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INFORMATION MEMO FOR AMBASSADOR LUIS ARREAGA, GUATEMALA AND CHARGÉ D'AFFAIRES ERIC KHANT, JAMAICA, WESTERN HEMISPHERE

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2019 PEPFAR Planned Allocation and Strategic Direction

We are grateful to you, Ambassador Arreaga and Chargé Khant, for your leadership of PEPFAR's Western Hemisphere Regional implementation and host country government engagement to enhance program impact. We are thankful for your attention to the continued need for core policy adoption/implementation and the importance of holding partners accountable for performance, improved outcomes, and greater impact. Finally, we are appreciative of your talented and dedicated PEPFAR staff across the region. We look forward to working together across agencies to ensure the most effective and efficient use of taxpayer dollars. Since FY 2004, PEPFAR has invested $148,484,893 in Central America and $144,666,994 in the Caribbean, totaling $293,151,887 invested across both regions.

PEPFAR continues to refine its organization to align operations with the PEPFAR 3.0 strategy of "focusing resources and leveraging finances to address the most vulnerable populations." Seeking innovative and more efficient ways to fight the HIV/AIDS pandemic, PEPFAR has shifted the management of our HIV/AIDS response in the previously designated STAR (Strategic Alignment for Results) operating units to an expanded regional model. The regional realignment planning began in FY 2018, when a regionalization meeting was held in September 2018 in Atlanta, GA. The plan for regionalization was agreed upon, progress towards regionalization began, and implementation of that plan will continue throughout FY 2019 for full operationalization at the start of FY 2020. The goal is to increase the sharing of resources, administrative functions and expertise across operating units (OUs) in the region, to more efficiently and effectively combat HIV/AIDS in regions where commonalities exist among epidemics (e.g. epidemics concentrated in key populations with systemic stigma and discrimination issues).

The regional realignment has resulted in the Caribbean, Central America, and Brazil transitioning into the Western Hemisphere operating unit. In this new model, Brazil now reports through Central America. Regional realignment efforts will not alter ROP 2018/FY 2019 implementation, monitoring or reporting requirements.

Countries need to adopt S/GAC innovative approaches and World Health Organization policy guidance, or PEPFAR funding will be at risk for those that fail to make the necessary policy shifts. The Western Hemisphere Region has fallen behind other countries receiving PEPFAR support, and programmatic changes need to be urgently made. S/GAC developed models in the past to show local governments how to best support key populations (KP), with the intent that the models would be adopted and implemented by local governments. If it is determined that the technical assistance to government model is not serving key populations to the extent necessary to reach epidemic control in the region, a change strategies should be considered. The Western Hemisphere Region is encouraged to explore alternative KP-friendly models that can meet the population's needs, possibly through more direct service delivery via non-governmental community based and/or peer led services. Moving forward, technical assistance must evolve in order to achieve improved outcomes and shift the trajectory for the region.

In addition to political will, a key component to successful programming in the region requires a whole of government approach. The success of one agency means very little if other agencies are not successful, as it is an indictment of the whole team. In the Caribbean, interagency tension and lack of ability to work effectively together continues to hinder PEPFAR's impact, and it must be addressed as funding is at risk. The Caribbean is encouraged to learn from Central America and their embrace of a one-PEPFAR approach and their seamless work across agencies. Region-wide discussions and increasing technical exchanges between the Central America and the Caribbean will benefit the entire region. We look forward to working with and learning from you and your teams as we move together toward this exciting future.

Regional Operational Plan 2019

We have noted the following key successes and specific areas of concern across the region:

While there are distinct differences in how Central America and the Caribbean operate, the two regions comprise very similar key population epidemics and both regions struggle with stigma and discrimination issues. Though the regions have experienced different successes and struggles, there is a lot to learn from each other and the collaboration to date has been promising, with the teams participating in each other's POART calls and expressing interest in increasing technical exchanges. Policy changes have been slow but both regions have now adopted or are in the process of adopting major changes that are important to achieving epidemic control, including Test & Start, transition to TLD treatment regimens, and self-testing. Both regions need to meet with partners on a quarterly basis in an interagency way. Teams must share the data, look at the data together, and revise programs accordingly.

Central America and Brazil: Central America's overall performance has been promising, and both HHS/CDC and USAID have exceeded their FY 2018 treatment targets. Central America is making great progress with recency testing and working with host governments to adopt other innovations.

However, countries in Central America are lagging behind in adoption of key policies and consistent implementation. Teams must work diplomatically to advocate for policy adoption and effective implementation. It is particularly important to expedite the transition to TLD/Dolutegravir regimens given concerns of drug resistance.

In terms of progress towards the 90-90-90 goals, substantial gaps remain and vary by country. In Nicaragua, 90% know their HIV status but only 53% are on treatment and only 44% are virally suppressed. Viral suppression numbers are concerning in Nicaragua, Panama, and Honduras. Overall viral suppression for the region is only at 60%.

Alarming rates of drug resistance need to be addressed and the TLD transition needs to be fully adopted and implemented throughout the region. According to Pandrug Resistance (PDR) survey results, Guatemala and Nicaragua both have prevalence of PDR greater than 10% (mainly driven by NNRTI resistance), and Honduras is struggling with one of the highest rates of drug resistance among countries that have completed nationally representative studies. This is another critical reason why the region must move to TLD immediately.

Central America is not reaching their TX_TB and TB_PREV targets for a variety reasons (e.g., in Honduras and Panama, national guidelines for the implementation of IPT in HIV patients include only newly diagnosed HIV patients; during Q1-Q2 FY 2018, El Salvador experienced a shortage of Isoniazid; the start and end dates of the TPI for HIV patients are not recorded systematically in the TB screening form; limited participation of the HIV clinic specialists to carry out TB screening in HIV patients).

Country-specific highlights:

- Guatemala (hub) – Highest disease burden in Central America (not including Brazil) and fewest numbers who know their status; No progress in first 90; Linkage to care remains a challenge.
- El Salvador – Fewest on treatment who know their status; Improvements in viral load suppression.
- Nicaragua – Political instability; 90% know their status but the country are lagging with getting them on treatment.
- Honduras – Suboptimal coverage and monitoring of viral load compliance per national guidelines; Reports of high level of HIV drug resistance. Results, released in October 2018, are the highest among countries who have completed nationally representative studies; Drug resistance needs to be better understood and addressed; TLD transition needs to be expedited.
- Panama – Gaps influenced by influx of migrants; Reports of hotspot in indigenous community; Low linkage and treatment initiation rates in PEPFAR-supported KP clinics; Panama has recently entered a new bracket and no longer qualifies for reduced drug rates.

- Brazil – High disease burden; Need to address a large cohort of untreated, but overall doing very well; conducting innovative pilots that can serve as models for the rest of region.

Caribbean: Over the past year, the regional hub for the Caribbean was transitioned from Barbados to Jamaica, given Jamaica's disease burden and higher number of new infections. PEPFAR has the ability to make the largest impact in the region in Jamaica. Flexibility of the Front Offices and the staff in the region during this transition and physical move was very much appreciated.

In general, countries in the Caribbean are also lagging behind on adoption of key policies and consistent implementation. Teams are encouraged to continue working diplomatically to advocate for policy adoption and effective implementation. It is particularly important to expedite the transition to TLD/Dolutegravir regimens given concerns of drug resistance. It is concerning that Jamaica is refusing to move forward with prescribing TLD for all women of childbearing age until the MOH receives official guidance from the World Health Organization.

The Caribbean is underperforming, mainly due to ineffective program implementation in Jamaica. Jamaica is the driver of the region's underperformance.

As already planned, some countries in the region are approaching the closeout phase and activities will be transitioned to local entities as outlined below.

Country-specific highlights:

- Jamaica (hub) – see below.
- Trinidad and Tobago – Big turnaround; Recent strong performance; Effective bilateral engagement with government; Minister of Health committed to implementing "Treat All".
- Suriname – Closeout scheduled for September 2019.
- Guyana – Closeout scheduled for September 2020.
- Barbados – Former hub; State-of-the-art lab which will continue servicing the region after closeout; Closeout scheduled for September 2020.

Jamaica used to be the leader of the Caribbean in their HIV response, but more recent analyses of the clinical cascade have shown that Jamaica has fallen behind. Jamaica is the priority country in the Caribbean and receives the majority of the regional program funds. The program is struggling to meet targets, which appears to parallel the state of the national HIV response. Jamaica has considerable distance to go in terms of reaching the 90-90-90 targets (cascade is 76-45-51). Of the estimated 34,000 people living with HIV in Jamaica, less than 12,000 are on treatment. While a high number of individuals know their status, too few are on life-saving treatment and viral suppression rates are low (51%). Over-testing is also common in Jamaica.

There are an estimated 7,000 patients lost to follow-up in Jamaica, and failure to make progress in returning them to care has contributed to the region's significant underperformance in achieving treatment targets. The PEPFAR team has been given specific direction (see below) on changes to which USG agencies will cover which regions moving forward in the loss-to-follow up (LTFU) campaign and have been given expectations on acceleration of LTFU activities to be completed by April. Beyond changes to this campaign, additional shifts are urgently needed in Jamaica to save lives.

PEPFAR pivoted the program to Jamaica several years ago to improve the 90/90/90 cascade for Jamaica. Globally, program practices have moved leaps and bounds; however, the Jamaica program has not fully adapted effective and efficient strategies to experience this same progress. The region needs to work in a drastically different way in order to reach epidemic control and it is critical to change practice now in order to accelerate impact and not wait until ROP 2019.

We will need to review the entire program in ROP 2019, ensuring all agency knowledge and strengths are brought to the table for shared impact. For now, as discussed with agency leads, the following changes took place in December 2018:

- HRSA will work in the sites in the North East and West of Jamaica to complete the LTFU activities (2,232 LTFU to resolve). HRSA will support these sites comprehensively across the cascade and will be the focal point within USG to coordinate other USG input from training, clinical mentoring, etc.
- CDC will operate in the sites in the South and Southeast (4,522 LTFU to resolve). CDC will support these sites comprehensively across the cascade and will be the focal point within USG to coordinate other USG input for training, clinical mentoring, etc.
- In cases where HRSA has hired staff for LTFU in some of these sites or parishes, there should be a seamless transition of staff to CDC support.
- USAID will continue to support the MoH through the Government-to-Government (G-to-G) agreement at the parish level and all sites. There may be additional staff brought on by CDC or HRSA to complete the LTFU activities.
- HRSA and USAID will continue to support Jamaica AIDS Support for Life (JASL) to actively and continuously resolve LTFU cases at their three treatment sites.

It is expected that all agencies will work in an interagency manner to troubleshoot activities in real-time. While recent results reported by HRSA are encouraging, progress needs to be accelerated and LTFU activities must be completed before the April 2019 planning meeting in Washington, D.C. CDC needs to have 80% of LTFU resolved by April 2019 in their sites.

In Jamaica, the Ministry of Health, funded by USAID, is not adequately supporting targeted MSM testing. Unnecessary testing of Female Sex Workers (FSW) is resulting in low yields. Moving forward, no resources should be spent on testing FSWs. Deeply rooted and institutionalized stigma and discrimination in Jamaica continue to make controlling the MSM epidemic difficult. There needs to be acceptance from the Government of Jamaica that the country is experiencing a MSM epidemic and needs to keep up with innovative strategies proven effective in other PEPFAR countries in order to achieve epidemic control. There is a new

Permanent Secretary of the MOH and we are hopeful the MOH will be more open to adoption and implementation of key policies, as it is critical to embrace new approaches and interventions.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) total planning level for Western Hemisphere for the 2019 Regional Operational Plan (ROP 2019) is **$24,285,830** for Central American countries and Brazil, and **$13,714,170** for Caribbean countries, inclusive of all new funding accounts and applied pipeline.

The $13,714,170 planning level for Caribbean countries represents a necessary reduction in funding. The public health system in Jamaica is not effectively retaining and virally suppressing HIV-positive KPs. It is time to identify an alternative way of working to serve the population and have increased impact. **Additional funding may be available contingent on strong performance supported by data; there needs to be demonstrated improvement and effective program implementation between now and April 2019.** The program will move toward non-public health delivery. Scale-up of NGOs such as JASL, which is making promising progress in Jamaica, should be considered.

A new program needs to be designed for Jamaica, as there is a need for clinical treatment services that serve the needs of key populations. This redesign needs to be KP-friendly and deliver services to support public health systems. There needs to be increased emphasis on retaining and virally suppressing patients. In order to see a different scale-up strategy with government, new ways of engagement with the MOH in the public health sector and non-public health sector should be explored. As the program shifts to other mechanisms that allow for a patient-centered approach, different types of models with updated practices should be pursued (e.g., models similar to Ryan White). One different approach of engagement could be to establish a few MSM friendly hubs for testing and treatment on the island. Again, improved interagency coordination and a whole of government approach are necessary.

While Central America and the Caribbean have similar approaches to addressing KP in some ways, in other ways the two regions operate quite differently. During the redesign of the Jamaica program, it is important to look across the region in strategic ways to determine what makes Central America a high performer while Caribbean has been underperforming.

If you have questions about the priorities and guidance laid out in this letter, please contact your Chairs and Program Manager. S/GAC is continually grateful for your team's work on the PEPFAR program, helping us to move towards an AIDS-free generation by supporting the HIV response in Western Hemisphere.

APPENDICES:

1. **ROP 2019 PLANNING LEVEL**
2. **ROP 2019 BUDGETARY REQUIREMENTS & GUIDANCE**
3. **PAST PERFORMANCE**
4. **ROP 2019 DIRECTIVES**

APPENDIX 1: ROP 2019 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the FY 2018 Q4 POART and performance information, the total COP 2019 planning level is estimated to be comprised as follows:

Table 1. ROP 2019 Budget

Western Hemisphere Regional TOTAL ROP 2019 PLANNING LEVEL: $38,000,000	
Total ROP 2019 New Funding (of which, Caribbean Region)	$10,065,437
Total ROP 2019 New Funding (of which, Central America Region)	$11,351,267
Total Applied Pipeline	$16,583,295
Of which, Caribbean Region	$3,648,733
Of which, Central America Region	$12,934,563
Caribbean Region Total	**$13,714,170**
Central America Region Total	**$24,285,830**
Total Base Budget for ROP 2018 Implementation	**$ 38,000,000**
****Applied pipeline by agency is provided in chart below**	

Table 2. Applied Pipeline

WESTERN HEMISPHERE ROP 2018 APPLIED PIPELINE BY AGENCY	
Total Applied Pipeline	$16,583,295
HHS/CDC	$2,567,354
HHS/HRSA	-
State	$565,504
State/WHA	$50,000
USAID	$13,400,437

All planning levels are subject to further adjustment, **based upon appropriations**, further analysis determining the availability of excessive pipeline, and other developments during the course of ROP 2018 implementation and the ROP 2019 review process. The total spend in the implementation of ROP 2019 (FY 2020) may not exceed the total ROP 2019 planning level of $38,000,000.

APPENDIX 2: ROP 2019 BUDGETARY REQUIREMENTS

Table 3. ROP 2019 Earmarks

WESTERN HEMISPHERE REGIONAL ROP 2019 EARMARK REQUIREMENTS	
Care and Treatment (C&T), Of which Caribbean Region	$2,156,741
% of base funds allocated to C&T	19%
Care and Treatment (C&T), Of which Central America Region	$2,315,051
% of base funds allocated to C&T	23%
HKID, of which Caribbean Regional	$4,541
Gender Based Violence (GBV)	$1,699,490

Care and Treatment: If there is no adjustment to the ROP 2019 new funding level due to an adjustment in applied pipeline, Western Hemisphere's minimum requirement for the care and treatment earmark is reflected in the chart above. Your care and treatment requirement is calculated as the sum of total new FY 2019 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS budget codes, 30% of the total funding programmed to the MTCT budget code, 80% of the total funding programmed to the HLAB budget code, and 30% of the total funding programmed to the HVCT budget code. This minimum care and treatment earmark has been derived based upon a requirement that your country programs a minimum of 23% (Central America) and 19% (Caribbean) of all **new FY 2019 Base Funds** to care and treatment of people living with HIV.

Orphans and Vulnerable Children (OVC): Western Hemisphere's minimum requirement for the OVC earmark is $7,741 in the Caribbean. Your OVC earmark is calculated as the sum of total **new FY 2019 funding** programmed to the HKID and HVAB budget codes, 25% of the total funding programmed to the HVOP budget code, and 25% of the total funding programmed to the MTCT budget code.

Gender Based Violence (GBV): Western Hemisphere's ROP 2019 minimum requirement for the GBV earmark is reflected in the chart above. Your GBV earmark requirement is calculated as the total **new FY 2019** funding programmed to the GBV crosscutting code. Your ROP 2019 earmark is derived by using the final ROP 2018 GBV earmark allocation as a baseline. The ROP 2019 planned level of new FY 2019 funds for GBV can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-

direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY 2020, and must meet 40% by FY 2019. Each region has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each Western Hemisphere agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY 2020 as appropriate through their ROP 2019 submission.

ROP 2019 Applied Pipeline

All agencies in Western Hemisphere should hold a 4-month pipeline at the end of ROP 2019 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending ROP 2018 implementation (end of FY 2019) with a pipeline in excess of 4 months is required to apply this excessive pipeline to ROP 2019, decreasing the new funding amount to stay within the planning level.

The Applied Pipeline amount of $16,583,295 given by S/GAC as a part of the ROP 2019 planning level has been calculated to reflect the projected excessive pipeline as of the beginning of the ROP 2019 implementation cycle (FY 2020), and is the minimum amount that Western Hemisphere must apply as pipeline in the ROP 2019 submission. The distribution of new base funds and Applied Pipeline was calculated to ensure 4 months of pipeline remains with mechanisms, based upon the financial data submitted for the FY 2018 Q4 Obligation and Outlay and FY 2018 End of Fiscal Year (EOFY) reports. Expired funds, funds on expired mechanisms and projected FY 2019 outlays as submitted in the EOFY report were all taken into consideration to inform the projected excessive pipeline and the required ROP 2019 applied pipeline amount.

Unliquidated obligations on closed mechanisms identified in the FY 2018 EOFY report should be de-obligated in a timely manner. This will continue to be monitored throughout FY 2019 (ROP 2018 implementation) and into ROP 2019.

APPENDIX 3: PAST PERFORMANCE TRENDS

Table 4. ROP 2017/ FY 2018 Outlays versus Approved Budget

Row Labels	Sum of Approved COP 2017 Planning Level	Sum of Total FY 2018 Outlays	Sum of Over/Under Outlays
Central America	**$ 21,541,744**	**$ 16,610,109**	**$ (4,931,635)**
HHS/CDC	$ 7,365,246	$ 7,189,885	$ (175,361)
State	$ 360,070	$ 144,021	$ (216,049)
USAID	$ 13,816,428	$ 9,276,203	$ (4,540,225)

*Brazil not included

Row Labels	Sum of Approved COP 2017 Planning Level	Sum of Total FY 2018 Outlays	Sum of Over/Under Outlays
Caribbean	**$ 26,401,975**	**$ 21,155,002**	**$ (5,246,973)**
HHS/CDC	$ 10,443,241	$ 7,716,654	$ (2,726,587)
HHS/HRSA	$ 1,807,200	$ 2,026,003	$ 218,803
State	$ 447,500	$ -	$ (447,500)
State/WHA	$ -	$ -	$ -
USAID	$ 13,704,034	$ 11,412,345	$ (2,291,689)

Caribbean's total FY 2018 outlay level of $21,155,002 is under your approved spend level of $26,401,975 (ROP 2017 budget). Within this total, HHS, USAID, and State spent below their approved FY 2018 budgets. The following Implementing Mechanisms also outlaid at least 125% in excess of their ROP 2017 approved planning level.

Table 5. IP FY 2018 Over-Outlays

Caribbean

Mech ID	Prime Partner	Funding Agency	COP17/FY18 Budget (New funding + Pipeline + Central)	Actual FY18 Outlays ($)	Over/Under FY18 Outlays (Actual $ - Total COP17 Budget $)
13335	African Field Epidemiology Network	HHS/CDC	$ -	$ 156,964	$ 156,964
17469	Abt Associates	USAID	$ 559,184	$ 1,143,439	$ 584,225
17810	Management Sciences for Health	USAID	$ -	$ 107,321	$ 107,321
17902	Palladium Group	USAID	$ 729,928	$ 1,087,155	$ 357,227
18187	John Snow Inc. (JSI)	USAID	$ 1,100,000	$ 1,834,893	$ 734,893

Central America's total FY 2018 outlay level of $16,610,109 is under your approved spend level of $21,541,744 (ROP 2017 budget). Within this total, HHS, USAID, and State spent below their approved FY 2018 budgets. The following Implementing Mechanisms also outlaid at least 125% in excess of their ROP17 approved planning level.

Central America

Mech ID	Prime Partner	Funding Agency	COP17/FY18 Budget (New funding + Pipeline + Central)	Actual FY18 Outlays ($)	Over/Under FY18 Outlays (Actual $ - Total COP17 Budget $)
16725	University Research Corporation, LLC	USAID	$ -	$ 92,367	$ 92,367

Brazil's outlays were unable to be calculated given lack of available financial data and reporting requirements for FY 2018.

Table 6. ROP 2017/ FY 2018 Results versus Targets*

** Financial and target performance data not a one-to-one correlation as program classification expenditures encompass more than those towards indicator/target presented.*

Central America[b]

Agency	Indicator	FY18 Target	FY18 Result	% Achievement	Program Classification	FY18 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	10,839	**17,615**	162%	HTS	$966,708	100%
	HTS_TST_POS	759	**1,170**	154%			
	TX_NEW	803	**1,514**	189%	C&T	$1,108,894	45%
	TX_CURR	689	**665**	97%			
				Above Site Programs		$1,908,560	
				Program Management		$1,627,188	
USAID	HTS_TST	10,220	**11,401**	111%	HTS	$692,302	100%
	HTS_TST_POS	590	**993**	168%			
	TX_NEW	1,224	**3,253**	266%	C&T	$2,260,152	38%
	TX_CURR	35,592	**38,414**	108%			
				Above Site Programs		$1,855,262	
				Program Management		$2,746,381	

[b]Brazil not included

Caribbean

Agency	Indicator	FY18 Target	FY18 Result	% Achievement	Program Classification	FY18 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	2,405	2298	95%	HTS	$294,335	33%
	HTS_TST_POS	72	73	101%			
	TX_NEW	1,245	1,380	111%	C&T	$1,373,869	50%
	TX_CURR	5,086	4,165	82%			
				Above Site Programs		$2,825,066	
				Program Management		$1,061,670	
HHS/HRSA	HTS_TST						
	HTS_TST_POS						
	TX_NEW					$1,383,163	100%
	TX_CURR	20,726	17,643	85%			
				Above Site Programs		$77,813	
				Program Management		$505,802	
USAID	HTS_TST	10,295	10,668	103%	HTS	$3,033,324	62%
	HTS_TST_POS	904	454	50%			
	TX_NEW	2,250	1,504	67%	C&T	$2,597,365	51%
	TX_CURR	13,200	9,512	72%			
				Above Site Programs		$1,926,535	
				Program Management		$2,994,907	

ROP 2017/ FY 2018 Performance

Central America

No major partner management issues have been observed in Central America and overall performance has been strong. Regular engagement with partners contributes to strong partner performance. Central America under-outlayed by approximately $5 million, driven largely by political instability in Nicaragua and USG procurement delays.

Caribbean

The Caribbean had three major over-outlays with unsatisfactory explanations. The mechanisms with over-outlays are Advancing Partners and Communities Project (Prime Partner John Snow Inc), Health Finance and Governance (Prime Partner Abt Associates), and Health Policy Plus (Prime Partner Palladium Group), all funded by USAID.

Poor partner management has led to regional underperformance. Moving forward, closer oversight and regular engagement with partners is urgently required. At a minimum, Caribbean needs to conduct quarterly meetings with partners in an interagency way.

APPENDIX 4: ROP 2019 DIRECTIVES

ROP 2019 (FY 2020) Targets

In this year's ROP, each country within the region should continue to support HIV patients on treatment unless transitioned to government. This should be the minimum current on ART.

ROP 2019 Minimum Requirements

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements no later than the beginning of ROP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs. Failure to meet any of these requirements by FY 2020 will result in reductions to the Western Hemisphere budget.

Table 8. Minimum Requirements

Minimum Requirement	Western Hemisphere Specific Guidance
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.	Central America: Aside from Nicaragua and El Salvador, the region has adopted Test and Start policies. A USG focus on supply chain and ARV procurement is essential for successful implementation of Test and Start (as well as TLD transition). Once adopted, all countries need to ensure consistent implementation. Caribbean: Jamaica, Barbados, Suriname, and Trinidad and Tobago have adopted Treat All at the national level. Guyana is in the process of adopting Treat All. Once adopted, all countries need to ensure consistent implementation.
2. Adoption and implementation of differentiated service delivery (DSD) models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.	Central America: DSD and MMS have been largely adopted or are being adopted in the region but it is not clear how widely and consistently these policies are being communicated and implemented.

	Caribbean: All five countries have adopted DSD models and need to ensure consistent communication and implementation.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine|based regimens.	Central America: Given the high rates of HIV drug resistance, the region needs to more aggressively catalyze transition to TLD. Nicaragua in particular is lagging behind on the TLD transition, which is now further delayed due to political instability. Honduras HIV clinicians are to be commended for issuing a position paper demanding an expedited transition plan. Caribbean: TLD transition is in process for most of the region but dates have not been confirmed in Jamaica, Trinidad and Tobago, and Suriname. Jamaica has refused to move forward with prescribing it to pre-menopausal women until the MOH receives official guidance from WHO. The region needs to make efforts to ensure every country is on track for TLD transition starting this year.
4. Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.	Central America: Index-testing has been largely adopted in the region but it isn't clear how widely and consistently it is being communicated and implemented. Brazil is making great strides in self-testing. Caribbean: Index-tested has been adopted in Barbados and Trinidad and Tobago, and to a smaller scale in Guyana. Jamaica has unacceptable implementation of index-testing. In Barbados self-testing is not formally considered by MOH yet and current national policy does not allow for it. HIV testing must be validated and approved by MOH in Barbados.
5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.	
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Continued progress on immediate linkage should be emphasized in both Central America and Caribbean.

7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.	
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.	
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.	
11. Evidence of resource commitments by host governments with year after year increases.	Both Central America and the Caribbean should continue to collaborate with host governments regarding resource commitments, particularly as some Caribbean countries closeout.
12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Both Central America and the Caribbean should continue making progress toward local, indigenous partner prime funding.
13. Scale up of unique identifier for patients across all sites.	Both Central America and the Caribbean should continue making investments in systems and patient-level tracking, particularly in Jamaica where unique identifiers do not exist. Jamaica has a policy issue related to MSM, and policy reform related to the criminalization of MSM practices serves as a barrier to the fidelity to individual-level data.

In addition to meeting the minimum requirements outlined above, it is expected that Western Hemisphere will ensure appropriate progress towards viral load management and improved use of efficient testing strategies.

Table 9. Other Requirements

Requirement	OU Specific Guidance (if applicable in ROP 2018 or ROP 2019)
1. Viral load management: Country policy updated.	Continue scale-up of access to viral load
2. Screen better and test smarter: Stop over-testing.	Continue scale-up of index testing across the region. In Jamaica, unnecessary testing of FSW is resulting in low yields so no resources should be spent on testing FSWs.

ROP 2019 Stakeholder Engagement

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of ROP 2019 remains a requirement for all PEPFAR programs, and as such the ROP 2019 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2018 Q4 and FY 2018 APR results and analyses and the convening of an in-country planning retreat with local stakeholders no later than the week of January 28, 2019 in order to introduce and discuss all ROP 2019 tools, guidance, results and targets as well as the proposed trajectory and strategy for ROP 2019. In February, initial ROP tools will be submitted to S/GAC for review and feedback. S/GAC will provide feedback prior to the in-person meetings in March and April, and teams should reflect the feedback with their revised submissions. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team.

In April 2019, PEPFAR will convene an in-person meeting in Washington, DC where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Engagement with all stakeholders is required beyond the meetings and throughout the ROP 2019 development and finalization process. As in ROP 2018, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the ROP 2019 Guidance for a full list of requirements and engagement timelines (Section 2.5.3).