assessment. This qualitative assessment is limited by the focus on subjective perspectives and opinions of key stakeholders that form the basis for the majority of the findings. Findings do not have any quantitative significance and should only be considered informative as qualitative insights and perspectives to be considered in future programming decisions.

FINDINGS AND CONCLUSIONS

Based on the fieldwork and survey results, overall it is clear USG efforts are widely valued across the region, and continue to fill important resource and technical gaps in national HIV/AIDS strategies. In many cases PEPFAR supported activities can be seen as providing otherwise absent leadership and political support for priority efforts focused on KPs, and have contributed significantly to improving capacity and the policy environment in the region. As one of two major external funding sources for HIV/AIDS programs (PEPFAR and the Global Fund), PEPFAR's contributions have had a major impact in the region, including strengthening of STI

services targeting key populations, and the institutionalization and strengthening of key implementing and decision-making structures such as the National AIDS Councils (NACs) and the 'Three Ones', while also providing direct and targeted support to priority program areas. In general, the quality of technical assistance delivered through the four USG agencies and their partners is highly valued within the spheres they work in, but there is a perception of poor coordination and sharing of information across the agencies and with their partners. Collaborating partners at the national level feel that there are missed opportunities to share strategies and tools beyond the immediate beneficiaries or USG reporting channels.

This report organizes findings, conclusions and specific recommendations by the four technical areas of the Partnership Framework, with a focus sustainability and country ownership. While there are many suggestions for the next generation of PEPFAR investment, the core strategy with four technical areas holds up robustly across the region. In the area of Prevention, PEPFAR is seen as taking the lead in keeping the focus on KPs against strong political tides towards more general population strategies in most countries, and plays a critical role in promoting data-driven decision-making. PEPFAR technical assistance in health system strengthening is considered to be the gold standard in quality, but operates within health systems plagued by larger level challenges such as chronic problems with accountability, and challenges with information and human resource systems which continue to thwart well-designed capacity building efforts. Similarly, the technical quality of focused strategic information investments within sub-systems are perceived as very good, but ultimately not able to overcome the severe coordination and transparency challenges within national health and other public sector agencies, and efforts also continue to be hampered by donor agency reporting requirements that are still not harmonized. At the policy environment level, the largely successful effort to establish the "Three Ones" as national policy infrastructure provides the space to focus on the next challenges of taking national plans to implementation down to the ground levels where systemic lack of transparency, and governance and resource management weaknesses continue to take their toll. Several NAC structures are at risk not only of changes in government but also of losing their critical multi-sectoral coordination functions, which are key to achieving sustainable impact. KPs face on-going stigma and discrimination in the public sector and in society in general and these issues continue to represent major barriers to progress across all technical areas.

Key recommendations include moving towards a vulnerability approach in addition to a risk approach to address the larger barriers such as stigma and discrimination that make key populations vulnerable in the first place. PEPFAR should focus efforts on sustainability for KP prevention and the promotion of public and other funding streams in light of reduced donor funding in the future. To address the challenges of human resources and weak health systems, PEPFAR should increase emphasis on building institutional capacity to ensure improvements made to date are not lost. PEPFAR should support countries to improve capacity for research and continue to strengthen ability to produce and use information through harmonization of systems and indicators. PEPFAR should link with larger efforts to address public sector governance and accountability. While PEPFAR has helped bring key populations and civil society to the table of decision-making bodies like National AIDS Committees, the quality of their engagement and participation has been limited and PEPFAR should now renew emphasis on increasing their technical and leadership capacity.

I. INTRODUCTION

With funding from the President's Emergency Plan For AIDS Relief (PEPFAR), the Partnership Framework (PF) between the United States Government (USG) and seven countries of Central America (Belize, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama), represents a five year strategic plan that describes how host governments, national and regional organizations, the USG, and other major donors will direct their efforts and resources to fight HIV/AIDS. The overall purpose of the PF is to reduce HIV/AIDS incidence and prevalence in Most at Risk Populations (MARPs), or key populations (KPs as referred to in this document) in the Central America region by joining resources and coordinating initiatives to enable a robust and more effective response to the region's epidemic.

The regional PEPFAR strategy works across four technical areas that respond to identified gaps:

- Prevention: promoting behavior change among most at risk populations (KPs); overcoming barriers to Voluntary Counseling and Testing (VCT), especially among the most vulnerable groups; and diagnosing and treating STIs.

- Health System Strengthening (HSS): increasing human resource capacity among health care providers, especially those working with members of vulnerable populations and people living with HIV (PLHIV); developing effective information systems for monitoring community-based care; and improving supply chain management.

- Strategic Information (SI): strengthening surveillance; conducting special studies; improving capacity for collecting, analyzing, and using information for decision making; and monitoring and evaluation.

- Policy Reform: increasing implementation and enforcement of policies already approved that would provide enabling environments for addressing needs of KPs, especially those policies related to reducing stigma and discrimination; and coordinating multi-sectoral support to achieve policy reform.

This Framework represents a consensus of all the major partners to focus on evidence-based approaches that are tailored to the specific conditions of the epidemic in the countries in the region. The document also outlines how the USG provides technical assistance to strengthen the countries' capacity and creates conditions to address HIV/AIDS in a more sustainable way.

EVALUATION PURPOSE

The five-year PEPFAR Partnership Framework (2010 – 2015) is entering its fourth year of implementation, and this independent mid-term evaluation was designed to assess the high level strategy as it is perceived in implementation across the region, particularly looking at factors that either promote or impede sustainability and country ownership.

Specifically, this evaluation serves the purpose of both accountability and learning to:

1) Ascertain if the PEPFAR Central America Regional Program is helping countries reach a sustainable and epidemic-relevant, national AIDS program model.
2) Identify key factors contributing to or impeding program results.
3) Make recommendations for program adjustments.

This evaluation intends to inform the immediate and long-term future direction of PEPFAR's program implementation by identifying recommended adjustments, changes or possible new activities. The findings and recommendations of this evaluation will be used to inform future strategic planning by the USG and its partners.

EVALUATION QUESTIONS

The evaluation focuses on the following three questions:

(1) To what extent the PF has been implemented across the four technical areas?

(2) How are contextual factors affecting PF outcomes?

(3) What is the level of sustainability reached by USG supported interventions, taking into account activities performed by the four USG agencies (Peace Corps, Department of Defense (DoD), USAID and CDC)?

The Scope of Work also includes detailed evaluation questions for each of the four PF technical areas that delve into more specific analysis of the general questions.

II. BACKGROUND

The Central America Partnership Framework is based on considerable national government commitment to fighting HIV/AIDS to date, with increasing levels of host government support over time, complemented by international donors. PEPFAR and the Global Fund support an average of around 30% of total funding across the region. The PF emphasizes the importance of leveraging local and other partners' funding to strengthen the overall response to the epidemic. The shared, overarching vision of the Framework is to sustainably deliver highly effective, quality HIV/AIDS prevention, treatment, care and support services to increased numbers of beneficiaries through strengthened Central American regional and national health systems and personnel by the end of the five-year Framework period.

With the PF led technical assistance model, the USG brings limited additional financial resources and does not displace the significant role that host governments and other partners play in addressing HIV/AIDS in the region. The USG agencies aim to increase institutional and human resource capacity to provide high quality, appropriate strategic HIV/AIDS interventions. The USG works to support the regional goals and framework of the *Consejo de Ministros de Salud de Centroamérica* (COMISCA/Central American Council of Ministers of Health). As capacity is strengthened, the assumption of the Partnership Framework is that the Central American countries will continue fighting the epidemic with local and other donor resources, with minimum continued input from the USG.

Due to the fact that the epidemic in Central America is concentrated among specific populations, the Framework address the following key populations: Men who have sex with men (MSM), female and male sex workers (SW) and their clients, certain ethnic groups such as the Garifuna, mobile populations (e.g. truckers, migrant workers) and other vulnerable groups, such as at-risk youth and military personnel. Activities undertaken in the four goal areas of the PF should seek to reduce infection rates among KPs through improved behavior change strategies; increased access to quality HIV/AIDS services through health systems strengthening; improved implementation of policies that protect the rights of KPs and ensure equal access to quality services; and increased access to and use of strategic information, especially regarding HIV/AIDS among KPs.

Incidence and Prevalence of the HIV/AIDS Epidemic

According to existing HIV prevalence data, the epidemic in Central America is classified as "concentrated", with certain subgroups of the population being particularly affected. In specific geographic areas in Belize, Honduras and Guatemala, generalized infections do exist. According to the 2008 UNAIDS report, adult HIV prevalence appeared to be the highest in Belize (2.1%), followed by Panama (1.0%), El Salvador (0.8%), Guatemala (0.8%), Honduras (0.7%), Nicaragua (0.2%) and Costa Rica[1] (0.4%).

These countrywide prevalence data mask high rates of HIV among the specific subgroups of the population previously mentioned, in particular MSM, FSW and MSW and their clients, and transgender persons. It is estimated that twice as many Central American men are living with HIV than women. Belize represents the only country where women make up the majority of those estimated to be living with HIV, at around 59%, possibly distorted by more aggressive testing within Prevention of Mother to Child Transmission (PMTCT) programs. Many countries

[1] While Costa Rica's prevalence rate appears to be the lowest in the region, the rate may actually be higher than it appears due to lack of reliable data.

lack data to help them understand the characteristics of KPs and while some regional multi-site studies have been conducted; they are now out of date.

III. EVALUATION METHODS & LIMITATIONS

To respond to this scope of work, the evaluation team met with the expanded PEPFAR team at the beginning of the field assignment to clarify and define the design parameters for the evaluation process, based upon the original scope of work (Annex I). In the discussions with the PEPFAR team, it was agreed that the design should focus on obtaining insights and information from the expanded list of recommended stakeholders which complements and adds to the PEPFAR team understanding of the key questions in the SOW, without repeating or compiling information already available through project activity reports, and other routine reporting.[2]

It was also agreed that the primary focus of the evaluation is to gauge the degree to which PEPFAR support contributes to *country ownership and sustainability* of national HIV/AIDS programs, and that the team would develop a protocol for accomplishing this through its proposed interview protocols and online survey instruments. The PEPFAR team contributed significantly to the database of key informants who would be contacted for group and individual interviews (in person and by phone), and for the online survey response.

INTERVIEW GUIDE

An interview guide was developed to explore the core questions about sustainability and ownership, and used as a guide for both group and individual interviews conducted in the field (Guatemala, Nicaragua, Honduras and Belize) and by telephone in the countries not visited (El Salvador, Costa Rica and Panama). Each interview was adapted for each partner category (public sector, implementing agency, NGO, etc.), with a total of 162 key informants participating in those interviews. It should be noted that the limited number of respondents from the three countries not visited limits the depth and range of observations gathered, but they serve to validate general recommendations made in this report.

Table I. No. Persons who participated in interviews by country

Country	No. Persons who participated in interviews (in person & by phone)
Nicaragua	55
Honduras	40
Belize	14
Guatemala	39
Panamá	4
Costa Rica	6
El Salvador	4
TOTAL	162

[2] Memory aids – meetings with PEPFAR team, Guatemala May 2013.

ONLINE SURVEY DESIGN

To complement the country interviews and to reach more stakeholders, the team proposed using an online survey, which could reach all recommended contacts in all seven countries, as well as provide data on key areas of the evaluation, which would not be possible from the interview format. A draft survey instrument was developed in Survey Monkey, in collaboration with the PEPFAR team, in both English and Spanish. The survey link was sent out by invitation to 328 key informants identified by the PEPFAR team as highly informed implementers or partners in each country. The survey was available on line from June 17 to July 4, with the English version for Belize online from June 26 to July 4. The on-line survey should not be considered to be more than an additional channel for perspectives and observations from the field which have been integrated into the findings and recommendations made in this report. The timeframe of the evaluation did not allow for additional follow-up with either respondents or non-respondents. The instrument was designed for country specific perceptions of key policy components and of social participation in the policy cycle, among other areas within the scope of the evaluation.

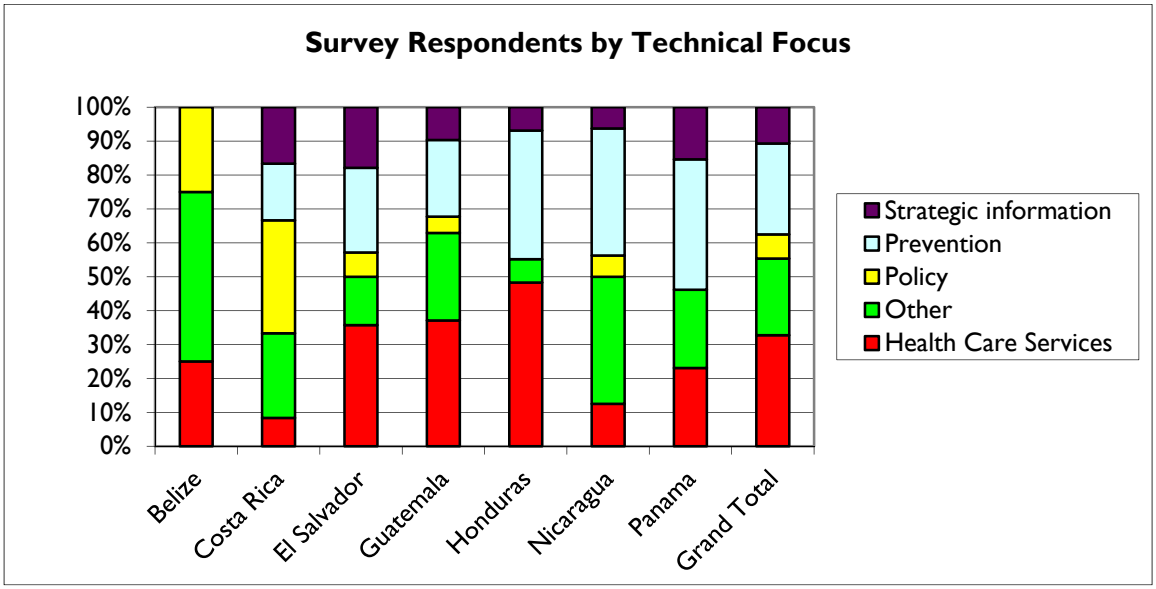
TABLE 2: Responses to Online Survey by Country

Country	Invitations Sent	Responses	%
Guatemala	114	62	54%
Honduras	49	29	59%
Nicaragua	35	16	46%
El Salvador	64	29	45%
Costa Rica	19	12	63%
Panama	30	13	43%
Belize	17	8	47%
	328	**169**	**52%**

The survey was structured around the four technical areas of the regional PF (Prevention, HSS, Strategic Information and Policy Environment). The profile of the online survey respondents maps directly from the expanded contact list generated by the regional PEPFAR team members, and should not be understood as being representative of all national program implementers. Of the 169 respondents, 44% self-identified as from the governmental sector, 25% from NGOs and CSOs, 10% came from other sectors and 12% from PEPFAR implementing agencies.

By PEPFAR´s technical areas, the survey respondents came predominantly from health care services, prevention and other (academia, international organizations).

Table 3: Survey Respondents' Technical Area



DESIGN & METHOLDOLOGY LIMITATIONS

The evaluation is based on stakeholder interviews and surveys and the information gathered represents the perspectives and opinions of the respondents. While some findings were supported by evidence in the document review, the majority of the findings reflect the subjective viewpoints of those interviewed and in some cases those viewpoints were contradictory. The respondent database represents all 328 of the suggested contacts from PEPFAR team members; therefore it is not considered a stratified sample of respondents with proportionate weights by category (agency representatives, implementing partners, host government representatives, local NGOs, etc.). Hence, the findings of this evaluation should be considered informative as qualitative insights and perspectives to be taken into account in future programming decisions, but without quantitative significance beyond the broad patterns of response represented in this report.

CONCEPTUAL FRAMEWORK FOR SUSTAINABILITY & COUNTRY OWNERSHIP

Two core mandates of the global PEPFAR program are to promote long-term program sustainability and country ownership, which have been defined by the USG with overlapping and inseparably related dimensions.

> *"To us, country ownership in health is the end state where a nation's efforts are led, implemented, and eventually paid for by its government, communities, civil society and private sector. To get there, a country's political leaders must set priorities and develop national plans to accomplish them in concert with their citizens, which means including women as well as men in the planning process. And these plans must be effectively carried out primarily by the country's own institutions, and then these groups must be able to hold each other accountable." Hillary Clinton, Secretary of State 2012, PEPFAR website.*

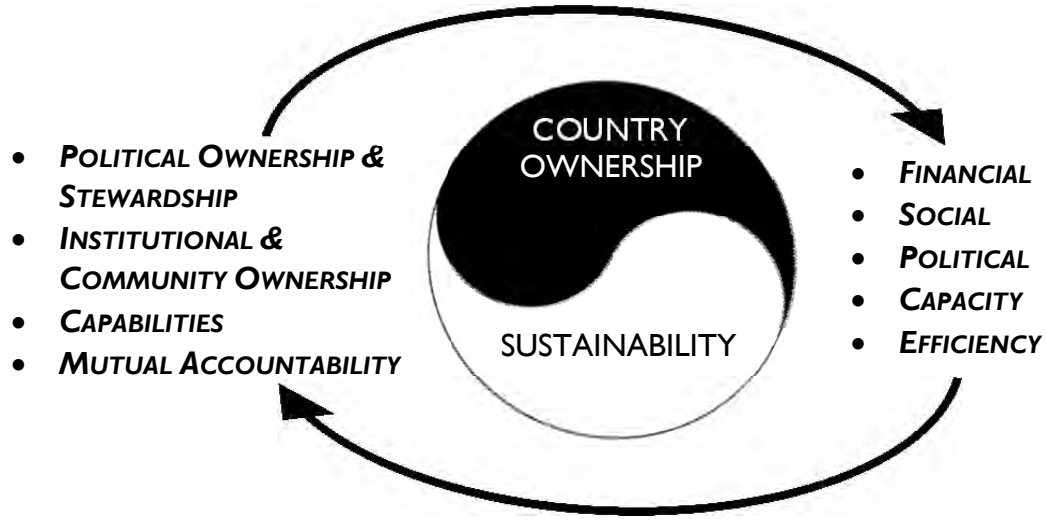
The second phase of PEPFAR has meant a transition from an emergency response to a focus on country ownership in the AIDS response, which is framed as the key to sustainability. Country ownership is described by four dimensions: 1) political ownership and stewardship; 2)

institutional and community ownership; 3) improved capabilities; and 4) mutual accountability. PEPFAR has built these concepts into each new five year Partnership Framework at regional and country levels. Sustainability is defined as the capacity to maintain program services after financial, managerial, and technical assistance from the United States and other external donors has ended.

While country ownership and sustainability have become drivers of the overall PF strategy, specific indicators are still under development by the Office of the Global AIDS Coordinator, leaving few explicit indicators to measure their progress within the results framework. Other references to measurement in PEPFAR documents refer to more subjective parameters, such as verbal or formal buy-in from national leaders, and perceptions of commitment of current national leadership.

PEPFAR definitions provide an initial structure for analysis of country ownership as a key contributor to sustainability. The two concepts are inextricably linked and supportive to each other, but do not offer a comprehensive framework for measuring contributing factors. Implicit in the language are a set of assumptions about the PEPFAR strategy and how its inputs contribute to sustainability. Political ownership leads to the creation of policies and committed budgets, which are essential criteria for long-term sustainability. The engagement and participation of key stakeholders in policy and strategy formulation contributes to the long-term multi-sectorial ownership and commitment to implementation, which are also key elements of sustainability. Mutual accountability ensures the most efficient use of resources and the respect and trust required for healthy collaboration and multi-sectorial engagement.

Figure 1. Country Ownership and Sustainability



After a review of these PEPFAR definitions, the team identified six cross cutting elements which cover the full spectrum of sustainability, including country ownership, forming the core for the development of the field interviews:

1. Financial sustainability, which has factors that vary widely for each program component and level (including national budget measures, payment for services, and ongoing support for civil society functions)

2. Social support (focused on both social networks and formal support for KPs' participation in policy, monitoring and decision-making)
3. Political (focused on creating an enabling environment for participatory policy development and monitoring, and KPs' involvement among the other stakeholders in these processes)
4. Capacity (focused on creation and long-term retention of capacity in institutional and human resources areas)
5. Efficiency (focused on lowering costs of services and programs and maximizing the relationship between resources available and effective epidemic management)
6. Accountability (including transparency as well as public, open and easy access to information pertaining to epidemic management in the countries and the region)

The team integrated these six elements into the design of the interview guide as core themes for respondent perspectives and recommendations, in order to provide a more comprehensive assessment of the barriers and opportunities for PEPFAR to contribute to overall program sustainability and country ownership.

IV. FINDINGS

The findings below synthesize comments and perspectives from the 162 interview respondents, complemented by selected results from the online survey and literature review, and represent diverse and sometimes opposing perspectives from a variety of key Partnership Framework stakeholders.[3]. The findings have been organized around the questions posed in the evaluation Scope of Work. General findings are followed by specific findings for each of the four PEPFAR Central America technical areas: Prevention, Health Systems Strengthening, Strategic Information, and Policy. The six elements of sustainability and country ownership were used as the core design of the interview process and are interwoven within each section and with key findings summarized for each technical area.

GENERAL FINDINGS

To what extent has the Partnership Framework been successfully implemented in Central America, with an emphasis on the principles of Country Ownership and a focus on KPs[4]?

PEPFAR technical assistance across the four technical areas is very well regarded and appreciated for its high quality and complementarity to national efforts. USG efforts are seen as well received by partners in country and the USG is recognized for keeping a clear focus on key populations.

Overarching challenges of governance, societal stigma and discrimination and financial sustainability at the country level threaten to overshadow more focused technical assistance efforts by the USG. In the context of decreased external funding, planning for financial sustainability is an increasingly important imperative and necessitates an increase in technical assistance to national programs to project and plan for ongoing national budget coverage of HIV programs, and to ensure comprehensive transition planning in national budgets. Despite donor efforts, stigma and discrimination are on the increase under new national leadership and there is limited evidence of official support or commitment to work these areas. Broader health reform efforts such as service integration and decentralization can work against HIV specific policy recommendations such as focused national programs, and a multi-sectoral focus.

Country "Donorship"

In general, non-government respondents are very appreciative of PEPFAR's role in promoting an epidemiology led strategy, KPs, policy engagement, and encouraging country driven programs, but skeptical that these priorities will continue if left entirely up to national leadership without serious strengthening of civil society networks. In most of the countries, civil society partners articulate an inherent mistrust of public sector stewardship and transparency, and skepticism that national programs and health ministries will implement evidence-based, KP focused programs without continued donor presence, and cite strong political forces against these programs that puts them at risk.

USG Coordination

There is a perception of poor coordination and sharing of information across the USG agencies and with their partners. This is in part due to the natural differences between the agencies and

[3] For confidentiality purposes, no specific data on the key informants will be provided, except from the sector they come from.

[4] The evaluation SOW questions use Most At Risk Populations (MARPs) but for consistency in this report Key Populations (KPs) has been substituted for MARPs.

the networks they work in. For example, DOD works within national military systems, the Peace Corps at community levels, and CDC and USAID focus on a mix of NGOs and public sector health institutions. National stakeholders feel that there are missed opportunities to share strategies and tools beyond the immediate beneficiaries or USG reporting channels. There is also a perceived imbalance among country level USG focal points, with significant differences in coordination and program quality seen across the region. Coordination between USG implementing partners varies widely by country and is proportionate to leadership from PEPFAR coordination. In countries where there is an explicit expectation of unified country team coordination like in Nicaragua and Belize USG programs showed exemplary collaboration levels, while opportunities are lost in other countries.

In addition, donor representatives in different countries have requested that USG share their information more with the other donors and the international community. They also request more overall coordination with the USG, via more joint concerted actions and more openness to a regular exchange of technical information. This call has been made in at least Belize, Guatemala, Honduras and Nicaragua.

PREVENTION FINDINGS

- *To what extent has prevention with KPs been adopted as a national priority in each country?*
- *How much money has been invested in prevention with KPs and what percentage is that of the overall HIV/AIDS budget in each country? What is the source of this financing in each country?*
- *How are evidence-based models and theories being used in each country for improving programs targeted at KPs?*
- *Are there formal policy statements reflecting government interest and prioritization of working with KPs, and are they implemented effectively?*

Prevention With Key Populations as National Priority

Prevention is a key component of the regional and the national responses to the HIV epidemic and is prominently placed in every policy document and strategic plan. As the region faces a concentrated epidemic, stakeholders are relatively aware of the importance of prevention and the need for KP focused interventions.

While the national policy of every country except for Belize[5] includes specific language focusing on prevention programs for key populations, significant differences still exist among countries, in regard to the commitment to implementing these programs and to understanding the barriers that KPs experience in accessing such prevention services as VCT and STI diagnosis and treatment. While the USG, especially CDC, has made significant investments to expand coverage to these services in the public system, key population respondents cite ongoing stigma related barriers as concerns, which reduce use and access to these services. In addition, the regional trend of health system integration is seen as another potential barrier for key populations and access as this reform often means incorporating these kinds of services into general population facilities.

Prevention programs for KPs are present in all seven countries, but they are less likely to be publicly funded and are more dependent on outside financial support, including from PEPFAR. Prevention activities also tend to be carried out primarily by NGOs or KPs organizations, and

[5] Belize has a policy that only speaks in general terms of "vulnerable populations" without specifying which ones they are and has specific legislation forbidding the kind of sexual behaviors that define some KPs. www.pasca.org

therefore tend to be smaller scale with little expectation of going to scale nationally. They are also highly dependent on voluntary work done by KPs themselves to carry out the prevention activities. All these situations need to be factored in when considering the extent to which prevention with KPs is a true priority in the region as a whole and in each country.

Country Contexts of Stigma and Discrimination

While Guatemala and Honduras are predominantly conservative societies, their official policy statements include KPs among their priorities for prevention activities.[6] Belize appears to be the most challenging country in the region, where stigma and discrimination towards KPs, specifically MSM, are legally institutionalized. In contrast, El Salvador, Nicaragua and Costa Rica seem to have made greater strides in society to reduce the effect of stigma and discrimination towards KPs, with specific language within the public health system protocols and laws forbidding discrimination towards clients and patients.[7] Panama also has policies with a focus on KPs but stakeholders still describe a context of stigma and discrimination as barriers to implementing those policies.

While the identification of key populations as priority in key national policy and strategy documents can be considered a positive first step, the reality of pervasive stigma and discrimination was reported at all levels in the public sector. For example in Honduras, it was fairly common to hear key informants, particularly in the public sector, referring to KPs as "those people". Section 53 of Belize Criminal Code and Section 5.1 of the Immigration Act represent specific criminalization of "unnatural acts" and restrictions on the immigration of homosexuals. Key informants from a Belizean CSO explained that there is a faith based organization actively engaged in promoting the status quo against sexual diversity, and this message is perceived to be reinforced by many health service providers, health system managers and politicians.

Specific instances of institutional bias against specific key population activities were cited, painting a pattern of passive resistance and obstruction of programs for the "undeserving" or "guilty" people (most often referring to sex workers, MSM and transgender groups). It was reported that it is more difficult for KP organizations and CSOs working with these populations to implement and expand their interventions. An organization working with SWs on HIV prevention activities in Honduras was denied the use of a public theater by the local authorities of the Secretary for Cultural Affairs. Interestingly, it was the local Catholic Church who lent them a locale to carry out their HIV awareness and educational activities.

In Nicaragua, the more authoritative management model of public services creates a barrier for greater involvement of KPs organizations in prevention programs. According to CSO and KP organizations, citizens' participation in public policy is strongly linked to a specific government sponsored structure: *Los Consejos del Poder del Pueblo* (Power of the People Councils). KP NGOs not linked to these Councils have little opportunity to participate in HIV decision-making mechanisms. On the other hand, a representative of an international organization in Nicaragua stated "*certainly, there is an authoritative structure in the Ministry of Health, and peoples´ participation has a strong relation to politics. Nevertheless, the system seems to be better structured and more open than ever to provide services to the KPs*".

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[6] In Guatemala they are referred as "Vulnerable populations" p.24-25 National Policy for HIV/AIDS (2005). In Honduras, the "Estrategia para el abordaje integral de la epidemia del VIH/sida" makes specific reference to vulnerable populations (p.27).

[7] El Salvador, Decreto número 56-2010.

Promising Practice: Public Funding Mechanism for KP Prevention in Honduras

In Honduras notable progress is being made to institutionalize some funding of prevention activities with the grant mechanism launched within the Secretary of Health in Honduras with USAID support. The mechanism administrates donations to NGOs through separate technical and financial units.

There is a general sense among stakeholders that prevention activities for KPs will always require external support both in financial and political terms, with international donor presence seen as key to maintaining programmatic focus on KPs. Even with the promising practice in Honduras of a public funding mechanism for KP prevention, some CSOs and KPs expressed doubt there is genuine commitment from the government to provide direct national budget support for these activities once USAID and other donor support tapers off.

Prevention Funding in Central America

The latest USAID PASCA supported MEGAS (Medición del Gasto en SIDA, or National AIDS Spending Assessment[8]) study conducted for the region dates from 2010[9], which coincides with the beginning of the current Partnership Framework. In 2010, a total of US$214.6 million was spent on the HIV epidemic in the region and HIV expenditure equals 1.8% of total annual health spending in the region. The breakdown of the regional HIV funding is as follows: 63% from public resources, 10% from private resources and the remaining 27% from external funding sources (half from the Global Fund). Overall, 38% of the total combined spending in the region went towards prevention.

PEPFAR contribution to the region has varied between $25.7 and 21.6 million with an average of around 30% going toward prevention:

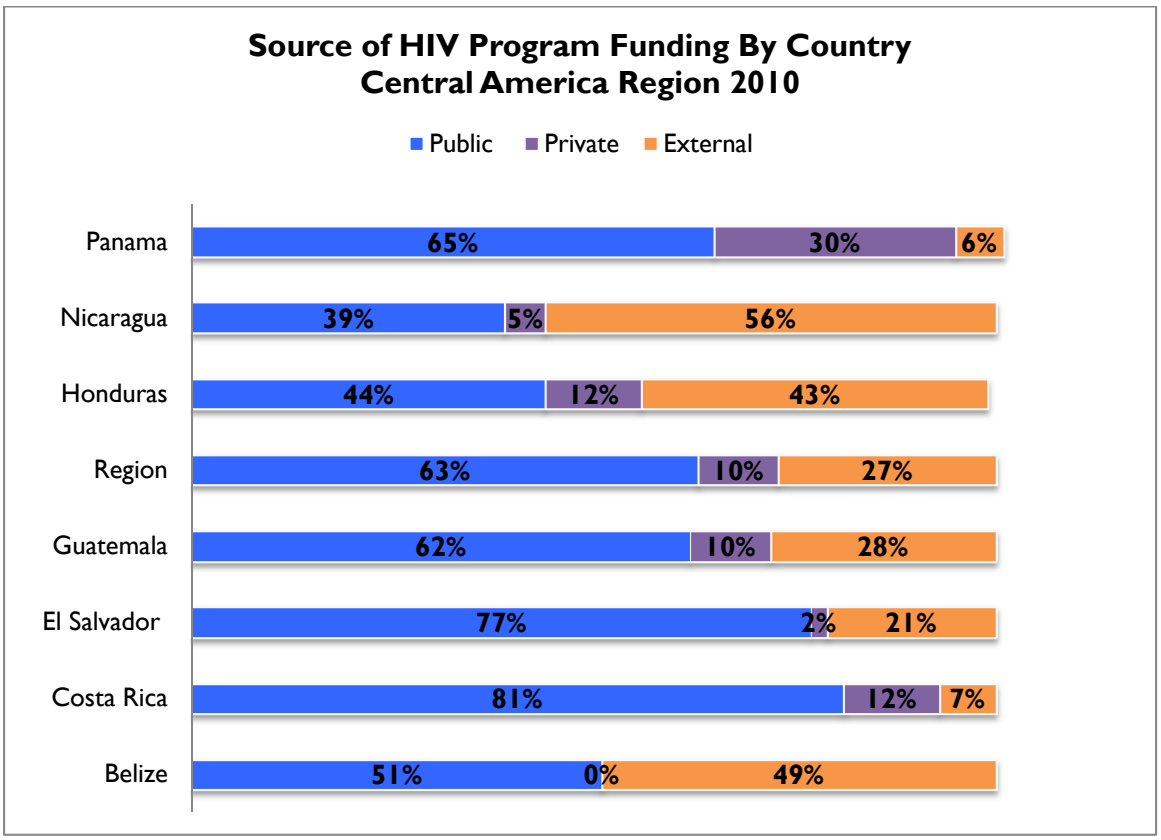
- 2009: **$25,759,000** ***($8,043,642 for Prevention)***
- 2010: **$23,614,000** ***($8,271,633 for Prevention)***
- 2011: **$23,614,000** ***($6,659,071 for Prevention)***
- 2012: **$21,614,000** ***($5,738,848 for Prevention)***
- 2013: **$21,614,000** ***($6,138,996 for Prevention)***

Nicaragua has the highest percentage of its HIV programs funded by external sources at 56%, followed by Belize (49%) and Honduras (43%). El Salvador (18%), Costa Rica (7%) and Panamá (6%) have external funding rates well below the regional average.

[8] While the acronym in English is NASA, the Spanish acronym MEGAS is primarily used and recognized throughout the region so is used throughout this document.

[9] An accurate and up to date measurement of funding is expected from the 2012 MEGAS study, but was not available yet for review during the fieldwork of this evaluation.

Table 4. Source of HIV Funding By Country



Source: USAID/PASCA

A total of 46.6% of external or international funding went toward prevention and 28.5% of public funding was dedicated to prevention. The percentage of resources allocated to changing the environment, social protection, and research does not add up to 5% of total resources for HIV in the region.

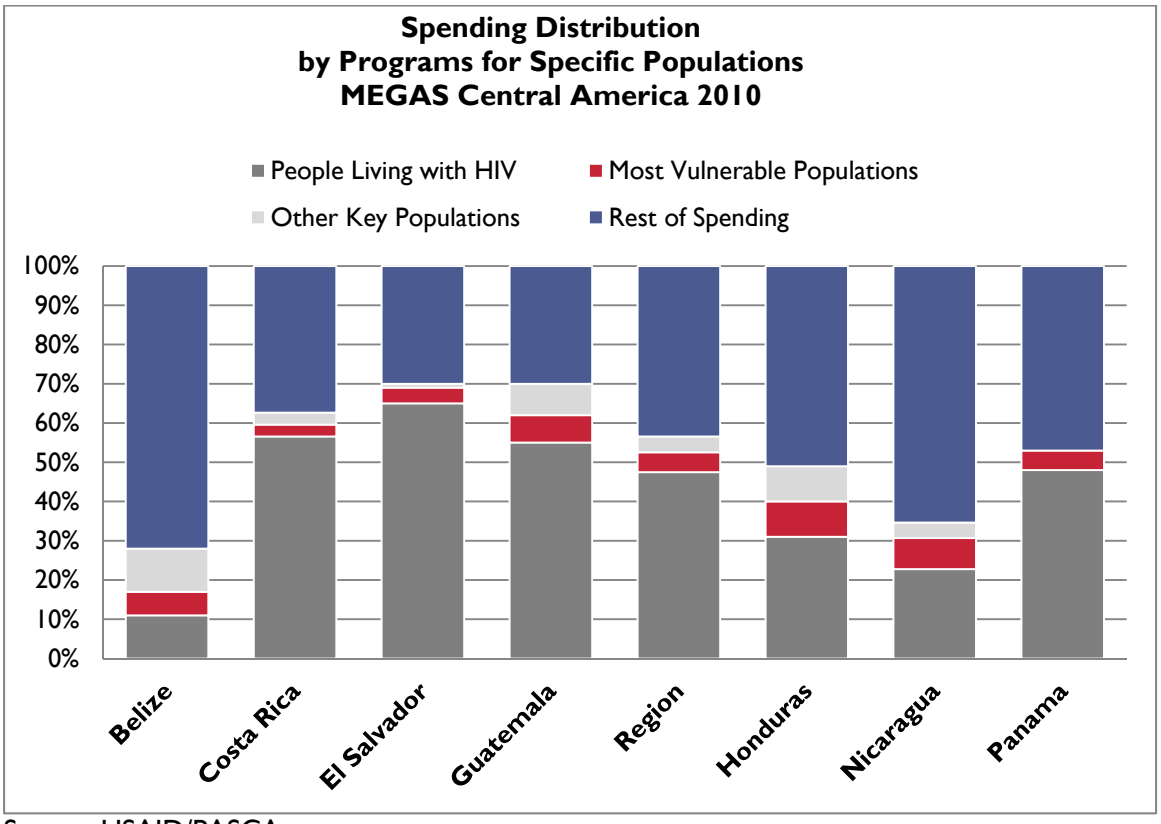
Table 5: Regional Breakdown of HIV Spending by Cost Category and Funding Source

Cost Category	International	Private	Public	Total
OVCs	0.96%	1.10%	0.11%	0.44%
Research	1.97%	0.05%	0.03%	0.62%
Protection and Social Services	2.49%	0.21%	0.10%	0.82%
Favorable Environment	2.93%	0.49%	0.74%	1.37%
Capacity Building	5.94%	1.05%	2.28%	3.28%
Care and Treatment	16.68%	10.69%	65.61%	46.82%
Program Management	22.43%	2.97%	2.61%	8.56%
Prevention	46.60%	83.43%	28.51%	38.09%

Source: PEPFAR supported MEGAS (NASA) study (2010) ppt.

The breakdown by general cost category shows 28.5% of public spending going towards prevention. Analyzing a breakdown of spending by population, 5% of total HIV resources in the region were 2010 were spent on programs for KPs per the last set of MEGAS (most vulnerable populations in Table 6).

Table 6. Spending Distributions by Specific Populations and by Country



Source: USAID/PASCA

Prevention Funding by Country from 2010 MEGAS

While the breakdown of prevention funding for KPs by source is not available for all countries, the 2010 MEGAS data does reveal a trend in each country of apparently limited overall funding for prevention with key populations and where the information is available, external resources are financing the majority of these programs. It is important to note that expenditures for KP prevention might be present in other MEGAS categories, such as condoms, but the following is limited to the MEGAS categories specifically defined as prevention for KPs (or SWs & MSM).

Table 7. Total Prevention Funding By Source

	Public	Private	External	Prevention Percentage of Total HIV Budget
Belize	70.9%	0%	29.1%	45.6%
Costa Rica	59.8%	30.2%	10.1%	37.0%
El Salvador	61.3%	3.6%	35.1%	30.3%
Guatemala	37.8%	24.9%	37.3%	36.2%
Honduras	35.2%	18.5%	46.4%	51.5%
Nicaragua	43.7%	5.7%	50.6%	38.2%
Panama	35.7%	58.4%	5.9%	49.2%

Source: USAID PASCA

Belize

For Belize, prevention represented 45.6% of the total budget. The majority of the prevention budget was financed with public funding (71%), and the programs covered include prevention of vertical transmission. Prevention programs for MSM, SW and other vulnerable populations were financed in their entirety by external funding.

Costa Rica

Overall prevention accounted for 37% of the Costa Rican HIV budget with 10% of the financing from external sources. With limited donor funding overall, Costa Rica provides an exception to external financing for prevention with KPs as the majority of their programs are financed with public funds. Prevention specifically geared towards KPs appears to represent 7.4% of the total prevention budget with 2.5% going to KP risk reduction, 4.7% towards SW and their clients, and 0.1% going to MSM.

El Salvador

In El Salvador prevention represented 30.3% of total expenditure, the lowest of the region, yet a relatively large percentage of 61% was financed with public resources. The majority of that amount goes to prevention for those living with HIV and prevention of vertical transmission. Public funds cover 1.3% of prevention for MSM and 0.0% of prevention for sex workers and their clients, with the majority of these prevention activities being covered by external funds.

Guatemala

For Guatemala the 2010 MEGAS shows that prevention expenditures were 36% of the total, which is an increase from 25% in 2008. Public funds accounted for 37.8% of the total prevention budget. Fourteen percent of the prevention budget was directed toward programs for the key populations. While 82% of the prevention funding for MSM was external, 63.5% of financing for prevention for SW came from the public sector, which is an outlier in the region.

Honduras

At 51.5% Honduras has the highest overall percentage going to prevention in the region, and public funds account for around 35% of the total funding for prevention. Prevention for vulnerable populations was mostly covered by external funding and 100% of prevention programs for SW and MSM as categorized in MEGAS are funded by external sources, which include Global Fund, the USG and others.
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Nicaragua

In Nicaragua, data for 2010 show that 38.2% of the overall HIV budget was destined for prevention and 43.7% of funding for prevention was public, which is relatively high as 39% of the total HIV budget was covered by public funding. When it comes to prevention programs for key populations, 100% of prevention for SW and MSM is covered by external sources per the MEGAS categories.

Panama

At 49.2%, almost half of Panama's HIV budget was geared toward prevention, and 35.7% of the prevention expenditure was public funding. Prevention for key populations was relatively low with prevention for SW making up 1.34% of the total budget and prevention for MSM represented 0.02% of the total HIV expenditure. It was noted that the expenditure for key

populations had increased from previous years. In total 2.7% of the prevention budget went to these key populations.

The MEGAS data allowed the mid-term evaluation team to understand the status of financing and spending in HIV in the region and by country. The interviews focused on the challenges faced by the countries to sustain and expand their prevention activities. Contrasting the MEGAS data with information gathered in the field interviews produced the following reflections:

Almost half of the prevention expenditures are subsidized either by the external funding or private out-of-pocket expenditures, mainly through purchasing condoms. The data available from some countries shows that the total expenditure for prevention for key populations from any source is extremely small and does not correspond to the epidemiology or the plans and policy that identify key populations as priority. With support from donors the private sector has shown a willingness to support positive HIV workplace policy development for employees, but there is a general sense that it is unlikely that the private sector will scale up HIV-focused activities under its own momentum, given the many other competing priorities it faces and it is unclear to some stakeholders how these programs can help target key populations.

Very few resources are being allocated to critical support functions for sustainability, such as promoting a favorable environment, research and human resources development. On average, these functions receive less than 2% of all resources allocated to HIV and they come mainly from international sources.

Use of Evidence Based Models for Prevention with Key Populations

There was not much discussion from stakeholders on the specific prevention models being used for key populations. In general, the USG was seen as providing science-driven models for all their interventions including for prevention with key populations.

While not discussed at length, DOD efforts within national military systems have had promising impact, and in many cases are stronger programs with full policy implementation and positive developments on discrimination issues than the public health counterparts, due to the smaller scale and more controlled environments.

Peace Corps (PC) prevention activities are limited to the range of their volunteers in their sites, but they appear to be well received. They are limited because of the scale of operation of PC in these countries and the fact that they work mainly in rural area. PC's role in HIV prevention activities should be better defined.

Key Populations as Policy Imperative

Each of the seven Central American countries has established a formal HIV Policy, as well as Strategic and M&E Plans and as previously noted, key populations are highlighted as priorities in these documents except for Belize. In most countries except Belize, there is also specific legislation that backs up and mandates the Governments´ response and funding to fight the epidemic. Some countries, like Nicaragua, Honduras, Guatemala and El Salvador, are at different stages of developing specific legislation against stigma and discrimination based on sexual orientation and gender identity. With the law outlawing homosexual behavior, Belize is in a different situation, but local network leaders in Belize acknowledge that PEPFAR is the only program working actively on the human rights front in terms of some of the key populations, and they point to the need for more network strengthening.

Prevention & Country Ownership

Interwoven throughout the stakeholders' feedback on prevention were references to the crosscutting country ownership and sustainability elements. As key population prevention receives relatively lower amounts of funding and is funded primarily by donors, social networks are concerned about long-term financial commitments to prevention efforts without continued pressure and support from the USG and other donors. Civil society stakeholders do not trust their governments to follow through on National Strategy commitments to KP activities without donor pressure.

Past USG efforts to strengthen social networks have been applauded, but there is concern that networks have been weakened in the prevailing political environment. Many national programs openly resist the focus on KPs (Honduras, Belize, Guatemala, Panama) amid strong sociocultural and religious sentiments ("those people deserve what happens"). There is concern that past mass media efforts have not been maintained, especially those focused on stigma and discrimination issues. The recent controversy over the Global Fund supported HIVOS campaign on stigma issues in Guatemala underscores this challenge, with church based groups immediately calling for its removal, and isolated vandalism occurring on sidewalk banners and posters focused on transgender persons.

HEALTH SYSTEM STRENGTHENING FINDINGS

- *To what extent do the USG supported and promoted models and systems (prevention, care, epidemiological surveillance, monitoring & evaluation, policy development and implementation, health system strengthening, etc. in the region have the capacity to be sustainable (technically and financially)?*
- *Are the models and systems promoted by the USG appropriate to the region's epidemic?*
- *How much personnel capacity has been created in countries to provide for the HIV response and is it being utilized strategically?*

In the Partnership Framework, the key HSS areas addressed include: improving human resource capacity among health care providers, especially those working with members of key and vulnerable populations and people living with HIV (PLHIV); developing effective information systems for monitoring community-based care; and improving supply chain management.

Sustainable Models and Systems

Based on stakeholder feedback, it appears quite likely that the systems and models developed under PEPFAR will stay in use in the Central American countries well after PEPFAR ends. Technical personnel, in governments and CSOs alike, find PEPFAR interventions useful and necessary to providing an appropriate response to the epidemic. While most of these programs were in place before the PF started, key informants report that PEPFAR support has built capacity to make better use of existing programs and structures. Some of the key informants explained this in the different countries:

"In Nicaragua, there is a systems approach to sustainable change. PEPFAR funds only have been there for two years[10], but the work dates from much earlier. Models have been developed in an integrated manner in Nicaragua. The work was carried out initially with the public sector, but now includes other strategic actors: universities, private companies, NGOs. We are using the experience with contraceptives and applying it to other processes. Ownership is reflected in policies, plans and programs and the commodity security plan."[11]

"In Honduras, the Global Fund had created an entire parallel model of service delivery to that existent at the Ministry of Health. Therefore, PEPFAR has supported the creation of a model that integrates HIV care into the national effort."

Strength of Existing Systems as Key Success Factor

In Panama, the national HIV program has been working closely with the USG to strengthen surveillance. More recently the USG has supported other system strengthening progress in Panama such as improved access to medication; availability of viral load tests; improved quality of HIV epidemic estimates; and improvement in the Ministry of Health's (MOH) supply chain management. PEPFAR has also supported activities to diminish stigma and discrimination in the anti-retroviral treatment (ART) clinics.[12]

In Costa Rica, the Ministry of Health acts as a normative and monitoring body, while the Social Security Program provides all public health services and both entities have extremely high technical capacity. In this case where the health system has worked relatively well in the past, PEPFAR's strategic interventions have helped the Ministry of Health to articulate and optimize resources, to provide access to better information, and to identify opportunities and develop plans according to the country's needs.[13]

In Guatemala, structural weaknesses in the public health system do not allow them to take full advantage of PEPFAR's contributions in the various technical areas. The complicated and fragmented institutional structure especially at the central level, the lack of a reliable information system to support monitoring and evaluation and epidemiological surveillance, and the lack of interest in HIV manifested by current MOH authorities, may seriously damage the advancements made in earlier years.[14]

The Nicaraguan health system looks far more structured and robust than the health systems of any of the four countries visited, and, together with El Salvador and Costa Rica, seems to have solid political and technical implementation of the HIV Program, including the work of all stakeholders. This contributes to their ability to take maximum advantage of the support and technical assistance provided by PEPFAR.

However, Nicaragua faces major financial challenges to keep its HIV programs functioning once international funding is not available. In addition, the current prohibition on all USG agencies and their implementing partners on providing any financial or technical assistance to the Nicaraguan government due to a USG denial to grant Nicaragua a transparency waiver is seriously affecting the technical work previously carried out with the public health sector.

[10] PEPFAR funding has been supporting programs in Nicaragua for more than two years but the informant could be referring to a specific organization that has received PEPFAR or simply may not have been aware of when PEPFAR funding initiated.
[11] Memory aid from meeting with implementers.
[12]Memory aid from Panama HIV Program.
[13]Interview memory aid with HIV
[14]Interviews with CSO and PEPFAR implementers

Strengthening Supply Chains

PEPFAR´s support for improving supply chain management systems is widely recognized across the region. This technical assistance plays a key role in strengthening the capacities of countries' health systems to prevent and deter corruption in this area of public investment. In Nicaragua and Honduras, this support has enabled the countries to comply with GF grant conditions before they could be eligible to receive funding. The quality of storage systems, warehouse conditions, management of inventory, establishment and use of information systems to keep control of stocks and reduce stock out periods, have been strengthened and have already benefitted the CA countries. New challenges have arisen recently in Honduras with the supply system decentralized to the health regions, resulting in procurement systems fragmented to lower levels of government with the goal of being more responsive, but with the central controls and priorities tending to become less consistently applied. Serological laboratories have been supported by PEPFAR as well, with emerging resource challenges in Nicaragua, Honduras, Panamá, Belize and El Salvador as they attempt to assume responsibility for procuring reagents and tests for follow up with the HIV positive population, and additional support has been requested with laboratory supplies.

Challenges of Key Populations and Health System Integration

With the trend towards reform and integration of health services in countries such as Belize and Honduras, stakeholders report fears that HIV programs for KPs could disappear or become diluted within the overall services provided by the health system. KPs are concerned that this situation may discourage them from using these services because of stigma and discrimination either by other health service clients, or from health providers themselves, who may not be trained and willing to care for KPs in the same way that already-trained professional providers can.

"In Belize, the trend towards incorporating HIV care into general services is worrying. The system is weak to provide care for patients. There is only one dedicated doctor for the HIV patients in the country. Stigma and discrimination in the medical system is very high because there is lack of confidentiality, quality and trust. Patients´ results are gossiped to the relatives before the patients even know them. No action is taken when a health care provider commits an abuse. There are documented cases of lack of confidentiality. There have been times when the lists of HIV positive people, with the personal data of patients, are hung in the social networks.

If the Donors went away, civil society would not have support, and then the MOH will not do anything [for KPS]. So far, the National Aids Program is one of the few programs that have a costing system. With the merging, it will be even harder to monitor costs and budgets. The MOH is making an argument: [that] HIV is the people's own fault. ARV is the single most important public investment in HIV, but there are a lot of people dying."[15]

In Honduras, the Centros de Atención Integral (CAI/Centers for Comprehensive Care) were a strategy to provide comprehensive care centers specifically targeting KPS. Their technical quality is high, but they have existed at a distance from the rest of the health system. The new model will integrate HIV services into the general health system and every individual will be offered an integrated package of services according to his or her position in the life cycle.[16] Honduran stakeholders acknowledge that a strengthening effort has been conducted so far to improve quality of care for KPs, but some CSOs and KPs have some concerns about possibly losing more

[15]Memory aid interview with CSO and implementers.
[16]Memory aid interview with those in charge of reform process.

than they will gain from this process, as it implies moving away from dedicated HIV services which are generally more client friendly and culturally competent, and runs the risk of decreasing accessibility and use of services by the most stigmatized people (especially MSM, SWs and transgender groups) who are not likely to feel safe or comfortable in waiting rooms with the general population. As in Belize, the KP NGO community has a general mistrust and feels the government will not continue support for KP-focused programs if there were no donor pressure to ensure that happens and there is a broad appreciation for PEPFAR presence through its implementing partners.[17]

Despite the potential challenges, survey showed that most Central American stakeholders feel that HIV services have been strengthened to deliver health care for the KPs. However, the pattern of that improvement differs widely among countries. In Belize, 30% of respondents knew about service delivery strengthening activities, whereas in El Salvador, more than 80% of respondents were aware of what is being done, especially in relation to services for men who have sex with other men. Half of the Guatemalan and Costa Rican stakeholders knew about the health system strengthening efforts for working with KPs.

Epidemic Appropriate Models & Systems

The models and systems promoted are appropriate if the epidemic is seen primarily as a public health problem. However, it is evident other factors and structures operating beyond the health systems prevent technical efforts from being as effective as possible and from becoming fully institutionalized. These other factors include: countries´ governance structures, the specifics of the health system´s governance structures, the role played by faith based institutions in molding public policy, stigma and discrimination and other social attitudes and poverty and inequality that make key populations more vulnerable and means they are not treated as equal citizens in their societies.

For example, in Nicaragua, and Honduras (San Pedro Sula), transgender women and CSW explained very clearly that they have no other economic option than working in commercial sex. Frequently, because of stigma and discrimination they do not have the qualifications to pursue other types of economic opportunities. Often, once their sexual orientation or gender identity was disclosed, they were either expelled from school or dismissed from their jobs. With increasing frequency, they are forced by their "padrote" (pimp) or by gang members to sell drugs, while also catering to clients or having to pay gangs for "protection" in order to be able to work. They do not trust the police to support and protect them. Rather, they see them as another aggressor from whom they have to protect themselves. In their circumstances, they feel the state is part of the problem, not part of the solution.

Creation of Strategic Personnel Capacity

According to the key stakeholders, PEPFAR is undoubtedly contributing to creating and expanding personnel capacities to respond to the region's HIV epidemic. However, the institutional problems inside the CA health systems do not encourage trained personnel to remain in the system. Some critical issues include:

- Turnover and stability in the civil service are key challenges, with particularly high attrition rates found in public sector programs. Trained personnel are highly susceptible to dismissal or substitution for political reasons, or quickly find that their new skills are more lucratively compensated outside the public sector. Even during one term of a

[17]Memory aids from meetings held with CSO & KPs in San Pedro Sula, Honduras.

specific government, personnel rotate from one position to another, often without proper training for their new jobs, and this turnover is a major obstacle to sustaining the capacity building process.

- The lack of regulations or a career ladder in the public sector that provides enough attractive incentives for staff to develop professionally, get promoted, etc., is an additional obstacle.

- In general terms, each CA country lacks enough highly trained professionals to deal effectively with the epidemic. The most extreme case is Belize, where there is no medical school with a full training curriculum; so all doctors must be trained abroad. There is only one doctor in Belize City who is both willing and certified to provide ART services.

- Ironically, while doctors, nurses, laboratory technicians, and other skilled health personnel are scarce to begin with, they also have huge incentives to migrate to other countries since the health system does not have the capacity to recruit them once they are trained.

- Health personnel, particularly at the community level, are expected to carry out all health program activities and interventions appropriate to the level of health care in which they work. In turn, they end up managing a dozen or more programs at the same time, with little support or resources. This situation affects quality of care. In addition, training opportunities are usually only for short term training rather than more formal and long-term capacity building processes.

Although training to manage the epidemic appropriately and HIV protocols may be provided, training on behavioral change and managing staff´s own prejudices, is not often provided. Health staff´s own attitudes, beliefs and misconceptions towards KPs often are the first obstacle to access and quality of service provision.

Promising Practice: Creating Human Resource Capacity at Universities in Nicaragua

In Nicaragua USG implementing partners and universities are working together to introduce a more comprehensive approach to the HIV epidemic in their curriculum at medical, pharmacology and nursing schools. This is an outstanding way of creating long-term personnel capacity in the country, since those curriculum changes will continue at least for the coming five years and will positively impact each student trained in those schools. Even though they are not yet focusing on KPs, this is a promising model for ensuring that capacity is created in a sustainable way in Nicaragua.

HSS & Country Ownership

As noted, while the overall impression is that PEPFAR supported models are and will be sustainable, building long term institutional and human resource capacity can be challenging. Despite credible capacity building efforts from all donors, the institutional context for human resources is not conducive to sustainable programs because of attrition, lack of incentives, and poor career opportunities. Ongoing training efforts do not keep up with turnover and market

pressures for public sector personnel, where retention of qualified personnel is a major challenge, along with unstable workplace conditions.

The high levels of public financing of commodities, such as ARV medicines, would seem to be a positive trend towards country ownership. While the region as a whole appears to have made progress in procurement reform, it is countered by skepticism about the transparency of public sector procurement practices especially in Honduras and Guatemala that are driven by the large profit margins and by conflicts of interest around profits that are at play in the global, regional and national pharmaceutical markets.

Belize represents a particular case in this regard, since it has chosen to refuse Global Fund resources for ART, preferring to use exclusively national resources to purchase ARVs. Outside the Ministry of Health, there is a widely-held perception that low quality pharmaceuticals are procured for first-line ART regimes at high final cost, while no second- line drugs are procured because of higher costs and tighter procurement controls from non-generic manufacturers. The concern is that when donors are not involved directly with procurement, transparency issues become more acute without sufficient controls and monitoring, resulting in poor quality care for key populations and wasteful public expenditures.

STRATEGIC INFORMATION FINDINGS

- *To what extent has the strategic information supported by the USG been utilized for decision making to improve the response to the HIV epidemic in Central America?*
- *Does sufficient strategic information related to KPs exist to facilitate an appropriate response to their needs?*

According to PEPFAR, strategic information refers to strengthening surveillance, conducting special studies, improving capacity for collecting, analyzing, and using information for decision-making, and monitoring and evaluation.

SI for Effective Decision-Making

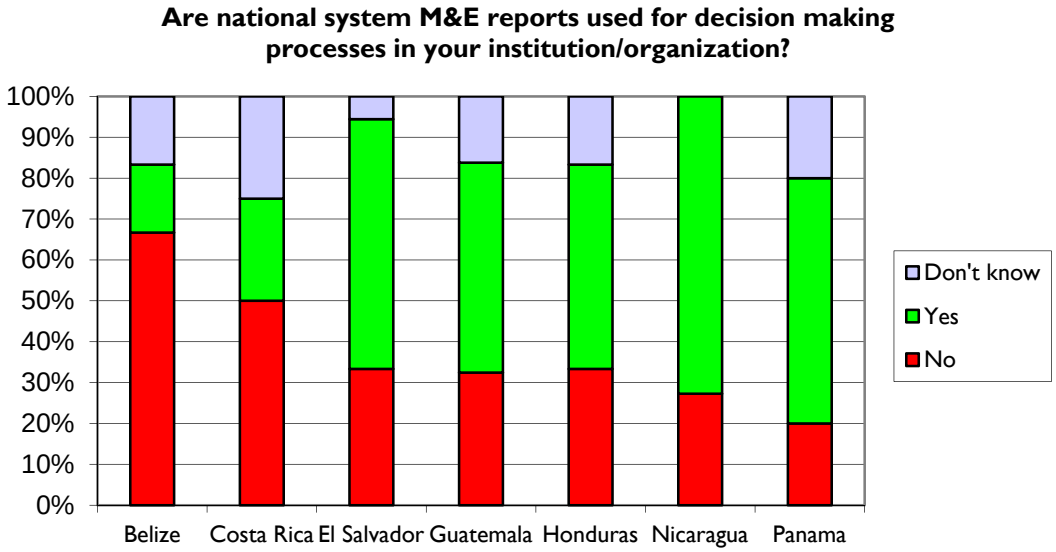
Studies supported by the USG are highly regarded by all stakeholders and considered a trustworthy source of information on the HIV epidemic. They are the main source of evidence used in official policy documents and project proposals, particularly those designed for the Global Fund. These studies and related SI activities include: CDC´s epidemiological data from the VICITS´s clinics; USAID/PASCA´s model for developing policy documents and MEGAS; Monitoring and Evaluation courses; key population KAP (Knowledge, Attitude and Practices) studies, and Behavioral Surveillance Survey –BSS. All these acronyms are familiar to most stakeholders and the studies are used to identify the status of the epidemic, the risk patterns associated with it, identifying at-risk populations and other information that is considered essential to policy formulation and follow-up. Without these studies, it would be extremely difficult to ascertain the state of the epidemic in the region, define priorities and identify key interventions.

Although local institutions, such as MOH, universities, NGOs, and individuals are always involved in implementing these studies, there has not been sufficient institutional and financial capacity to conduct these high-quality studies on their own. Moreover, there is a strong contrast between the quality of these studies and that of regular national information and statistical systems. At present special studies are often the main and sometimes the only source

of reliable information on the epidemic. According to the regional MEGAS 2010, HIV research receives relatively limited public (0.03%) or private funding (0.05%) in Central America. Therefore, the level of reliance on USG support for this essential research is very high.

In most CA countries, a significant number of respondents do not know that there is a functioning M&E system. Even those who know about them could not identify reporting outcomes, or the frequency of the reports, indicating low use of the data available.

Table 8. Survey Response to Question on Use of M&E Reports in Decision-Making



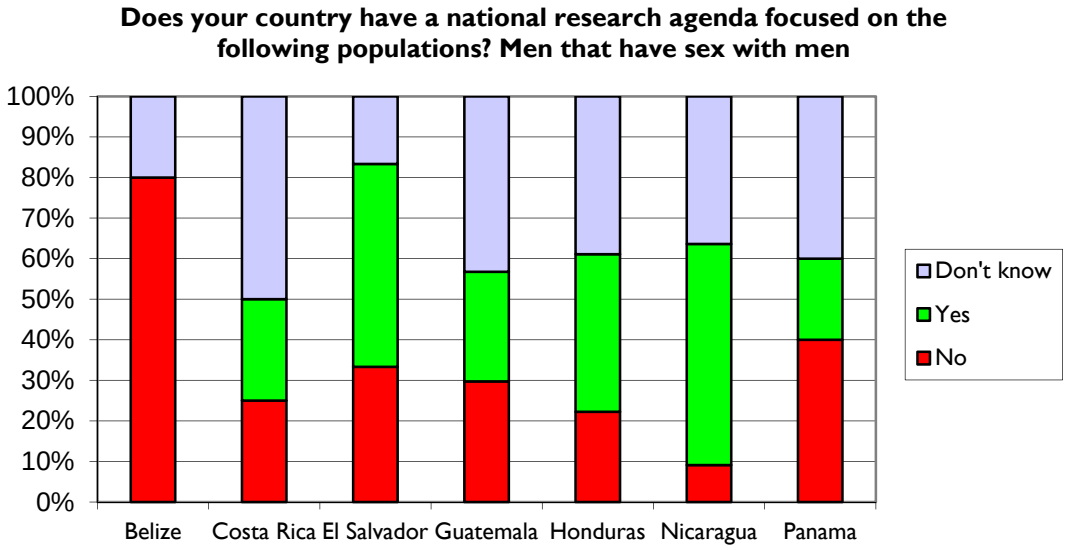
Often health information systems are not reliable, are fragmented, or do not connect with each other, amid different donor reporting requirements and frameworks. Data collected may have different levels of consistency and sometimes information does not come back to the health service facility at all, or in a timely manner to the community level. Most information feeding the information and epidemiological surveillance or community systems, does not necessarily come directly from the patient's medical records, but instead tends to be a sum of demographic and aggregated data.

SI for Key Populations

The needs of the KPs go well beyond traditional public health information and it is important to recognize the complex socio-economic and cultural environments and dynamics that lead them to be particularly vulnerable in the epidemic, due to stigma and discrimination and basic human rights infringements.

There are resource and capacity limitations to building a more robust research agenda at country level, as indicated by the response to the online survey question below which shows the narrow awareness of research on one of the key populations (MSM), which is borne out similarly for the other KPs. Interview respondents suggest that USG support focus on building local and national capacity to design and implement these studies, and on the need for improved coordination and sharing of existing research with implementers and stakeholders.

Table 9. Survey Response to Question on Research Agenda for MSM



SI & Country Ownership

Capacity and accountability are two of the sustainability elements that arose during consideration of strategic information. National capacity for quality epidemiological research and information systems, and their place in policy development, continue to be areas for sustained USG investment. There is significant concern among stakeholders about the access and reliability of official information regarding the HIV epidemic, and specific instances mentioned where distortions of national information have been used to justify politically expedient program decisions. Respondents articulated a mistrust of the data from their government and, there is a significant lack of awareness about national M&E systems. Continued fragmentation among donors around indicators and strategic information in general, continues to make it very difficult to strengthen National Health Information Systems. Concerns were expressed that USG sponsored monitoring and research serves USG needs, but is not sufficiently shared with national partners such as universities, MOH / national epidemiological units, routinely, and do not contribute to unifying national data systems.

POLICY ENVIRONMENT FINDINGS

- *To what extent has the USG supported the positive and productive engagement of different sectors in the HIV epidemic response? (civil society, faith-based organizations, governments, donors, private sector, media)*

The focus of PEPFAR's policy work is to support efforts to create an enabling policy environment for KP-focused activities and services, especially policies related to reducing stigma and discrimination. As part of a broader ecological prevention framework, this includes policy advocacy and promoting and coordinating multi-sectoral engagement in program development and implementation.

Combined efforts from major donors (UNAIDS, The Global Fund and USAID in particular) have been successful in moving the macro level HIV/AIDS policy agenda forward, and most CA countries now have in place the core set of "Three Ones" which is the creation of National HIV/AIDS plans, Monitoring and Evaluation Plans, and National Coordinating Authorities. Legal and policy frameworks have been built and provide basic sustainability to HIV/AIDS interventions.

Respondents from across the region are for the most part aware of National Strategic Plan (NSP) components, and can cite specific elements found in these documents. However, there is a broadly articulated concern that the country programs are not progressing beyond these plans into implementation, and the national budget commitments are slim outside of the larger procurement line items such as ART, and there is little progress in operationalizing the plans at the ground level.[18]

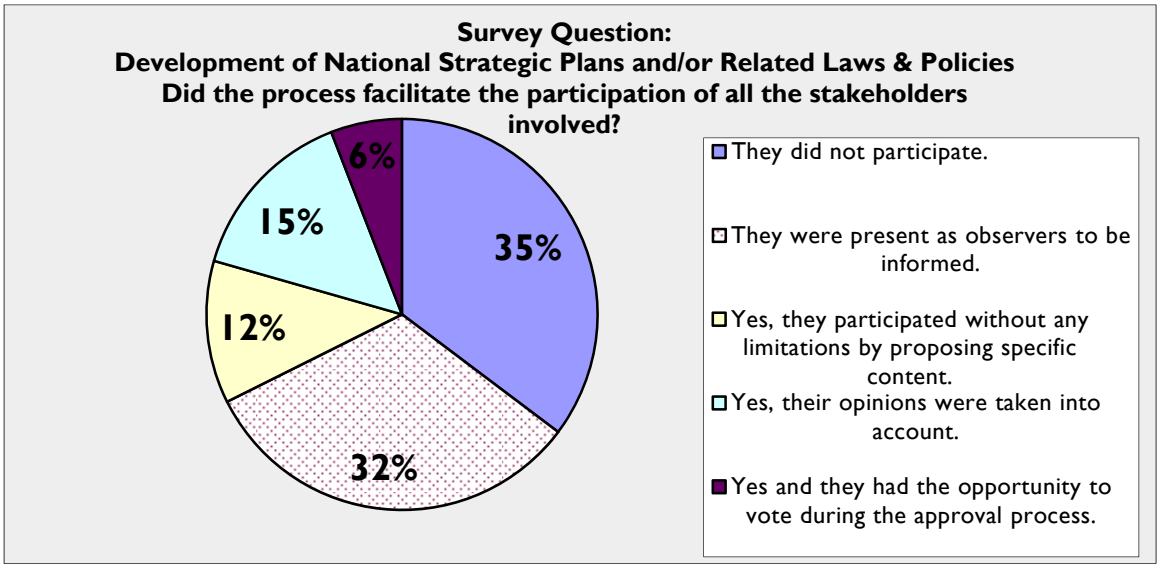
A potentially important role in this process has been the regional COMISCA structure that brings together the Health Ministers from across the region. However, based on the results of the online survey, few implementers seem to know of it (45%) or are aware of what it does (28%). Few implementing partners outside of Ministry of Health respondents were able to cite specific examples of COMISCA's contributions during country interviews, while those who knew of its work were quick to point out that HIV/AIDS is not a priority to the health ministers in the region despite its presence on the COMISCA meeting agendas, given the many other health priorities in a packed agenda. COMISCA has a vital role to play in becoming the regional Champion of HIV/AIDS interventions and maintain them as a visible priority at the Ministerial level throughout the region.

Quality & Productive Engagement of Key Populations

PEPFAR continues to play a key and sometimes solitary role in support of KPs, which is highly valued by civil society stakeholders, but concerns about sustainability without direct donor involvement are strong. The key populations cover a broad and diverse group, which includes MSM, CSW, transgender people, military personnel and less visibly engaged, the Garifuna populations. Prison populations have been identified as an underserved key population at risk, but have not been included in PEPFAR or other national program priorities in current programming.

[18]From interview notes of key respondents.

Table 10. Survey Response to Question on Participation in NSP Development



While all national programs have made provisions for at least token representation of key populations on their advisory structures, primarily National AIDS Councils (NACs) and Country Coordinating Mechanisms (CCMs) the degree and impact of their participation is low, as few of these leaders come prepared to play an effective role in the policy making and budgeting processes which are discussed. In addition, the more recent trend towards health services integration as part of a broader health sector reform process seems to be putting the stand-alone NAC structures at risk. In Guatemala, for example, the NAC has been considered inactive from inception; in Honduras, the real decision-maker is the Secretariat of Health (SOH), not the NAC (even to the point of substituting the NSP for an HIV- Strategy led by SOH); and in Belize, the NAC is at risk of either disappearing altogether or being placed as a department within the Ministry of Health. El Salvador and Nicaragua appear to have stronger NACs, but are still dominated by the public sector representatives who control budget and policy processes.

Apart from NACs, PEPFAR has contributed to CSO, including KP organizations´ involvement in the response, by supporting their capacity development, promoting their open participation and networking among similar organizations and working with their peers. A significant statement of PEPFAR´s importance to KP organizations was given by a transgender coalition in Nicaragua, who confirmed that the USG is the only donor directly supporting their efforts and activities in the country. In Honduras and Guatemala, several important donors have discontinued their activities, leaving a void for ongoing support to KP-focused efforts which only PEPFAR has continued to partially fill with its programs Stakeholder express concern that this pullout of several international donors is a trend which will make it difficult to find replacement funding for these programs as few alternative funding sources appear on the horizon.

Promising Practice: Guatemalan NGO Improves Public Service Delivery

PEPFAR has also supported promising alliances between civil society and public sector institutions to improve efficiency, access and quality of services. An NGO was organized by a group of HIV positive individuals who contribute to social security through the Guatemalan Social Security Institute (Instituto Guatemalteco de Seguridad Social -IGSS) and therefore, have rights to access prevention, treatment and care services. Initially, tensions and conflict were generated when members of the HIV+ organization brought charges of human rights violations against the IGSS, but the NGO leadership developed a better way to be effective by working closely with IGSS officials to address concerns about service delivery.

Now, after two years of working together, this NGO is in charge of providing daily supervision of the quality of services the IGSS offers to its members in the specialized HIV clinic. A representative of the NGO is permanently located on the premises and handles complaints from patients and helps ensure constructive communication between patients and the staff. According to these representatives, about 90% of complaints made by patients can be easily solved inside the clinic management structure, without requiring further intervention by higher ranking authorities. Every two months, the NGO meets formally with the clinic's staff and discusses problems that have occurred and they come to an agreement on how to overcome them in a more structured way. PEPFAR/GF resources are currently supporting this initiative, which deserves a closer look since it could be a very good model of positive and collaborative engagement between CSO and public institutions working towards the same end.

Engaging the Private Sector

PEPFAR has also promoted private sector engagement in HIV interventions, with promising workplace HIV policy and prevention pilot programs. The USG has strongly promoted private-sector involvement in the national HIV response, with the USAID Alianzas project actively developing innovative private sector HIV programs. In Guatemala, Alianzas is developing peer education and HIV workplace policy programs with the sugar and banana industries. In Nicaragua, the USG works with COSEP (The National Council of Private Enterprise) in piloting comprehensive HIV workplace policies in the tourism industry and free trade zones, reaching directly and indirectly 230,000 beneficiaries. Candid commentaries from stakeholders affirm the value of these programs, but respondents express concern about whether these industries will initiate and support these programs without donor involvement, considering how low a priority HIV continues to be compared to other demands on the industries in competitive environments.[19] Other initiatives such as Peace Corps partnering with the telecommunication giant Claro to provide HIV text messages free of charge is an example of opportunities to explore for expanding corporate social responsibility in the HIV/AIDS arena.

Finally, the engagement of non-health public sector entities continues to be a challenge, particularly in the face of the trend to integrate HIV/AIDS efforts within the Health Ministries. Key roles envisioned for Ministries of Education, Labor, and Justice could be strategic for improving the quality and impact of the response in the future, while other strategic Ministry level collaborations (such as Planning, Finance, Economic Growth) should be pursued so that they can play more explicit roles in the response especially considering country ownership.

[19]Ayudas de memoria private sector organizations and implementors.

Policy & Country Ownership

The political element of country ownership appeared especially relevant in the policy discussion as national programs are at risk in current political environments, such as noted by stakeholders in Guatemala and Belize, of losing the multi-sectoral focus that has taken 15 years to build. The political and social support contexts present challenges to meaningful participation of KPs. The token participation of KPs in Global Fund CCM's has been mentioned, while other efforts to mobilize participation have dwindled, and networks are weak without funding for advocacy efforts.

While all countries are close to having the "Three Ones" established, National HIV/AIDS Programs are in critical condition, except in Nicaragua and El Salvador. National policies have not translated into implementation and commitment, and national budgets in general are not capable of sustaining planned strategies. There continues to be a disconnect between the strong science that USG efforts have led to focus the national strategies with a concentration on KPs and the general population focuses of the Ministries of Health. NACs are at risk with reduced roles, and of losing their multi-sectoral mandate as they are integrated into some country health ministry structures.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

While there are many suggestions for new or expanded areas for PEPFAR investment implicit in the findings section, the core strategy with four technical areas holds up robustly across the region, with recommendations for new emphasis in response to emerging changes in the political environment and to progress in stages of development.

Overall Conclusions

- PEPFAR technical assistance is very well regarded for its high quality and interventions across the different areas contribute to the quality and sustainability of services focused on key populations, but the impact is limited by macro level factors beyond technical quality, such as transparency, social and political support, stability of public health employment, weak fiscal policies, and other elements currently beyond the scope of the CA Region PF. The PEPFAR framework is similar to a good solid tabletop, but without fixing the macro environment it runs the risk of being mounted on spindly folding table legs. The four table legs include: information systems, human resources, financial systems and institutions.

- You cannot sustain what you cannot finance in the four technical areas. If financial sustainability and political sustainability are not addressed, then programs and the advances they have made could be lost.

- PEPFAR has invested in social and technical sustainability for the most part and some in political and financial sustainability and accountability. Nothing has been invested in efficiency or at least it has not been identified as an essential component.

- Stigma & discrimination continue to be major challenges that limit technical level work across all the Partnership Framework areas.

- Coordination between USG implementing partners varies widely by country (proportionate to leadership from PEPFAR coordination. In countries where there is an explicit expectation of unified country team coordination, they show exemplary collaboration levels as in Nicaragua and Belize, while opportunities are lost in the other countries. There is an imbalance among country level USG focal points, with significant differences in coordination and program quality seen across the region.

Technical Area Conclusions: Prevention

- ***Societal and legal stigma & discrimination towards KPs present major barriers to effective HIV prevention in these populations.*** KPs are trapped in a cycle of poverty, abuse, lack of opportunities and violence that leaves them in a very vulnerable position to become infected by HIV. Health service providers, health system managers and health officials reinforce stigma and discrimination against KPs. One of the main barriers to access of prevention services is the adverse environment in which the KPs live and work. El Salvador and Nicaragua seem to have made greater strides in reducing the effect of stigma and discrimination towards KPs, with specific language within the public health system protocols and laws forbidding discrimination. Other Central American

countries have not yet passed antidiscrimination legislation and other regulations to protect the human rights of all KPs.

- ***The current thinking among key stakeholders is that prevention activities will always require external support both in financial and political terms, with international donor presence seen as key to maintaining programmatic focus on key populations.*** PEPFAR is the dominant or sole funder of some key population focused activities, especially in the area of prevention, despite many efforts to identify alternative long-term funding sources. The public sector in each country does not yet invest enough on prevention for key populations. While progress has been made to prioritize and institutionalize key population prevention elements in national strategic plans, there is concern that these activities would not be sustained were it not for PEPFAR and other donor pressure and their direct funding.

- ***Prevention activities tend to be carried out more by NGOs or KPs organizations, yet these tend to be more financially unstable and frequently underfunded, with high dependence on voluntary work done by KPs themselves to carry out the activities.*** It is difficult for KP organizations and CSOs working with KP to push for proper services for this vulnerable population group. NGOs in general are weak in all areas - technical, administrative, policy and financial skills. There are few alternatives to NGOs for funding, thus limiting their financial sustainability. CSOs tend to have a confrontational or conflictive relationship with public and private sector institutions, which prevents synergies for tackling the epidemic. In the long term civil society will continue to depend on outside funding, except in rare cases of public sector funding (e.g., Honduras' Ministry of Health funding mechanism).

Technical Area Conclusions: Health System Strengthening

- ***The models and systems promoted are appropriate if the epidemic is seen only as a public health problem. However, it is evident that there are other factors and structures operating beyond the health systems that prevent technical efforts from being better used and becoming fully institutionalized.*** While PEPFAR programs and models are technically highly relevant and also highly valued by national counterparts, they face serious contextual restrictions for maximizing their usefulness because of structural problems in health systems.

- ***Institutional context for human resources is not conducive to sustainable programs because of attrition, lack of incentives, and poor career opportunities and this continues to threaten progress in building and sustaining health services focused on key populations.***

- There is a need to continue strengthening the supply chain management system in countries such as Belize, Guatemala, Honduras and Nicaragua. New challenges have arisen recently with the decentralization of the supply system to the health regions. Central American countries have still limited financial capacity to acquire reagents and tests for follow up the HIV positive population. When there are shortages of tests or reagents in the general clinics, the first areas to experience cut-offs are facilities that care for KPs.

Technical Area Conclusions: Strategic Information

- ***To different degrees all countries still face structural challenges with their health information and epidemiological surveillance systems that do not allow appropriate follow up and surveillance of the HIV epidemic***, unless specific epidemiological studies are conducted with targeted populations. There is uneven quality between HIV specific studies and the national health information systems that they feed into, which should be taken into consideration in future donor supported efforts to strengthen SI systems across sectors. No country in the Central American region has developed sufficient institutional and financial capacity to conduct the high-quality studies on their own. PEPFAR has an opportunity to work directly with universities and research institutions to build capacity for research design, implementation and analysis, in tandem with its efforts to strengthen the use of data through its SI and policy activities especially for use in strategic planning.

- Targeted investments in building capacity to monitor and evaluate programs have produced important sources of data, strengthened specific strategic information systems within the health sector, but continued challenges in harmonizing and integrating information systems across donor and sector reporting platforms create barriers to access, analysis and use of strategic information for policy making. Promising models using open data architecture platforms have proven potential to increase access and use of timely strategic information, but require increased commitment to coordination across sectors and donor reporting requirements.

- Timely strategic information is hard to generate. Many countries lack data to help them understand the characteristics of KPs significantly. It is necessary to collect information and study the complex socio-economic and cultural environments and dynamics that lead them to be particularly vulnerable to the epidemic, to stigma and discrimination and to the denial of their basic human rights.

Technical Area Conclusions: Policy

- ***Overarching challenges of governance at the country level overshadow more focused technical assistance efforts by the USG, and must be taken into account in future HIV and health sector strategies***. Coordinated donor efforts to reinforce policy and implementation accountability are needed to improve confidence in current governance and procurement systems in order to safeguard progress made within the HIV programs. Despite donor efforts stigma and discrimination appear to be on the increase under new national political leaderships in most CA countries. Legal and policy frameworks have to be completed and prioritize elimination of stigma and discrimination.

- ***PEPFAR's investments in building social and political support for KP programs have contributed to capacity building and ultimately, sustainability, but might benefit from a renewed emphasis on strengthening the advocacy networks, and a new focus on preparing leaders from key populations to play a more effective role in decision-making bodies.*** Achievements in gaining high level KP representation are perceived as threatened by a low capacity of these representatives to engage effectively, as well as by the weaknesses of existing social networks that they represent. While most National Aids Committees and Country Coordination Mechanisms have at least one seat for KPs, the substantive participation is token at best in most countries, and dwarfed by the government dominant representation at the table. The legacy of

USAID support for social networks, advocacy and policy engagement is highly regarded, but seen as taking a back seat in recent years to data generation and service delivery.

- Broader health reform efforts including service integration and decentralization often work against HIV specific policy recommendations such as focused national programs, and a multi-sectoral focus. Tension exists between national programs and policy level aiming at staying focused on KP versus general and political pressures to address the general population.

RECOMMENDATIONS

The recommendations that follow are presented with a regional perspective, within which PEPFAR's regional strategy is seen as an efficient mechanism to provide high quality, cutting edge technical assistance to national partners. Specific recommendations include areas of improvement in existing program activities, as well as new areas for consideration as PEPFAR looks at the next generation of investments in the region, in coordination with other international and national partners. It should be noted that many recommendations also include cross-cutting elements as there is overlap between technical areas.

Prevention Recommendations

Move from Risk to Vulnerability

PEPFAR should consider placing a greater emphasis on a vulnerability approach in addition to the risk factor approach already in use to take into consideration the sociocultural, political and economic barriers faced by KPs. Facing these issues would require a stronger focus on the human rights and governance challenges, while complementing the more common BCC prevention activities. The challenge lies in opting out from a model that considers KPs mainly as "high risk" populations because of their sexual orientation or gender identity, to a model that understands that the social, economic, cultural and political environment prevents KPs from being treated as equal citizens in society, independent of their sexual orientation or gender identity. This means that the context in each country increases their vulnerability and not their sexual orientation or gender identity per se. Therefore, the strategies to be implemented should primarily cater to that reality.[20] No PEPFAR program or GF initiative strictly focuses on these determinants. The PF Policy component is related to these issues, but it does not go as far as is needed to make a difference in this reality.

PEPFAR resources should be reoriented during the next 3 years and directed towards changing the environment conditions that are more closely related to the way society stigmatizes and discriminates KPs and the way the socioeconomic environment does not allow them to move away from traditional stigmatized occupations.

PEPFAR should liaise with faith-based institutions to reduce stigma and discrimination and to minimize their potential negative influence that affect KPs. Priority countries for this effort should be Belize, Guatemala or Honduras, where faith-based organizations exercise significant of influence in both media and government circles.

[20] See for example, Estrada, John "Modelos de Prevención en la lucha contra el SIDA" in: Acta Bioethica 2006 (12) 1 p.91-100. Palen, John et al "PEPFAR, health system strengthening and promoting sustainability and country ownership" Journal of Acquired Immunodeficiency Syndrome 2012; 60S 113-119)

PEPFAR should complement prevention activities with a strong advocacy strategy & sensitization of the general population regarding KPs and human rights Advocacy activities have to be strongly supported in countries that show the greatest resistance to creating enabling environments for KPs. Priority should be given to Belize, Honduras and Guatemala, in that order, since they struggle with the most conservative social attitudes against KPs.

*Support countries to overcome legal restrictions to full exercise of KP's human rights***.** Belizean CSOs should be strongly and immediately supported in their advocacy efforts to try to overcome legal restrictions to full exercise of KP´s human rights and presence in the country.

In the coming 3 years, PEPFAR should:

- Support devising (or accelerating) specific policy initiatives for ministerial regulations and/or legislation banning stigma and discrimination from health services, similar to that in El Salvador and Nicaragua in the different countries that do not have one,
- Support all Human Rights Ombudsmen offices in the region install a specific human rights ombudsman/woman for Sexual Diversity.

During the coming 5 years, PEPFAR should:

- Show clearly that KPs are priority by making sure that at least 80% of the funding is directed towards working with KPs or organizations directly related to KPs human rights and HIV/AIDS issues based on vulnerability approach.
- Expand the implementation of a strong communication strategy that sensitizes the general population and public authorities about KPs and their human rights. This strategy has to be designed and implemented jointly between policy specialists and marketing/social media experts.

Focus on Financial Sustainability for KP Prevention

*Promote government & other funding streams for prevention***.** Advocacy among the private sector to discuss sustainable sources of income for the national HIV strategy should be continued.

*Strengthen NGOs to gradually find alternative sources of incomes***.** PEPFAR should support KP and CSOs working in HIV/AIDS to devise transition strategies so that they gradually find alternative sources of income to substitute funding from international donors.

During the next 5 years, PEPFAR should support:

- Funding mechanisms like the one established by the Honduran government to finance prevention activities. This model should be promoted in the other countries with priority in Belize, Guatemala, and Nicaragua. Private enterprise, private funds and other international organizations should be motivated to participate in funding.
- Lobbying activities and advocacy that focus on increasing the total amount of public resources allocated to HIV/Aids and increase the percentage of the budget allocated to prevention activities, seeking at least a 20% increase of the current amount.
- CSO and KP organizations seeking that the MOH and other public institutions introduce formal and legal mechanism by the Ministries of Planning and/or Finance to ensure that a budget will be allocated to prevention activities and that it is done in a transparent way as to facilitate being monitored by citizens.
- Prioritizing CSO and KP organizations so that their members can develop small business or other employable skills, for individual and organizational financial sustainability.
- Expansion of MOH's involvement in the direct delivery of the full range of prevention services and activities. Involvement of other ministries should be promoted as well.

Collaborative work between state institutions and CSOs should be fostered and supported.

HSS Recommendations

Build Institutional Capacity

Pursue a joint effort between the Central American Ministries of Health, USG programs and other donors in order to promote the adoption of more appropriate Civil Service laws in the Central American countries. PEPFAR alone cannot guarantee the permanence of positions for trained human resources.

PEPFAR should continue to support the improvement and strengthening of supply chain management at the technical and managerial level, but complement it with actions at the Ministerial policy level to highlight the importance and accountability of public authorities towards efficient and transparent management of supplies.

PEPFAR should continue the model of incorporating a comprehensive HIV approach to the curricula in medical, pharmacology, and nursing schools as way to build long-term human resource capacity and expertise. This approach should be promoted for expansion in the region.

PEPFAR should focus on behavior change in health service providers. Efforts to strengthen health services skills should include competency in working with KPs in a professional and respectful manner and programming should aim to overcome their potentially existent cultural biases against KPs in their work setting. This inter-personal communication strengthening is particularly important in Honduras, which is in the process of services integration and decentralization.

During the coming 3 years, PEPFAR should:

- Support the development of "Good behavior codes of practice" with corresponding training for all health services providers in order to prevent stigma and discrimination towards KPs.
- Support efforts to decentralize supply chain management and processes in order contribute to availability of tests, reagents and ARVs at the local level.
- Support efforts to strengthen laboratories in decentralizing the management and quality control of testing and reagents, as well as strengthening prioritized local laboratory units to perform quality testing and safeguarding/transporting of samples.
- Continue to work with military personnel across the region so as to make sure that the procedures, protocols and processes to take care of the personnel are institutionalized.

During the next 5 years, PEPFAR should:

- Continue and expand its support to increase institutionalization of methodologies, procedures and processes that enable health services personnel to provide continuous quality care to KPs.
- Support the CCMs and RCM to include funding for reagents and tests in Global Fund grant proposals for follow up the HIV positive population.
- Support the NACs and Financial and/or Planning Ministries to improve financial and budget planning in order to provide funds for tests and reagents.

Strategic Information Recommendations

Increase Focus On Strengthening Systems & Research Capacity

In the long run, countries should be supported to strengthen surveillance through the design of specialized studies that complement regular data collection by the national information systems. During the coming year USG agencies should support national governments and academic institutions to develop a research agenda and devise the mechanisms to finance it.

PEPFAR should move to country ownership of research by strengthening national universities and research centers with a focus on institutional and human resource capacities and processes to carry out epidemiological, policy, and socio-economic and cultural research. Masters degree programs in public health, as well as economics, sociology and anthropology could be selected for a pilot intervention on strengthening research skills.

During the coming 5 years, PEPFAR should:

- Support the National Statistics Institutes in the region, to generate updated population data, and specialized household surveys that help to identify conditions of vulnerability and link them to the KPs, and the demographic statistics that allow to establish baselines, specific studies, continuous statistic systems in sectoral units, such as MOH.
- Support the involvement of USG implementers in assisting MOH to design and implement unified systems of digitalized clinical registries (including prevention services) for HIV positive and KP.
- Support MOH in the region to improve the articulation of information from community based health systems to the national health data system.
- Continue to support the MOH to improve their epidemiological surveillance systems and the epidemiological analysis units.
- Support the strengthening of management information systems that have an interface with epidemiological data, so that decision makers can move towards results based management of the epidemic.
- Support MOH, CSOs, universities and research institutions to develop capacities to use the available information about the epidemic and the conditions that create vulnerability.

Prioritize Integration Of Information Systems

Harmonize the existent NGO and local health information systems. PEPFAR should try to contribute to the acceleration donor requirement integration as to ease the work of the national counterparts.

PEPFAR should continue to contribute to efforts to harmonize reporting methods, periodicity and indicators for monitoring and evaluation.

During the coming year, PEPFAR should support at the advocacy and policy level, the identification of the main barriers and factors that are preventing the existence of a reliable integrated information system for HIV epidemiologic monitoring.

During the coming five years, PEPFAR should:

- Contribute to the design and implementation of a national system in order to register monitoring activities and results of NGO's. This should include sociological, economic and anthropological information on KPS and HIV+

Broaden To Sociological & Anthropological Studies

Broaden the scope of the studies conducted or analyzed to include sociological and anthropological studies in addition to current epidemiological studies. Develop the skills needed to relate and interpret this information and better understand the political and socio-economical determinants of vulnerability and in turn translate these into program design and implementation.

Policy Recommendations

Address Governance & Accountability

PEPFAR should aim to develop stronger links between the HIV public health approach with governance efforts carried by other programs and USG agencies that relate management of the HIV epidemic to the countries´ governance structures, the specifics of the health system´s governance structures, the role played by faith based institutions in modeling public policy, stigma and discrimination, and poverty and inequality.

Give more visibility to COMISCA and its role as leader of the regional response. Over the coming 5 years PEPFAR could support, the development of an improved communications and interaction strategy from COMISCA to country authorities and NAC members. PEPFAR should reinforce COMISCA´s role in endorsing monitoring of regional and National HIV/AIDS strategies, as well as annual public reporting of the regional strategy and its results. The PEPFAR regional team could encourage the Regional Coordinating Mechanism to play a more vigorous role as the technical support unit for COMISCA. Over the coming 3 years, PEPFAR should support the RCM in renewed efforts in monitoring and accountability reporting and designate a full time liaison role with COMISCA.

Support countries to complete legal and policy frameworks that focus on the needs and human rights of key populations. In the next phase, PEPFAR should expand activities to allow CSO and KP organizations to work and advocate with Congress, political parties and other influential indirect stakeholders of HIV/AIDS interventions, in order to promote further changes in key legislation that promotes reduction of stigma and discrimination related to sexual orientation and gender identity.

Foster access to information for accountability. Donors should jointly support an annual HIV/AIDS monitoring report by the responsible authorities, which should be publicly presented and freely accessible to all, whereby authorities can inform the general public on the progress of strategy implementation and resources used, included those of donors.

During the coming 3 years PEPFAR should:

- Expand their activities to include key State institutions that have a role in the annual general operational planning, programming and budgeting process of the countries, and advocate in favor of prioritizing HIV/AIDS strategies among other competing demands. Key institutions to prioritize: Ministries of Financing, Planning and Civil Service.
- Consider including in their monitoring portfolio, a minimal set of key indicators reflecting the socio-political, economic and cultural processes that are taking place in each country and in the region that might be affecting adversely the execution of PEPFAR technical components. An office already doing this for USG, could provide this sort of information on a regular basis to the regional PEPFAR team which would in turn, use it for the specific PEPFAR purposes.

- Emphasize the monitoring of program and activity implementation in each country and develop a single quarterly reporting mechanism that allows partners to adopt timely interventions to speed up or maintain pace of implementation throughout the year.

Improve Quality Of Key Population Engagement

More and better quality KP representation PEPFAR should support building up KPs individual and institutional capacities and leadership to move their human rights and HIV/AIDS agenda.

Expand KP and CSOs organizational, technical and managerial capacities. A new focus on strengthening advocacy networks' capacity (training in policy and budgeting processes, formation of effective caucus and mobilization skills, use of data for advocacy, etc.) might serve to increase the quality of participation beyond the perceived token representation currently in place.

During the next planning cycle PEPFAR should decide whether prisoners and police are high priority vulnerable groups that are going to be included. Evidence on the prevalence and incidence of HIV among these populations in the region has to be collected and considered beforehand to make the decision.

During the coming 3 years PEPFAR should:

- Insist in safeguarding and protecting already established bodies for multi-sectoral participation, such as NACs and promote greater representation of KPs in them. Already existent participation structures have to be strengthened in order to allow more KP participation in real decision-making processes.
- Give priority given to expanding KP and CSOs organizational, technical and managerial capacities to promote human rights and HIV/AIDS prevention strategies for key populations

During the next 5 years, PEPFAR should:

- Give highest priority to reducing stigma and discrimination by means of leveraging and supporting KP and CSO organizations to carry out advocacy, and communication activities targeting the general population.
- Give priority to mapping and interacting with organized groups that might exert a negative influence on general opinion regarding KPs and their specific health and human rights threats. Sensitizing in favor of or at least, neutralizing their negative effects towards KPs and their human rights, should be the aim.
- Promote mechanisms for greater interaction and collaboration between KP and CSOs working in HIV/AIDS and public sector institutions.
- Support activities that give rise to a new generation of HIV/AIDS Champions among the key populations that are skilled and empowered to carry on advocacy, negotiation and policy-making initiatives with governmental authorities, politicians and private sector representatives.

Preserve Key Population Focus In Midst Of Health Reforms

There is a need to articulate and document how health reform, service integration and decentralization efforts contribute to efficiency and cost reduction, while also preserving the quality and access of KP focused services due to stigma and discrimination issues. PEPFAR should continue providing close support and advice to those Ministries of Health that are going through significant changes of their health systems or of the role of NAC, and ensure that specific HIV/AIDS and KP components are not undermined or eliminated as a result of the changes, by means of

supporting the establishment of specific prevention and treatment protocols inside the new protocols and regulations being developed for the integration of services, promote active participation of KPs in reform process committees and ensure that their voices and concerns are known and heard sufficiently in all decision-making spheres.

Systemize processes for HIV programming and budgeting. In the coming three years, PEPFAR should support the development of specific operational components in the annual programming and budgeting process in the MOH, especially in those that have gone through the "integration process", so that they keep targeting KPs and there is evidence of it for follow up.

In those specific cases where there is already a movement towards integration of services, like Belize and Honduras, PEPFAR should support the generation of base-line studies on current KP´s service utilization to be able to show changes in the pattern that are associated to this MOH policy and strategy change.

PEPFAR should insist on salvaging NAC bodies from being engulfed by MOHs by means of an explicit advocacy effort promoted from inside the own NAC bodies. Increase specific support to NAC to redefine their own positioning strategy and generate results-based activity plans.

During the coming 3 years PEPFAR should:

- Develop an advocacy and information strategy, directed at key decision makers in National Congresses and national government authorities to reinforce the importance of ensuring access, privacy and quality of care to key populations and thread those elements into any reforms in process.
- Give priority to strengthening the operational planning, programming and budgeting capabilities of pertinent MOH units, and the other public and CSO stakeholders that have implementing responsibilities, as stated in the National HIV/AIDS Strategies
- Focus on providing technical assistance and capacity building in costing, budgeting, cost/benefit analysis, and operational planning to selected local governments and service providers in municipalities located in areas prioritized in HIV/AIDS strategies.
- Support national authorities, including NACs, in the discussion and development of mid-term financial transition plans to allow them to prepare for the eventual reduction of Global Fund and/or PEPFAR support in the region. These transition plans should include alternative scenarios on how to involve the private sector in national program funding.

Cross Cutting Recommendations

Make Space For Innovative Initiatives

In the coming year, PEPFAR together with COMISCA should support systematization of pilot initiatives that are currently being implemented in the region, as well as of lessons learnt and expand the capacity of COMISCA to capitalize on the opportunity for leadership in promoting exchange of these experiences between countries.

PEPFAR should support COMISCA and national authorities to analyze the lessons learned from these pilot programs and introduce the relevant ones to the policy level documents and strategies.

PEPFAR should support implementing agencies to work towards developing sustainable management and financial frameworks, together with local authorities, for selected pilot initiatives to be sustainably scaled up.

Improve PEPFAR Coordination & Communication

Better division of responsibility between PEPFAR the regional coordination and the national focal points. PEPFAR team should agree to a division of responsibilities between the regional levels and the national focal points based on which level contributes the greatest value to obtaining the expected results.

PEPFAR focal points are still needed in at least 4 countries. Belize and Guatemala each need to have a PEPFAR national coordinator that focuses fully on managing and monitoring the complex environments in which activities have to be implemented. Honduras and Nicaragua have one already and full support should be given to continue and/or improve the quality work already being done.

Share, collaborate and coordinate with other donors. The need for closer collaboration between USG and UN / Global Fund efforts is a recurrent theme across the region. Stakeholders cite missed opportunities and an impression from other donors that USG does what it wants with little consultation.

I believe that for the next phase of PEPFAR, it is essential to continue the quality improvement processes and use of information for surveillance and monitoring the epidemic, as well as ***evaluations to continue adjusting the strategies and interventions to the reality of key populations and those that live with HIV/AIDS****.*

-Survey Respondent, Costa Rica

ANNEX I. SCOPES OF WORK

GLOBAL HEALTH TECHNICAL ASSISTANCE BRIDGE 3 PROJECT
SCOPE OF WORK
May 2, 2013

I. TITLE:

Evaluation of USG Central America Regional Partnership Framework (PF)

II. PERFORMANCE PERIOD

An estimated 141 days combined LOE between May and July 2013.

III. FUNDING SOURCE

USAID/Guatemala Regional PEPFAR Program

IV. PURPOSE OF ASSIGNMENT

The five-year PEPFAR Partnership Framework (2010 – 2015) is entering its fourth year of implementation and the USG interagency team is proposing an independent mid-term evaluation to assess (1) to what extent the PF has been implemented, (2) how contextual factors are affecting PF outcomes, and (3) the level of sustainability reached by USG supported interventions, taking into account activities performed by the four USG agencies (Peace Corps, Department of Defense (DOD), USAID and CDC-CAR-DGHA). The evaluation will inform the immediate and long-term future direction of PEPFAR's program implementation, by identifying recommended adjustments, changes or even new activities.

Specifically, this evaluation serves the purpose of both accountability and learning to:

4) Ascertain if the PEPFAR Central America Regional Program is helping countries reach a sustainable and epidemic-relevant, national AIDS program model.
5) Identify key factors contributing to or impeding program results.
6) Make recommendations for program adjustments.

V. BACKGROUND

With funding from the President's Emergency Plan For AIDS Relief (PEPFAR),the Partnership Framework (PF) between the United States Government (USG) and seven Central American countries (Belize, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama) consists of a five-year plan outlining the priority areas in which the participating partners, including host governments, national and regional organizations, the USG, and other major donors will devote their efforts and resources to fight HIV/AIDS. The overall purpose of the PF is to reduce HIV/AIDS incidence and prevalence in Most at Risk Populations (MARPs) in the Central American region by joining resources and coordinating initiatives to enable a robust and more effective response to the region's epidemic.

This Framework represents a consensus of all of the major partners to focus on evidence-based approaches that are tailored to the specific conditions of the epidemic in the countries in the region. The document also outlines how the USG provides technical assistance to strengthen the countries' capacity and create conditions to address HIV/AIDS in a more sustainable way.

This PF is based on considerable national government commitment to fighting HIV/AIDS to date. Host governments provide 63% of all HIV/AIDS funding in Central America, followed by the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) 20% contribution, the USG

contribution (9%[21]), and other donors (7%).[22] Thus, the Framework leverages local and other partners' funding to strengthen the overall response to the epidemic.

As a technical assistance model, the USG brings *limited* additional financial resources and therefore, it does not displace the significant role that host governments and other partners play in addressing HIV/AIDS in the region. Through this technical assistance model, rather than an "implementation model," the USG works to support the Concejo de Ministros de Salud de Centroamerica's (COMISCA—the Central American Council of Ministers of Health) goals and framework. It aims to increase institutional and human resource capacity to provide high quality, appropriate HIV/AIDS interventions. Once capacity is strengthened, the assumption of this Framework is that the Central American countries will continue fighting the epidemic with local and other donor resources, with minimum continued input from the USG.

The PF address four major identified gaps:

- **Prevention**: promoting behavior change among most at risk populations (MARPs); overcoming barriers to Voluntary Counseling and Testing (VCT), especially among the most vulnerable groups; diagnosing and treating STIs.
- **Health system strengthening (HSS):** increasing human resource capacity among health care providers, especially those working with members of vulnerable populations and people living with HIV (PLHIV); developing effective information systems for monitoring community-based care; improving supply chain management.
- **Strategic Information (SI):** strengthening surveillance; conducting special studies; improving capacity for collecting, analyzing, and using information for decision making; monitoring and evaluation.
- **Policy Reform**: increasing implementation and enforcement of policies already approved that would provide enabling environments for addressing needs of MARPS, especially those policies related to reducing stigma and discrimination; coordinating multi-sectoral support to achieve policy reform.

The **shared, overarching vision** of the Framework is to sustainably deliver highly effective, quality HIV/AIDS prevention, treatment, care and support services to increased numbers of beneficiaries through strengthened Central American regional and national health systems and personnel by the end of the five-year Framework period.

The PF goals that respond to the identified gaps are:

- **Prevention:** To increase healthy behaviors among MARPS to reduce HIV transmission[23]
- **Health Systems Strengthening (HSS):** To build capacity of countries' health systems in three key areas[24]: Service delivery, health workforce and essential medical products; to integrate efforts among implementing partners and sustainably deliver high quality HIV/AIDS services.

[21] This does not include the 27% o f the GFATM contribution that comes from the USG, which would put the USG contribution closer to 15% of the total.
[22]Key background documents include a tabulation of the estimated contributions of the various parties to the PF and the upward trend in overall HIV/AIDS expenditures.
[23] Healthy behaviors include: Increased condom use, reduced number of sexual partners and increased access to and use of HIV testing.
[24] These areas represent three of the six building blocks as defined by WHO for HSS.

- **Strategic Information (SI):** To increase availability and use of information in support of the regional and local HIV/AIDS response in order to characterize the epidemic and take appropriate actions with sustainable, evidence-based, and cost-effective program interventions.
- **Policy Environment:** To improve the policy environment to address HIV/AIDS in Central America in order to reach the ultimate goal of Universal Access[25].

The following key documents will be available:

- Partnership Framework
- Partnership Framework Implementation Plan
- Regional Operational Plan (ROP) ROP 2009, 2010, 2011, 2012
- Progress Reports (including Annual and Semi-annual Performance Reports - APR and SAPR)
- Monitoring and Evaluation Plans
- National and Regional HIV/AIDS Strategic Plans
- National and Regional HIV/AIDS Progress Reports
- Interview data and summary of the PF site visits conducted by PEPFAR Regional Coordinator in Summer 2012
- Detailed meeting notes and summary from the Regional PF consultation meeting (September 4-7, 2012)
- Matrix that lists PEPFAR implementing partners by agency and by country, including a list activities and points of contact
- The evaluation of the prevention strategy implemented by USAID in Honduras (2010)
- The results of the evaluation of VICITS in Honduras (2010)

VI. SCOPE OF WORK

Within the estimated timeframe (May 2013 – July 2013), the consultant team will provide input and recommendations regarding the following evaluation questions. Question 1 looks at the PF performance on a broad level, including all the sectors involved in the AIDS response. USG attribution is specifically noted in questions 2, 3, and 4.

GENERAL

To what extent has the Partnership Framework been successfully implemented in Central America, with an emphasis on the principles of Country Ownership and a focus on MARPs?

SPECIFIC QUESTIONS

1. To what extent has prevention with MARPs been adopted as a national priority in each country? How much money has been invested in prevention with MARPs and what percentage is that of the overall HIV/AIDS budget in each country? What is the source of this financing in each country? How are evidence-based models and theories being used in each country for improving programs targeted at MARPs? Are there formal policy statements reflecting government interest and prioritization of working with MARPs, and are they implemented effectively?

2. To what extent has the strategic information supported by the USG been utilized for decision making to improve the response to the HIV epidemic in Central America?

[25]Universal Access refers to a commitment of worldwide leaders to develop and implement measures to move toward "universal access" for prevention, treatment, care and support services by 2010

Does sufficient strategic information related to MARPs exist to facilitate an appropriate response to their needs?

3. To what extent do the USG supported and promoted models and systems (prevention, care, epidemiological surveillance, monitoring & evaluation, policy development and implementation, health system strengthening, etc. in the region have the capacity to be sustainable (technically and financially)? Are the models and systems promoted by the USG appropriate to the region's epidemic? How much personnel capacity has been created in countries to provide for the HIV response and is it being utilized strategically?

4. To what extent has the USG supported the positive and productive engagement of different sectors in the HIV epidemic response? (civil society, faith-based organizations, governments, donors, private sector, media)

VII. METHODOLOGY

The consultant team will first conduct a desk review of key background documents as well as initial consultations with the regional interagency team by conference call. The team will then travel to Guatemala where they will develop, during the team planning meeting (see below), a mixed method approach for the evaluation using quantitative and qualitative methods to assess performance as well as to understand how contextual factors affect PF outcomes. Evaluation data should be analyzed and reported at the regional and country level as well as disaggregating the results by key stakeholder groups (e.g. National AIDS Programs, Civil Society, multi-lateral donors, etc.). Key stakeholders in the process include: National AIDS Programs, Health, Finance, Education, Defense, and Planning Ministries, Tuberculosis Programs, Regional Networks of People Living with HIV, Sex Workers, MSM, Transgender groups, PEPFAR Implementing Partners, UNAIDS and other multi-lateral donors, National and Regional Coordinating Mechanisms, etc. The evaluation team should propose an appropriate sampling framework and criteria for choosing a representative sample of key stakeholder groups. In order to collect the data, the team will travel together to various countries in the region to conduct site visits and interviews. The final schedule and countries to be visited will be finalized during the team planning meeting and in consultation with the PEPFAR team. The team will tentatively plan to conduct site visits in Guatemala, Honduras, Nicaragua, El Salvador, and Belize. Phone interviews will be conducted with key stakeholders in the remaining countries.

In preparation for the evaluation, the team should plan to hold a two-day team planning meeting (TPM) upon arrival in Guatemala, planned and facilitated by the Team Leader, as the full team begins the work planning. The team will meet with USAID during the TPM to discuss the scope of work in detail and obtain any necessary clarifications. The purpose of this meeting will be as follows:

- Clarify team members' roles and responsibilities;
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- Develop and finalize a work plan for the assignment and share with field POCs;
- Review and finalize the assignment timeline and share with USAID and field POCs;
- Finalize data collection plans and tools;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a preliminary draft outline of the team's report; and

- Assign drafting responsibilities for the final report.

VIII. TEAM COMPOSITION, SKILLS, AND LEVEL OF EFFORT

The evaluation team should be composed of individuals with HIV/AIDS program experience and a range of monitoring and evaluation skills needed to conduct mixed methods analysis activities. A team leader and two more members are required.

Team Leader Qualifications

- Minimum ten years' experience in the design, implementation, monitoring and evaluation of international health programs, using appropriate quantitative and qualitative methods
- PhD or Master's level degree in public health, epidemiology, behavioral science or related field
- Demonstrated skills in relevant technical areas such as behavior change methodologies, health system strengthening, prevention and education, health care, treatment and support; prior experience working with MARPS preferred
- At least three to five years' experience working in HIV and AIDS program planning and implementation in an international or resource challenged setting; experience with PEPFAR and familiarity with Latin America/Central America/Caribbean region highly desirable
- Prior experience as an effective leader of an evaluation team
- Fluency in Spanish and English
- Ability to travel to posts in Central America (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama) to conduct evaluation activities
- Strong interpersonal, communication, and collaboration skills working with multiple US and host country government agencies, non-governmental organizations, faith-based organizations, and the private sector in diverse cultures

Team Member Requirements

- Minimum five years' experience in the design, implementation, monitoring and evaluation of international health programs, using appropriate quantitative and qualitative methods
- Master's level degree in public health, epidemiology, behavioral science or related field
- Demonstrated skills in relevant technical areas such as behavior change methodologies, health system strengthening, prevention and education, health care, treatment and support; prior experience working with MARPS preferred
- At least three to five years' experience working in HIV and AIDS program planning and implementation in an international or resource challenged setting; experience with PEPFAR and familiarity with Latin America/Central America/Caribbean region highly desirable
- Fluency in Spanish and English
- Ability to travel to posts in Central America (Guatemala, Honduras, and Nicaragua) to conduct evaluation activities
- Strong interpersonal, communication, and collaboration skills working with multiple US and host country government agencies, non-governmental organizations, faith-based organizations, and the private sector in diverse cultures

The estimated level of effort for this activity is shown below:

Activity	Level of Effort
Pre-travel preparation (conference calls, key document review, etc.)	5 days x 3 consultants = **15 d**
Travel to Guatemala	1 day x 3 = **3 d**
In-briefing with USAID and team planning meeting (development of methodology/tools/work plan, etc.)	3 days x 3 = **9 d**
Field visits in Guatemala	3 days x 3 = **9 d**
Travel to Honduras	1 day x 3 = **3 d**
Field visits in Honduras	3 days x 3 = **9 d**
Travel to Nicaragua	1 day x 3 = **3 d**
Field visits in Nicaragua	3 days x 3 = 9 **d**
Travel to Belize	1 day x 3 = **9 d**
Field visits in Belize	3 days x 3 = **9 d**
Travel to El Salvador	1 day x 3 = **3 d**
Field visits in El Salvador	3 days x 3 = **9 d**
Return to Guatemala	1 day x 3 = **3 d**
Begin synthesis & analysis of findings	1 day x 3 = **3 d**
Phone calls to countries not visited	2 days x 3 = **6 d**
Draft report writing and debriefing preparation	4 days x 3 = **12 d**
Debriefing presentation to USG interagency team	1 day x 3 = **3d**
Report revisions and submission of draft report	4 days x 3 = **12d**
Return travel to U.S.	1 day x 3 = **3 d**
Interagency team review/feedback on draft	---
Preparation and submission of final report	5 days x 3 = **15 d**
Total LOE	**47 days x 3 = 141 d total**

IX. LOGISTICS

GH Tech Bridge 3 will be responsible for all international travel and consultant logistics. The USG team will provide names, contact information, and other information on the stakeholders proposed to participate in the evaluation, and will help facilitate contacts, communication, and meeting schedules. USG agencies will help communicate with selected stakeholders about the purpose and dates of the evaluation.

X. DELIVERABLES

The evaluation team will prepare and submit the following final deliverables:

1. Draft and revised methodology plan/work plan, including the instruments to be applied to collect and analyze information and data. The methodology/work plan will be prepared during the team planning meeting and submitted for USAID and the field POCs for approval at the end of the meeting.
2. Debriefing presentation using Power Point with preliminary findings and recommendations for USG interagency team prior to departure from region.
3. Draft and final evaluation report in English. The report format should include:
    - Executive summary, 2 – 3 pages(this section of the report should also be translated into Spanish)
    - Table of Contents
    - Acronym List

- Narrative (40 pages max) which comprehensively addresses each of the objectives and questions listed in the Statement of Work as well as the findings, interpretations, conclusions, and recommendations which should be clearly supported by the collected and analyzed data. Findings should be presented graphically where feasible and appropriate using graphs, tables and charts.
- Annexes to include: Scope of Work, description of the methodology used, lists of individuals and organizations consulted, data collection instruments (i.e. questionnaires and discussion guides etc.) and bibliography of documents reviewed.

GH Tech will have the report professionally edited and formatted once the report has been approved by the USG interagency team. In addition, if there is adequate time prior to the end of GH Tech's contract end date, the report will be translated from English into Spanish.

Once the report has been edited and formatted, GH Tech will provide USAID with one electronic copy of the report. In the event that the final report approval process is delayed, GH Tech will work with USAID to identify other mechanisms that would be able to edit, format, and translate the final report.

XI. RELATIONSHIPS AND RESPONSIBILITIES

GH Tech Bridge 3 will coordinate and manage the evaluation team and undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the evaluation team, with consultants approved approval by the USG Interagency Team.
- Make logistics arrangements for the consultants, including travel and transportation, country travel clearances, lodging, and communications.

Interagency USG Team will provide overall technical leadership and direction for the evaluation team throughout the assignment.

XII. POINTS OF CONTACT

Rodrigo Boccanera
PEPFAR Coordinator for Central America
BoccaneraRA@state.gov

Giovanni Melendez, USAID/Guatemala Regional Program
HIV/AIDS Specialist
gmelendez@usaid.gov

The PEPFAR Coordinator and USAID POC will ensure communication and coordination with interagency M&E team members (list to be provided)

XIII. COST ESTIMATE

The GH Tech Bridge 3 Project will provide a cost estimate for this activity.

GLOBAL HEALTH TECHNICAL ASSISTANCE BRIDGE 4 PROJECT
SCOPE OF WORK
August 27, 2013

I. TITLE

Final evaluation report and power point presentation in both English and Spanish of the PEPFAR Central America Interagency Partnership Framework Evaluation

II. PERFORMANCE PERIOD

An estimated 25 days between on/around September 1 and 30, 2013.

III. FUNDING SOURCE

USAID/Guatemala Regional PEPFAR Program

IV. PURPOSE OF ASSIGNMENT

The five-year PEPFAR Partnership Framework (2010 – 2015) is entering its fourth year of implementation and the USG interagency team proposed an independent mid-term evaluation to assess (1) to what extent the PF has been implemented, (2) how contextual factors are affecting PF outcomes, and (3) the level of sustainability reached by USG supported interventions, taking into account activities performed by the four USG agencies (Peace Corps, Department of Defense (DOD), USAID and CDC-CAR-DGHA). The fieldwork of the evaluation was conducted in June and July 2013, and the final draft report was prepared by the GH Tech evaluation team, but the final evaluation report, the Spanish translation of the report, and the final power point presentation are still pending. GH Tech Bridge 4's assistance is requested to prepare the remaining deliverables.

V. BACKGROUND

With funding from the President's Emergency Plan For AIDS Relief (PEPFAR), the Partnership Framework (PF) between the United States Government (USG) and seven Central American countries (Belize, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, and Panama) consists of a five-year plan outlining the priority areas in which the participating partners, including host governments, national and regional organizations, the USG, and other major donors will devote their efforts and resources to fight HIV/AIDS. The overall purpose of the PF is to reduce HIV/AIDS incidence and prevalence in Most at Risk Populations (MARPs) in the Central American region by joining resources and coordinating initiatives to enable a robust and more effective response to the region's epidemic.

This Framework represents a consensus of all of the major partners to focus on evidence-based approaches that are tailored to the specific conditions of the epidemic in the countries in the region. The document also outlines how the USG provides technical assistance to strengthen the countries' capacity and create conditions to address HIV/AIDS in a more sustainable way.

VI. SCOPE OF WORK

Within the estimated timeframe (approximately September 1 – September 30, 2013), the consultant(s) will finalize the evaluation report based on the inputs provided by the

PEPFAR interagency team. The report will also be translated into Spanish and a power point presentation prepared to be shared with the countries.

VII. METHODOLOGY

The consultant(s) will be in touch (via teleconference if it's not a Guatemalan resident or in person if lives in Guatemala) with the interagency team, through the USAID Activity Manager (Giovanni Meléndez) in order to keep a fluent communication channel.

VIII. TEAM COMPOSITION, SKILLS, AND LEVEL OF EFFORT

The evaluation team should be composed of 1 or 2 individuals with some HIV/AIDS program experience and strong ability to write, edit, and review documents as well as to prepare succinct and high level presentations to share with the countries.

Consultant Qualifications

- Fluency in Spanish and English
- Demonstrated skills in documents translations in relevant technical areas such as behavior change methodologies, health system strengthening, prevention and education, health care, treatment and support; prior experience working with MARPS preferred.
- At least three years' experience working in HIV and AIDS program planning and implementation in an international or resource challenged setting; experience with PEPFAR and familiarity with Latin America/Central America/Caribbean region highly desirable
- Strong interpersonal, communication, and collaboration skills working with multiple US and host country government agencies, non-governmental organizations, faith-based organizations, and the private sector in diverse cultures

Activity	Level of Effort
Introduction to the activity	1 day
Receive and review inputs on final draft report	1 day
Make final revisions and prepare the final evaluation report	5 days
Review and approval by the Field Team	5 days
Translation from English to Spanish	5 days
Review and approval of translated report by the Field Team	5 days
Power Point presentation preparation	2 day
Review and approval of presentation by the Field Team	2 days
Total LOE	**25 d total**

IX. LOGISTICS

GH Tech Bridge 4 will be responsible for the logistics. The USG team may provide names, contact information, and other information of potential candidates.

X. DELIVERABLES

The consultant(s) will prepare and submit the following final deliverables:

1. Final evaluation report with inputs from the field team.
2. Final evaluation report translated from English to Spanish.
3. Final report edited, branded and ready to be printed or uploaded
4. A power point presentation in English and Spanish, with key elements of the evaluation report.

XI. RELATIONSHIPS AND RESPONSIBILITIES

GH Tech Bridge 4 will coordinate and manage the consultant(s) and undertake the following specific responsibilities throughout the assignment:

- Recruit and hire the evaluation team, with consultants approved approval by the USG Interagency Team.
- Make logistical arrangements for the consultants, including travel and transportation, country travel clearances, lodging, and communications if necessary.

Interagency USG Team will provide overall technical leadership and direction for the evaluation team throughout the assignment.

XII. POINTS OF CONTACT

Rodrigo Boccanera
PEPFAR Coordinator for Central America
BoccaneraRA@state.gov
mailto:BoccaneraRA@state.gov
Giovanni Melendez, USAID/Guatemala Regional Program
HIV/AIDS Specialist
gmelendez@usaid.gov
mailto:gmelendez@usaid.gov
The PEPFAR Coordinator and USAID POC will ensure communication and coordination with the PEPFAR interagency M&E team members (list to be provided).

XIII. COST ESTIMATE

The GH Tech Bridge 4 Project will provide a cost estimate for this activity.

ANNEX II. INTERVIEW GUIDE

GROUP INTERVIEW

INTERVIEW CODE:	
COUNTRY:	
COMPONENT:	
DATE:	
TIME OF INTERVIEW:	
NAME/TITLE/AFFILIATION OF RESPONDENT:	
CONTACT INFORMATION OF RESPONDENT:	
INTERVIEWER:	

I. INTRODUCTION

Thank you for making the time to speak with us today. We are Tito Coleman, Gregorio Soriano and Karin Slowing, and we are conducting a midterm evaluation of the PEPFAR Central American Regional Partnership Framework (Marco de Cooperación PEPFAR), which has been active since 2010, serving 7 countries and the COMISCA (Regional Council of Central American Ministers of Health) in supporting national and regional efforts to improve the capabilities and quality of response to the HIV/aids epidemic. As you may know, these activities are supported through the four USG agencies working in country: USAID, CDC, DoD and Peace Corps and their implementing partners.

The overall purpose of the midterm evaluation is to assess the following:

1. to what extent the PF has been implemented,
2. how contextual factors are affecting PF outcomes,
3. the level of sustainability reached by USG supported interventions.

Let us clarify to you that this is not a project performance evaluation. Rather, it will inform the immediate and long-term future direction of PEPFAR's program implementation by identifying recommended adjustments, changes or even new activities, as well as identifying the key factors that are contributing to or impeding program results.

In the end, we want to come with a set of recommendations that will allow the USG , through PEPFAR, to make appropriate program adjustments.

As you might remember, the PF addresses four major identified gaps:

- **Prevention**: promoting behavior change among most at risk populations (MARPs); overcoming barriers to Voluntary Counseling and Testing (VCT), especially among the most vulnerable groups; diagnosing and treating STIs.

- **Health system strengthening (HSS):** Improve and expand HIV/aids quality of service delivery; Improve institutional and human resource capacity as it relates to HIV/AIDS; strengthen commodities and supply chain management systems.

- **Strategic Information (SI):** strengthening surveillance; conducting special studies; improving capacity for collecting, analyzing, and using information for decision making; monitoring and evaluation.

- **Policy Reform**: increasing implementation and enforcement of policies already approved that would provide enabling environments for addressing needs of MARPS, especially those policies related to reducing stigma and discrimination; coordinating multi-sectoral support to achieve policy reform.

You were suggested as a key informant for this evaluation in the field of **HSS,** PREV, ST, PR and we greatly appreciate your perspective and views on PEPFAR's current implementation, its degree of progress, and help us examine what are the successes, challenges and gaps not being addressed so far.

Our interview will take about **60** minutes.

Before we begin, I want to let you know that any information or examples we gather during this interview, will not be attributed to any specific person or institution, unless you tell us that you would be willing to have your responses quoted in the evaluation report or otherwise attributed to you. You are also free to not respond to any of our questions or to stop the interview at any time.

I also want to ask if we would be allowed to tape the interview, to make the writing session afterwards far easier.

Before we begin, do you have any questions?

II. GROUP INTERVIEW

A) HEALTH SYSTEMS STRENGTHENING

As you remember, we are conducting a midterm evaluation of the PEPFAR Central American Regional Partnership Framework (Marco de Cooperación PEPFAR), which has been active since 2010, serving 7 countries and the COMISCA (Regional Council of Central American Ministers of Health) in supporting national and regional efforts to improve the capabilities and quality of response to the HIV/aids epidemic.

POLICY

Political Ownership and Stewardship

Political (policy and supportive environment)

1. Are the necessary HSS strategies included in the following National HIV/AIDS instruments to respond efficiently to the HIV/AIDS epidemic in your country?
    a. National HIV/AIDS Policy
    b. National HIV/AIDS Strategic Plan
    c. National M&E Plan
    d. National budget

2. Are the HSS strategies and indicators targeted to MARPs included in the following instruments:
    a. National HIV/AIDS Policy
    b. National HIV/AIDS Strategic Plan
    c. National M&E Plan
    d. National budget

3. To what degree do you perceive PEPFAR support for these activities? (Before/After PEPFAR...contribution)

4. What are the obstacles you are encountering for making the most out of PEPFAR´s support to HSS?

5. What would you recommend to PEPFAR for its next phase of assistance in this area?

6. Does the national strategic plan include HSS components:

    a. Service delivery: packages; delivery models; infrastructure; management; safety & quality; demand for care
    b. Health workforce: national workforce policies and investment plans; advocacy; norms, standards and data
    c. Information: facility and population based information &surveillance systems; global standards, tools
    d. Medical products, vaccines & technologies: norms, standards, policies; reliable procurement; equitable access; quality
    e. Financing: national health financing policies; tools and data on health expenditures; costing
    f. Leadership and governance: health sector policies; harmonization and alignment; oversight and regulation

SOCIAL AND INSTITUTIONAL OWNERSHIP

Popular support / multisectoral support

Degree of participation

7. What mechanisms or systems are in place in your country to continue activities of HSS after PEPFAR ends? What concerns do you have about them?

8. Do all the HSS strategies and indicators (included in the National HIV/AIDS Policy, Strategic Plan, M&E Plan, and/or national budget) have toolkits and/or national guidelines necessary to standardize their implementation and follow up?

INSTITUTIONAL CAPACITY
Management/governance/HR capabilities (labor force)

9. How would you rate progress that has been made in strengthening health systems (in the 3 specific areas) so far, through PEPFAR contributions?

    a. way below expected 5 year target
    b. on track
    c. targets close to be met
    d. target already met
    e. Need of defining new targets

10. Are the three component specific interventions in HSS (Improve and expand HIV/AIDS quality of service delivery; Improve institutional and human resource capacity as it relates to HIV/AIDS; strengthen commodities and supply chain management systems) progressing at the same pace?

MUTUAL ACCOUNTABILITY
Country Finances (ownership)

11. Can you give some examples of how the "mutual accountability" process is implemented in your country. We are interested in the follow up of the efficiency of the budgeted investments made to implement the HSS strategies and indicators, which are included in:

    a. National HIV/AIDS Policy,
    b. National HIV/AIDS Strategic Plan,
    c. National M&E Plan
    d. National budget.

REDUCTION OF CONTINUING COSTS / INCREASED EFFICIENCY
Sustainability

12. Explain how does your organization or the country measure and improve efficiency of the budgeted investments made to implement the HSS strategies and activities included in:

    a. National HIV/AIDS Policy;
    b. The National HIV/AIDS Strategic Plan;
    c. National M&E Plan;
    d. National budget;

B) PREVENTION

The PEPFAR regional strategy focuses on Prevention for MARP populations in each country in need of improved prevention services. The following questions focus on the status and opportunities in this area.

POLICY
Political Ownership and Stewardship

Political (policy and supportive environment)

13. Are there explicit MARP Prevention provisions in these policy component areas?
    a. National HIV/AIDS Policy
    b. National HIV/AIDS Strategic Plan
    c. National M&E Plan
    d. National Budget

14. What worked well in the development process for these areas?

15. What were the obstacles encountered?

16. What would you recommend to PEPFAR for its next phase of assistance in this area?

17. Does the national strategic plan include these Prevention components:
    a. University Curriculum on HIV Prevention
    b. Mass media campaign focused on MARPS
    c. Integrated prevention services in public health system?
    d. Integrated HIV prevention in public schools
    e. Stigma and Discrimination focused efforts?
    f. Specific programs focused on MARPS (MSM, CSW, indigenous, transsexual)
    g. OTHER>>>>>

18. To what degree do you perceive PEPFAR support for these activities? (Before/After PEPFAR?...contribution)

19. What are the obstacles you are encountering for making the most out of PEPFAR´s support to HSS?

SOCIAL AND INSTITUTIONAL OWNERSHIP
Popular support / multisectoral support
Degree of participation

20. Describe degree of participation of representatives of MARPs in the following:
    a. National HIV/AIDS Policy
    b. National HIV/AIDS Strategic Plan
    c. National M&E Plan
    d. National Budget

21. Have there been specific contributions to these components made by representatives of the MARPs which have been taken into account?

22. To what extent has the USG supported the positive and productive engagement of different sectors in the **HIV Prevention** response? (civil society, faith-based organizations, governments, donors, private sector, media)

23. Tell us more about how this engagement has happened. (formal mechanisms, advocacy, members of advisory groups..).

INSTITUTIONAL CAPACITY
Management/governance/HR capabilities (labor force)

24. National: Describe specific capacity building activities focused on developing and expanding MARP / HIV Prevention services and interventions:
    a. University Curriculum on HIV Prevention
    b. Mass media campaign focused on MARPS
    c. Integrated prevention services in public health system?
    d. Integrated HIV prevention in public schools
    e. Stigma and Discrimination focused efforts?
    f. Specific programs focused on MARPS (MSM, CSW, indigenous, transsexual)
    g. Others

25. MARP focused network activities (describe existing efforts and their status/strength).

26. Community Level: describe existing MARP focused activities:
27. To what degree do you perceive PEPFAR support for these activities? (Before/After PEPFAR contribution)

28. What are the obstacles you are encountering for making the most out of PEPFAR´s support to HSS?

MUTUAL ACCOUNTABILITY
Country Finances (ownership)

Mutual accountability implies that there are explicit mechanisms for participation and monitoring responsibilities and implementation of all elements included in the National Strategic Plan (including Public Sector, civil society, media, private sector and other key stakeholder groups). For this to occur, each group must feel safe and able to access information and participate in its use for decision making.

29. Explain the "mutual accountability" process from your perspective and role in HIV Prevention.

REDUCTION OF CONTINUING COSTS / INCREASED EFFICIENCY
Sustainability

30. Explain how does your organization or the country measure and improve efficiency of the budgeted investments made to implement the HSS strategies and activities included in:

    a. National HIV/AIDS Policy;
    b. The National HIV/AIDS Strategic Plan;
    c. National M&E Plan;
    d. National budget;

C) POLICY

POLICY

Political Ownership and Stewardship

Political (policy and supportive environment)

31. What is the status of the following National Policy components?
    a. National HIV/AIDS Policy
    b. National HIV/AIDS Strategic Plan
    c. National M&E Plan
    d. National Budget

32. What role has your organization played in the development and monitoring of these components?

33. From your experience, has the policy development process engaged key stakeholders meaningfully in the development process?

SOCIAL AND INSTITUTIONAL OWNERSHIP

Popular support / multisectoral support

Degree of participation

34. Describe the degree of participation of representatives of MARPs in the implementation and follow up of the HIV/AIDS national policy.

35. To what extent has the USG supported the positive and productive engagement of different sectors in the HIV epidemic response? (civil society, faith-based organizations, governments, donors, private sector, media)

36. Are you aware of specific contributions from key stakeholders that have been included in the National Strategic Plan?

37. Describe the degree of participation of representatives of MARPs in the implementation and follow up of the HIV/AIDS National Strategic Plan.

38. To what degree do you perceive PEPFAR support for these activities? (Before/After PEPFAR...contribution)

INSTITUTIONAL CAPACITY

Management/governance/HR capabilities (labor force)

39. What specific activities have been undertaken to increase the quality and level of participation in the policy making process at the national level?

40. Which sectors or stakeholder groups participate
    a. the most?
    b. The least?

41. What are the main challenges encountered in strengthening the capacity of the MARPs to participate in policy process?
42. What could PEPFAR do to improve this participation in the coming years?

MUTUAL ACCOUNTABILITY
Country Finances (ownership)

43. What components or provisions of national policy encourage or block improved "mutual accountability"?
    a. Improve
    b. Block

44. Explain the "mutual accountability" process implemented in order to follow up the efficiency of the budgeted investments in order to implement the National Policy, and to track its implementation.

REDUCTION OF CONTINUING COSTS / INCREASED EFFICIENCY
Sustainability (focus on long term chances for implementation/permanency)

45. How do you envision the success factors for sustainability?
46. What are the elements you see in your program?
47. What are the obstacles you see?
48. To what degree do you perceive PEPFAR support for these activities? Before/After PEPFAR?...contribution ???
49. What are the obstacles you are encountering for making the most out of PEPFAR´s support to Policy?
50. What do you suggest to PEPFAR to support sustainability and transition?

D) STRATEGIC INFORMATION

The PEPFAR regional strategy focuses on building capacity to improve the quality and access to information for strategic decision-making and program monitoring.

51. Are Policy, program and budget decisions made based on scientific evidence?
52. To what degree do you perceive PEPFAR support for these activities? (Before/After PEPFAR contribution)
53. What are the obstacles you are encountering for making the most out of PEPFAR´s support to SI?
54. Are there explicit policy level provisions to build capacity for SI in the following areas?
    e. National PMP for HIV/AIDS in the Policy.
    f. National PMP for HIV/AIDS Strategic.

g. National M&E Plan.

h. National Budget

55. How does your institution/organization participate in the M&E Plan?

56. Is the information generated by the National M&E Plan and/or National M&E System available at your organization/institution?

57. Is the information generated by the National M&E Plan and/or National M&E System used by your organization/institution for your own program needs?

58. What worked well in the development of the PMP process for these areas?

59. What were the obstacles encountered?

60. What would you recommend to PEPFAR for its next phase of assistance in this area?

INSTITUTIONAL CAPACITY

Management/governance/HR capabilities (labor force)

61. National: Describe specific capacity building activities focused on Monitoring and Evaluation interventions in HIV/AIDS:

    a. University Curriculum on Monitoring and Evaluation?

    b. Integrated Monitoring and Evaluation in public health system?

    c. Integrated Surveillance HIV/AIDS in public health system?

    d. Specific indicators in the M&E focused on MARPS (MSM, CSW, indigenous, transsexual)

62. Community Level: describe existing system for M&E activities:

63. To what degree has PEPFAR supported the development of the M&E activities (specific examples)?

64. How frequently does the National M&E System generate reports to follow up the indicators on the M&E National Plan?

65. Are these reports used to support decision making processes at the institutional level?

MUTUAL ACCOUNTABILITY

Country Finances (ownership)

Mutual accountability implies that there are explicit mechanisms for participation and monitoring responsibilities and implementation of all elements included in the National Strategic Plan (including Public Sector, civil society, media, private sector and other key stakeholder groups). For this to occur, each group must feel safe and able to access information and participate in its use for decision-making.

66. Describe how your organization participates in a "mutual accountability" role with relation to strategic information and other partners and stakeholders in the HIV/AIDS program.

67. What factors enable mutual accountability from your perspective?

68. What factors make it more difficult?

REDUCTION OF CONTINUING COSTS / INCREASED EFFICIENCY
Sustainability

69. How does your organization use SI to control programs costs and promote efficiency?

70. Are there specific kinds of information that are missing or inaccessible for this purpose?

71. What tools do you use to monitor costs and improve efficiency?

72. What do you suggest to PEPFAR to improve its impact in this area?

73. To what degree do you perceive PEPFAR support for these activities? (Before/After PEPFAR...contribution)

E) LESSONS LEARNED AND RECOMMENDATIONS

74. What would you say that are PEPFAR's main operational and/or management challenges going forward from your program perspective? (policy direction, planning, programming technical interventions, budget programming, financial allocation, monitoring and evaluation systems, information management systems, or others)?

75. Do you have specific suggestions or recommendations for PEPFAR as it designs the next phase (1015-2020) of its strategy in the region?

76. Since PEPFAR initiated and began to work, what have been the most significant changes that have occurred?

77. Are there any other comments/insights/questions you would like to share?

THANK YOU VERY MUCH FOR YOUR TIME AND INSIGHTS.
Do you have any questions for me?

ANNEX III. ON-LINE SURVEY INSTRUMENT

(PDF File)

ANNEX IV. PERSONS INTERVIEWED

No.	Country	Date	Name	Title	Institution
1	Nicaragua	06.03.13	Oscar Núñez*	COP	USAID / Prevensida
2	Nicaragua	06.03.13	Ivonne Gómez Pasquier*	Director	USAID/HCS
3	Nicaragua	06.03.13	Melissa McSwegin*	COP	RTI / Alianzas
4	Nicaragua	06.03.13	Carolina Arauz*	Resident Advisor	USAID/Deliver
5	Nicaragua	06.03.13	Anne Chistina Largaespada*	Country Representative	USAID/PASCA
6	Nicaragua	06.03.13	Jairo Núñez*	Logistics Advisor	USAID/Deliver
7	Nicaragua	06.03.13	Marta Carolina Ramírez*	Combined Prevention Project Official	PASMO
8	Nicaragua	06.03.13	Nancy Adilia Rodríguez*	Secretary	PDDH
9	Nicaragua	06.03.13	Dina Soza*	Technical Coordinator	USAID/PASCA
10	Nicaragua	06.03.13	Verónica Jacamo*	HIV Doctor	INSS-SR
11	Nicaragua	06.03.13	Olga Escobar Fonseca*	Director DSP-SR	INSS-SR
12	Nicaragua	06.03.13	José Alfonso Castaño*	DPAS	Ministerio de Gobernación -MIGOB
13	Nicaragua	06.03.13	Enrique Beteta*	General Secretary	MINSA
14	Nicaragua	06.03.13	Margarita Cortez Sandino*	Advocate	Ministerio de la Familia
15	Nicaragua	06.03.13	Francisco Maldonado*	Secretary	CONASIDA
16	Nicaragua	06.03.13	Mística Guerrero*	Vice-coordinator	Red Trans
17	Nicaragua	06.03.13	Félix O. Olivos López*	Department Chief MP	CMM/Ejército
18	Nicaragua	06.04.13	Kristhel Morales*	Promotor	Red Trans: ADESENI/Occidente
19	Nicaragua	06.04.13	Melvin Carrión*	Promotor	Red Trans: ADESENI/Occidente

No.	Country	Date	Name	Title	Institution
20	Nicaragua	06.04.13	Marlene Vivas*	Representative	Red Trans: ADESENI
21	Nicaragua	06.04.13	Cristabella Berrios Pérez*	Promotor	Red Trans: ADESENI
22	Nicaragua	06.04.13	Bárbara Quiroz*	Promotor	Red Trans: ADESENI
23	Nicaragua	06.04.13	Jesús Castellón*	R. M&E	Red Trans
24	Nicaragua	06.04.13	Gabriel Centeno*	Administrator	Red Trans
25	Nicaragua	06.04.13	Ludwiga Vega*	Coordinator	Red Trans: ANIT
26	Nicaragua	06.04.13	Artur Brown	Mission Director	USAID
27	Nicaragua	06.04.13	Charles Barclay	Deputy Chief of Mission	Embassy of the United States Nicaragua
28	Nicaragua	06.05.13	Fernando Campos	Sub Director	NicaSalud
29	Nicaragua	06.05.13	Stacy Gran	HIV/AIDS Program Manager	DoD HIV/AIDS Prevention Program
30	Nicaragua	06.05.13	Maria Germania Carrión	Executive Director	COSEP
31	Nicaragua	06.05.13	Mariela Terán	HIV Program Coordinator	COSEP
32	Nicaragua	06.05.13	Hugo René Pérez Díaz*	Vice-Dean, Medicine / Pharmacy	Universidad Nacional Autónoma de Nicaragua
33	Nicaragua	06.05.13	Aura Vanessa Paredes*	Coordinator Pract. Com.	Universidad Nacional Autónoma de Nicaragua - León
34	Nicaragua	06.05.13	Blanca López Monge*	Public Health Department Director	Universidad Nacional Autónoma de Nicaragua - León
35	Nicaragua	06.05.13	Denia Espinoza*	Faculty	Universidad Nacional Autónoma de Nicaragua - León
36	Nicaragua	06.05.13	Bayardo Hernández Socis*	Pediatric Director	Universidad Nacional Autónoma de Nicaragua -Managua
37	Nicaragua	06.05.13	María Elena Suárez*	Career Coordinator	Universidad Nacional Autónoma de Nicaragua -Managua
38	Nicaragua	06.05.13	Charles Wolleu Boudisa*	Public Relations Director	Universidad Nacional Autónoma de

No.	Country	Date	Name	Title	Institution
					Nicaragua -Managua
39	Nicaragua	06.05.13	Ramón Cáceres*	Chemistry-Pharmacy Coordinator	Universidad Nacional Autónoma de Nicaragua -Managua
40	Nicaragua	06.05.13	Rosa María Gonzalez*	Chemistry Department Director Sciences & Engineering School	Universidad Nacional Autónoma de Nicaragua -Managua
41	Nicaragua	06.05.13	Karla Molina*	Coordinator	Universidad Nacional Autónoma de Nicaragua -Managua
42	Nicaragua	06.05.13	Alma Lila Pastora*	Dean	UNICIT
43	Nicaragua	06.05.13	Gloria M. Uhen*	Faculty	Universidad Nacional Autónoma de Nicaragua Managua
44	Nicaragua	06.05.13	Flavia V. Palacios*	Faculty	Universidad Nacional Autónoma de Nicaragua Managua
45	Nicaragua	06.05.13	María Jesús Largaespada	Not indicated	Embassy of the Kingdom of the Netherlands, Managua
46	Nicaragua	06.05.13	Martha Karolina Ramírez,		PASMO
47	Nicaragua	06.06.13	Mariela Terán*	Coordinator	Proyecto VIH
48	Nicaragua	06.07.13	José Gómez	Resident Representative	PAHO
49	Nicaragua	06.07.13	Danny Murphy	Health Program Specialist	Peace Corps
50	Nicaragua	06.07.13	Ximena Matamoros	Program Manager	Peace Corps
51	Nicaragua	06.07.13	Paola Ferst	Health Volunteer	Peace Corps
52	Nicaragua	06.07.13	Talia Langman	Health Volunteer	Peace Corps
53	Nicaragua	06.07.13	Sara Dunbar	Health Volunteer	Peace Corps
54	Nicaragua	06.07.13	Norman Gutierrez	Executive Director	CEPRESI
55	Nicaragua	06.07.13	Salvador Reyes	Technical Coordinator	CEPRESI

No.	Country	Date	Name	Title	Institution
56	Honduras	06.10.13	Kellie Stewart*	Health Office Director	USAID
57	Honduras	06.10.13	Ritza Avilez de Briceño*	HIV/AIDS Project Management Specialist	USAID
58	Honduras	06.10.13	Rita Meza	Director	Central Laboratory
59	Honduras	06.10.13	Rolando Pinel*	Director	AS 1
60	Honduras	06.10.13	Luis Bolaños*	Director (a.i.)	Leadership Management and Governance (LMG)
61	Honduras	06.10.13	Mónica Palencia*	M&E Specialist	Leadership Management and Governance (LMG)
62	Honduras	06.10.13	Ana Lucía Rendón*	Resident Advisor	SCMS
63	Honduras	06.10.13	Juan Valladares*	Technical Advisor	SCMS
64	Honduras	06.11.13	Ricardo Avilés	Medical Officer	Medical Element, JTF-Bravo / Soto Cano Air Base
65	Honduras	06.11.13	Mirna Moreno*	Executive Director	Unidad de Extensión de Cobertura y Financiamiento
66	Honduras	06.11.13	Hary Galeas*	Financial Director	Unidad de Extensión de Cobertura y Financiamiento
67	Honduras	06.11.13	Cinthia Valladares	Executive Secretary	Secretariado Mecanismo Coordinador de País MCP
68	Honduras	06.12.13	Sandra Pinel	Director of Integrated Services Network	Secretaria de Salud
69	Honduras	06.12.13	Ivis Uvaldo Moreno, Capitán de Navío	Ex director	Dirección de Sanidad Militar de las Fuerzas Armadas de Honduras
70	Honduras	06.12.13	Javier Cálix*	Project Coordinator	Programa de Desarrollo Integral de la Mujer - PRODIM
71	Honduras	06.12.13	Ana Ruth Lezama*	Educator	Programa de Desarrollo Integral de la Mujer

No.	Country	Date	Name	Title	Institution
					- PRODIM
72	Honduras	06.12.13	Leonel Cruz*	Educator	Programa de Desarrollo Integral de la Mujer - PRODIM
73	Honduras	06.12.13	Martha Berrios*	Educator	Programa de Desarrollo Integral de la Mujer - PRODIM
74	Honduras	06.12.13	Five leaders from MTS*	MTS Leaders	Programa de Desarrollo Integral de la Mujer - PRODIM
75	Honduras	06.12.13	Maytee Paredes*	HIV Program Advisors Technical Surveillance	Programa de VIH/SESAL,
76	Honduras	06.12.13	Marco Antonio Urquía*	Head of National STI Program	SESAL
77	Honduras	06.12.13	Justa Urbina	Decentralizaed Management Unit Director UGD/SESAL	Secretaría de Salud
78	Honduras	06.13.13	Elda Reyes Savaya	Technician	DGC / SESAL
79	Honduras	06.13.13	Mario Chiesa Bahady	Technician	DGC / SESAL
80	Honduras	06.13.13	Javio J. Salgado E	Medical Specialist	DGC / SESAL
81	Honduras	06.13.13	Piña Mónica Boquín	Technical Advisor	DGC / SESAL
82	Honduras	06.13.13	Javier Alcides Martínez	Head of Primary Care in Secretariat of Health	DAPS / SESAL
83	Honduras	06.13.13	Carmen Sevilla H.	Technician	DAPS, SESAL
84	Honduras	06.13.13	Rosario Cabañas	Director	Departamento de Garantía Calidad
85	Honduras	06.13.13	Fredy Tinajeros	Not indicated	Tephinet
86	Honduras	06.13.13	Karla Zepeda	Technical Director	Global Community
87	Honduras / San Pedro Sula	06.14.13	Amanda B. Sevilla H.	Coordinator	CSMPA, Clínica Visits

No.	Country	Date	Name	Title	Institution
88	Honduras / San Pedro Sula	06.14.13	César Augusto Cárcamo	Choloma Regional Coordinator	CASM
89	Honduras / San Pedro Sula	06.14.13	Denis Martinez	Director	National Association of People Living with HIV AIDS ASONAPVSIDAH
90	Honduras / San Pedro Sula	06.14.13	Concepción Cáceres,	NGO Director and Project Coordinator	Asociación Hondureña Mujer y Familia (AHMF)
91	Honduras / San Pedro Sula	06.14.13	Claudia Spellmant	Director	Colectivo Unidad Color Rosa.
92	Honduras / San Pedro Sula	06.14.13	Gabriela Redondo	Coordinator	Colectivo Unidad Color Rosa.
93	Honduras / San Pedro Sula	06.14.13	Fernanda Vallejo	Coordinator	Colectivo Unidad Color Rosa.
94	Honduras / San Pedro Sula	06.14.13	Viena Nicole Ávila	Legal Advisor	Colectivo Unidad Color Rosa.
95	Honduras / San Pedro Sula	06.14.13	Jaime Caballero V.	Head of Service Delivery	Control de gestión, Secretaria de Salud.
96	Belize	06.18.13 *	Vinai K. Thummalapally	US Ambassador & DCM in Belize	US Embassy
97	Belize	06.18.13	Jessica Pfleider	Political Officer	US Embassy

No.	Country	Date	Name	Title	Institution
		*			
98	Belize	06.18.13 *	Margaret D. Hawthrone	Deputy Chief of Mission	DCM
99	Belize	06.18.13	Asad J. Magaña	Monitoring and Evaluation officer	United Nations Development Programme
100	Belize	06.18.13	Marvin Manzanero,	Director	National TB, HIV/AIDS and other STIs Programme, MOH
101	Belize	06.19.13	Guadelupe Huitron*	Director	PASMO
102	Belize	06.19.13	Eric Castellanos*	Ex-Director	C-Net
103	Belize	06.19.13	Deysi Mendez	Director	Capacity
104	Belize	06.19.13	Adele Catzim	Not indicated	PASCA
105	Belize	06.19.13	Lucia Merino	Chief of Party – Regional	PASCA
106	Belize	06.19.13	Martin Cuellar*	Executive Director	National AIDS Commission
107	Belize	06.19.13	Elío Cabanas*	Communications & Programs Officer	National AIDS commission Secretariat
108	Belize	06.19.13	Caleb Orozco,	Executive President	United Belize Advocacy Movement (UNIBAM)
109	Belize	06.20.13	Elfryn Reyes	Force Medical Officer	Belizean Defense Force
110	Guatemala	05.20.13	Sandra Juárez*	Lab Advisor	CDC-CAR
111	Guatemala	05.20.13	Diana Forno*	TB / HIV Specialist	CDC-CAR
112	Guatemala	05.20.13	Jode Baker*	DGHA Deputy Director M&E	CDC-CAR-DGHA
113	Guatemala	05.20.13	Tom Divincenzo*	Economist	USAID
114	Guatemala	05.20.13	Giovanni Meléndez*	HIV Prevention Specialist	Health and Education Office Central America HIV/AIDS Regional Program

No.	Country	Date	Name	Title	Institution
					USAID
115	Guatemala	05.20.13	Sanny Northbrook*	DCP Director Science & Program	CDC-CAR
116	Guatemala	05.20.13	Beatriz Hernández*	Epidemiologist	CDC-CDR
117	Guatemala	05.20.13	Rodrigo Boccanera*	Coordinator	PEPFAR
118	Guatemala	05.20.13	Ángel López*	M&E	USAID
119	Guatemala	05.20.13	Helmuth Castro*	HIV Coordinator for CA / Office Global Health and HIV	Peace Corps Central America
120	Guatemala	06.21.13	Delia Marie Smith,	Director	Proyecto Vida
121	Guatemala	06.21.13	Jorge López	Executive Director	Oasis
122	Guatemala	06.24.13	Dory Lucas	Technical Secretary	CCM
123	Guatemala	06.24.13	Iris López	Coordinator	CONASIDA (NAC)
124	Guatemala	06.24.13	Víctor Eduardo Mendoza Arriaga	Coronel, Doctor and Surgeon (President of COPRECOS)	Sanidad Militar, Ejercito de Guatemala
125	Guatemala	06.25.13	Joel Ambrosio Arrecis	President of the Board	Asociación Vida
126	Guatemala	06.25.13	Fernando Cano Flores*	Monitoring & Evaluation	UNAIDS
127	Guatemala	06.25.13	Dr. Enrique Zelaya*	UNAIDS Director	UNAIDS
128	Guatemala	06.25.13	Karelia Ramos*	Human Rights / VS	UNFPA
129	Guatemala	06.25.13	Mariana Manzur*	RP Hivos - FM / HIV/AIDS Principal Recipient Program Director	HIVOS
130	Guatemala	06.25.13	Rodrigo Pascal	Human rights & Gender Advisor	UNAIDS
131	Guatemala	06.25.13	Sergio Aguilar*	HIV Component	PAHO
132	Guatemala	06.25.13	Lucrecia Méndez*	HIV/Aids Program	UNDP

No.	Country	Date	Name	Title	Institution
				Implementation Consultant	
133	Guatemala	06.25.13	Sra. Tere Ligorria	Director, Chief of Party	USAID/Alianzas Multisectoriales Alianzas Guatemala; RTI (Research Triangle Institute)
134	Guatemala	06.26.13	Yadira Villaseñor*	Regional Executive Director	The Central America Capacity Project/Programa Regional (Comprehensive Care in C.A.) IntraHealth International Inc.
135	Guatemala	06.26.13	Karla Oliva*	Not indicated	Central America and Mexico HIV/AIDS Program: Combination Prevention for MARPSs. Population Services Intl. PASMO/PSI (REGIONAL / BILATERAL)
136	Guatemala	06.26.13	Rocío González*	Not indicated	Peace Corps Guatemala
137	Guatemala	06.26.13	María Elena Guardado*	Central America Technical Director, Senior Epidemiologist	TEPHINET
138	Guatemala	06.26.13	Luis R. Santizo*	M&E	TEPHINET
139	Guatemala	06.26.13	Delmy Pajares de Guinea*	Resident Logistics Advisor	SCMS - Supply Chain Management Systems; Partnership for Supply Chain Management (JSI - MSH, etc.)
140	Guatemala	06.26.13	Edgar Orantes *	VIH Manager	PASMO Guatemala
141	Guatemala	06.26.13	Zonia Aguilar*	Monitoring & Evaluation Coordinator	USAID/PASCA
142	Guatemala	06.26.13	Edna Edith García *	Technical Advisor STI & HIV Specialist	APROFAM
143	Guatemala	06.26.13	Pedro Rosales*	M&E	Proyecto VIH, UVG
144	Guatemala	06.28.13	Carlos Romero Prieto	Executive Secretary	REDNAS
145	Guatemala	07.01.13	Bruce Williamson	Deputy Chief of Misión	Embassy Of The United States Guatemala

No.	Country	Date	Name	Title	Institution
146	Guatemala	07.02.13	Julie Boccanera	Office of Health & Education	USAID Guatemala
147	Guatemala	07.02.13	Lucrecia Castillo	Program Manager	USAID
148	Guatemala	07.02.13	Nelson Arboleda	Global AIDS Program Central America Director	CDC
149	Panamá**	06.27.13	Aurelio Núñez	Program Head	Programa Nacional ITS-VIH y Sida
150	Panamá**	06.27.13	Miguel Sánchez	Director	Grupo Génesis Panamá
151	Panamá**	06.27.13	Dulce Ana Torres	Director	Mujeres con Dignidad y Derechos
152	Panamá**	06.27.13	Ricardo Beteta	Executive Director	Asociación Hombres y Mujeres Nuevos de Panamá
153	Costa Rica**	06.28.13	Nubia Ordóñez	Coordinator	Asociación Sala
154	Costa Rica**	06.28.13	Ana Cecilia Morice	Technical Director	INCIENSA
155	Costa Rica**	06.28.13	Daria Suárez Rehagg,	Director	Centro de Investigación y Promoción para América Central de Derechos Humanos –CIPAC-
156	Costa Rica**	06.28.13	Francisco Madrigal	Not indicated	Centro de Investigación y Promoción para América Central de Derechos Humanos –CIPAC-
157	Costa Rica**	07.01.13	Teresita Solano	HIV and ETS Surveillance	MOH
158	Costa Rica**	07.01.13	Manuel Agüero	President	Asociación Movimiento de Apoyo hacia una Nueva Universalidad – MANÚ-
159	El Salvador**	07.05.13	Ana Isabel Nieto Gómez	National HIV/AIDS/STI Program Coordinator	Ministerio de Salud
160	El	07.05.13	Mónica Linares	Executive Director	ASPIDH ARCOIRIS HSH y Transversti

No.	Country	Date	Name	Title	Institution
	Salvador**				
161	El Salvador**	07.05.13	William Hernández	Executive Director	Asociación Entre Amigos
162	El Salvador**	07.08.13	Francisco Carrillo	Secretary	Conasida

*Participated in a group interview.

** Electronic interviews: telephone or Skype

ANNEX V. DOCUMENTS REVIEWED

AG06188S04 Convención interamericana contra el racismo, la discriminación racial y otras formas de intolerancia social. Organization of American States -OAS- Guatemala, June 2013

Central America Regional Partnership Framework (2010) March 2010

Central American Regional Partnership Framework Implementation Plan (2010) "A five year implementation plan to support the governments and people of Central America to respond to the impacts of the HIV epidemic" October 2010 COMISCA-USG

CONISIDA "Informe Nacional sobre los avances en la lucha contra el SIDA" El Salvador, Decreto número 56-2010

Estrada, John "Modelos de Prevención en la lucha contra el SIDA" in: Acta Bioethica 2006 (12) 1 p.91-100

MEGAS/NASA Studies (Medicion de Gastos, Studies of HIV/AIDS expenditures in the region supported by USAID/PASCA)

Palen, John et al "PEPFAR, health system strengthening and promoting sustainability and country ownership" Journal of Acquired Immunodeficiency Syndrome 2012 ; 60S (113-119)

PEPFAR CA Framework PMP, 2010

PEPFAR Central America Regional Operational Plans (ROPs) 2010-2013

ANNEX VI. CONSULTANT CONFLICT OF INTEREST FORMS

(PDF Forms)

For more information, please visit
http://www.ghtechproject.com/resources

GH Tech Bridge 4 Project
1725 Eye Street NW, Suite 300
Washington, DC 20006
Phone: (202) 349-3900
Fax: (202) 349-3915
www.ghtechproject.com