



Panama Country Report

Transition Readiness Assessment

Aceso Global

1400 16th Street NW, Suite 430, Washington DC 20036

www.acesoglobal.org | abonfert@acesoglobal.org

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This report is prepared in collaboration with APMG Health.



APMG Health Inc.

5618 Kansas Avenue NW
Washington DC 20011
www.apmghealth.com

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This Country Report is based on the Guidance that Aceso Global and APMG Health developed to guide Transition Readiness Assessments in Latin America and beyond. For a detailed description of the methodology of the report please refer to the [Guidance](#).

The Guidance builds on the work of various organizations highlighting the tremendous value of cross-institutional collaboration. Drawing on tools and frameworks already developed and implemented helped us to focus our contribution on specific sub-areas, but we borrowed heavily from existing tools whenever possible.

We especially benefitted from Curatio's Transition Preparedness Assessment Framework, PEPFAR/HPP's Readiness Assessment for Key Populations, the World Bank's Checklist for Transition Planning, Eurasian Harm Reduction Network's Transition Readiness Tool, and PEPFAR's Sustainability Index and Dashboard.

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List of Abbreviations

ART	Antiretroviral therapy
CCM	Country Coordinating Mechanism
CHW	Community health worker
CLAM	Clínicas Amigables or KP-friendly facilities
COMISCA	Consejo de Ministros de Salud de Centroamérica
CONAVIH	Comisión Nacional para la Prevención y Control del VIH
CONEP	Consejo Nacional de la Empresa Privada
CS	Civil Society
CSO	Civil Society Organization
CSS	Caja de Seguridad Social
DOTS	Directly Observed Treatment Short Course (for TB)
FSW	Female Sex Workers
GBV	Gender Based Violence
GCL	Gorgas Central Laboratory
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GoP	Government of Panama
HIV/TB	HIV/Tuberculosis
HR	Human resources
HTC	HIV Testing and Counseling
INEC	Instituto Nacional de Estadística y Censo
KP	Key Populations
LAC	Latin American and Caribbean
MDR-TB	Multidrug-Resistant Tuberculosis
M&E	Monitoring and evaluation
MEGAS	La Medición del Gasto en VIH/SIDA
MINGOB	Ministerio de Gobierno
MINSA	Ministerio de Salud
MEF	Ministerio de Economía y Finanzas
MoT	Modes of Transmission
MSM	Men who have Sex with Men
MTCT	Mother To Child Transmission

NGOs	Non-Governmental organizations
PAHO	Pan-American Health Organization
PCR	Polymerase chain reaction
PDL	People deprived of liberty
PEFA	Public Expenditure and Financial Accountability
PER	Public Expenditure Review
PFM	Public Financial Management
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PNCTB	Programa Nacional de Control de la Tuberculosis
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PSPV	Health Protection for Vulnerable Populations program
PWID	People Who Inject Drugs
RBF	Results-Based Financing
RR-TB	Rifampicin-Resistant Tuberculosis
SCDT	Social Contracting Diagnostic Tool
SID	Sustainability Index and Dashboard
SISVIG	Sistema de Vigilancia de Salud
SR	Sub-Recipient
STI	Sexually Transmitted Infection
SW	Sex Workers
TB	Tuberculosis
TG	Transgender
UBA	Basic Health Units
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VL	Viral Load
WHO	World Health Organization

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1. Introduction

This report summarizes the findings of the Transition Readiness Assessment for Panama. It is based on a Guidance document developed by Aceso Global and APMG Health, with financial and technical support from the Global Fund (GF), to support countries to undertake transition analysis and planning.

The Republic of Panama is an upper-middle income country with a population of roughly 3.9 million. As the southernmost Central American country, Panama bridges North and South America, and links the Pacific Ocean to the Caribbean Sea via the Panama Canal which bisects the country. Administratively, this small country is divided into ten provinces and three indigenous territories, or *comarcas*. The population includes an estimated 12 percent indigenous minority; the majority of people live in urban areas and are concentrated in the canal region while the eastern third of the country is sparsely populated.

Table 1 contains key indicators for Panama, comparing data from 2003, when the first Global Fund grant was issued, to most recent data. Bolstered by a strong service economy, Panama has experienced some of the fastest economic growth in the Latin America and Caribbean (LAC) region, which has translated into high health spending per capita— US\$959 in 2014, up from US\$298 in 2000—well above the regional average of US\$714. Despite positive trends in social spending, growth has not been equal across the population. Major rural-urban disparities persist, with improvements in indigenous *comarcas* particularly sluggish: while extreme poverty is less than 4 percent in urban areas, it rises to 27 percent across all rural populations and above 40 percent in the *comarcas*. Geographic and financial barriers, combined with limited infrastructure and resources, impede access to healthcare and other social services in rural regions. Urban centers also face challenges including influxes of migrants that strain existing infrastructure and social resources.

Table 1: Key Indicators for Panama, 2003 and 2014/15

Indicator	2003 (year of first GF grant)	Latest year available
UN Human Development Index Ranking	59 of 175	Tied for 60 of 188 [2015]
Population	3,202,511	3,929,141 [2015]
Urban Population	2,020,240	2,616,494 [2015]
Poverty headcount ratio at national poverty lines (% of population)	*	23% [2015]
GINI Index	56.4	50.7 [2014]
GDP per capita (current US\$)	\$4,276.01	\$13,268.11 [2015]
Literacy rate, adult total (% of people ages 15 and above)	94.1% [2010]	95.0% [2015]

Sources: World Bank DataBank (2017) and UN Human Development Report (2003/2015)

*2015 is the only year in which the poverty headcount ratio is available.

The public sector has a strong role in Panama's health system. The Ministry of Health (MINSA) and Social Security Fund (CSS) are the two largest public healthcare providers, with CSS covering roughly 75 percent of the population in 2015 (though there is considerable overlap between the two institutions). Private expenditure on health is lower than the regional average and is dominated by out-of-pocket spending, with limited uptake of private health insurance. Like many countries at its income level, Panama is undergoing a transition in disease burden, with chronic and non-communicable diseases—specifically heart disease, cerebrovascular disease and diabetes—comprising the top causes of death. Road injuries and violence also contribute significantly to premature mortality. Nonetheless, HIV remains within the top ten causes of death, and is especially prevalent among key populations including men who have sex with men, sex workers and the transgender population. The TB epidemic also persists in key populations, and TB death rates of 6.1 per 100,000 people remain stubbornly above the Central American average, 2.8 per 100,000 people.

The Global Fund has worked with Panama since 2003, providing significant technical and financial assistance to the two disease responses. Panama's TB component moved to transition in 2015 as Panama was classified as an Upper-Middle Income country and Panama's TB disease burden classification changed from 'High' in the 2014 Eligibility List to 'Moderate' in the 2015 Eligibility List. Panama's TB component continues to have a 'Moderate' disease burden classification and will therefore be eligible for a final allocation of Transition Funding to support transition to full domestic financing of activities currently financed by the Global Fund. Panama's HIV component is still eligible for Global Fund funding. However, the available income projections indicate that Panama will move to high income country for the next allocation, making Panama HIV ineligible for both regular GF funding and transition funding. Therefore, the current HIV allocation might well be the last one granted to the country. Within this context, in December 2016 the Global Fund communicated to Panama the allocation 2017-2019, which totaled US\$2.7 million, approximately one third of the current budget. The letter also included the recommendation of submitting a joint HIV/TB transition funding request.

The smaller and latest allocation might bring some challenges but the transition process need not be painful. To the contrary, it is a valuable opportunity to critically assess Panama's HIV and TB strategies and make adjustments, if needed.

This document aims to help Panama to identify: a) financial, programmatic and governance gaps, bottlenecks and risks that need to be addressed to promote a smooth transition; and b) priorities and options for solutions that could be incorporated in a transition strategy/plan and implemented with the support of transition grants. Boxes 1 and 2 outline the Global Fund's definitions of sustainability and transition.

Box 1: GF Definition of Sustainability

Ability of a health program or country to both maintain and scale up services coverage to a level, in line with epidemiological context, that will support efforts for elimination of the three diseases, even after the removal of funding by the GF and other donors.

Box 2: GF Definition of Transition

The process by which a country, or a country disease component, moves towards fully funding and implementing its health program, independent of GF support while continuing to sustain the gains and scaling up as appropriate.

*GF considers a transition to be **successful** where national health programs are able to maintain or improve equitable coverage and uptake of services through resilient and sustainable systems for health after GF support has ended.*

To achieve these objectives, the report is structured as follows:

Section 2 summarizes Global Fund financial and non-financial support to the country. Section 3 describes the epidemiological situation in Panama and section 4 provides background on the institutional, human rights and gender situation. Section 5 provides an overview of the Panamanian health system. Following the descriptive part of this report, the remainder of the report is dedicated to a thorough analysis of transition issues. Section 6 analyzes healthcare financing and fiscal space issues, section 7 considers delivery system enablers and barriers to transition, including supply chain, information systems and the health workforce, and section 8 assesses the role and future of Civil Society Organizations (CSOs). Recommendations on the way forward are summarized in Section 9. Aceso Global is responsible for Sections 2, 3, 5, 6, 7 and 9 of this report and APMG Health produced Sections 4 and 8.

2. Summary of GF Support

2.1 GF financial and non-financial support

Panama has received three Global Fund grants to date (see Table 2). The first, worth US\$553,817 and initiated in 2003, sought to expand the national TB response to better reach those in situations of poverty, extreme poverty and indigenous communities. In 2012, Panama received a US\$5.7 million grant for HIV/AIDS focusing on most-at-risk populations. The final, ongoing grant is for both TB and HIV activities for a signed amount of US\$6.9 million.

Table 2: List of all TB and HIV grants to Panama

Component	Round	Grant	Principal Recipient	Grant Start Date	End Date	Total Signed Amount (US\$)	Total Approved Budget (US\$)	Latest FPM Rating	Status
TB	1	PAN-102-G01-T-00	UNDP-Panama	1-Apr-03	31-Mar-05	\$553,817	\$553,817	B1	Administratively Closed
HIV/AIDS	10	PAN-H-CAI	Cicatelli Associates Inc.	1-Jan-12	31-Dec-14	\$3,934,878	\$5,729,517	B1	Financially Closed
HIV/TB	13	PAN-C-UNDP	UNDP-Panama	1-Jan-16	31-Dec-18	\$6,867,722	\$7,174,723	NA	Active

Source: The Global Fund (2017)

The two Principal Recipients (PR) for the grants—United Nations Development Program (UNDP) Panama, and Cicatelli Associates, Inc.— are in-country international and non-governmental organizations. UNDP-Panama is the PR of the ongoing HIV/TB grant.

GF grants have significantly improved the reach and quality of the national disease responses. GF monies have contributed to the acquisition of commodities such as condoms and lubricants, HIV tests, and TB laboratory supplies and equipment to modernize diagnostic techniques as well as nonmedical supplies (food, vehicles, building supplies).

Technical assistance and trainings supported by the GF have been equally important and have promoted adoption of best practices and expansion of services. Health worker training has focused on topics such as proper administration of DOTS, up-to-date practices on MDR-TB treatment, improving pre- and post-HIV testing and counseling, increasing treatment adherence, and raising awareness for the needs of key and vulnerable populations. Community peer promoters have also been trained to assist in active searching for HIV and TB cases to increase detection rates. For example, before the initial GF TB intervention, DOTS coverage in indigenous *comarcas* was essentially nonexistent at just 3 percent; through the GF-supported project, coverage expanded to nearly 100 percent in these regions (though challenges related to coverage, follow-up and drop-out nonetheless remain). Other training has focused on programmatic strengthening, such as human resources and equipment maintenance.

In terms of non-monetary support, one of the most important roles of the GF has been its elevation of civil society and key populations in the national dialogue and disease responses. In addition to the space and role given to civil society in the CCM, all three grants included objectives related to increasing and strengthening the role of CSOs: the first TB grant aimed in part to increase the number of CSOs involved in the TB response; the first HIV/AIDS grants significantly increased the operational capacity of the CSO sub-recipients; and the current grant includes civil society strengthening as a goal. Further, to align with GF priorities and funding allocations, issues of human rights, particularly as they relate to eliminating stigma and discrimination against key and vulnerable populations (e.g. MSM, SWs, trans populations, people deprived of liberty, drug users), have gained importance on the national agenda. This empowerment is reflected in the fact that CSOs and groups representing KPs were involved in the development of the most recent national TB and HIV strategic plans. The government of Panama (GoP) has also started to specifically support testing and treatment of KP through the opening of new CLAMs (*Clínicas Amigables*, or KP-friendly facilities) for HIV/AIDS.

The current grant supports numerous programmatic interventions related to HIV and TB, as well as joint HIV-TB activities, including prevention, treatment and care, procurement and supply chain management, monitoring and evaluation, eliminating legal barriers to access, strengthening community systems, and program management (see Table A2.1 in Appendix 2). Prevention among men who have sex with men and the transgender population comprises the single largest component of the grant (27 percent of total grant funds, or approximately US\$1.9 million). TB care and prevention-related activities make up the second largest component (22.8 percent, or approximately US\$1.6 million). Another 9.4 percent, or US\$ 677,044 of the total GF grant budget for 2016-2018 is spent on prevention among sex workers and their clients. In terms of costing groups, human resources and travel related costs are the two largest sources of expenditure, at a combined 54.8 percent of total grant costs (see Appendix 2, Table A2.2).

Given that these investments complement the government's efforts, there is a risk that a funding shortfall in certain areas may emerge upon GF exit. The most pressing risk appears to be in the area of funding of prevention activities. On average, the GF will support Panama to invest approximately US\$650,000 annually on prevention for MSM and TG and US\$220,000 on prevention for SW during the period 2016-2018. In order to maintain the gains that have been achieved over the last years and that are anticipated to result from the investments under the current grant, prevention efforts should not subside.

The other main area of risk relates to GF investments in TB. The current grant allocates about US\$550,000 annually to TB prevention and care. Withdrawing this support could imply a widening of the funding gap, estimated at US\$361,777 for fiscal year 2016 (see Section 6.3), unless the government decides to fill the gap with domestic resources.

In summary, GF monetary and programmatic support, including technical assistance and empowerment of CSOs and KPs through targeted funding, has helped to strengthen the national TB and HIV/AIDS responses. By promoting global best practices on prevention and treatment, encouraging monitoring and evaluation based on data collection and indicators, increasing disease understanding through improved

surveillance and elevating the role of KPs and CSOs, the GF has enabled Panama to strengthen its disease responses.

2.2 Record of Absorption and co-financing commitments

The TB response is largely funded by domestic resources. The Panama Concept Note (funding gap table) estimated that the TB Strategic Plan required at least US\$2.3 million in 2014 and around US\$2.6 million annually in the period 2015-2017. In 2014, domestic resources were approximately US\$1 million (roughly US\$700,000 and CSS roughly US\$350,000), insufficient to fund the estimated overall need. Panama committed to increase its funding for TB to a total of US\$7.7 million, US\$ 3.4 million above the total funding for the period 2012-2014. With the new GF grant initiated in 2016, MINSA agreed to cover the cost of procurement of reagents for TB diagnosis and pharmacoresistance, as well as to continue funding programs for TB prevention, diagnosis and treatment. Additionally, MINSA made a willingness-to-pay commitment of US\$180,000 to hire additional staff for the TB response over the course of the grant.

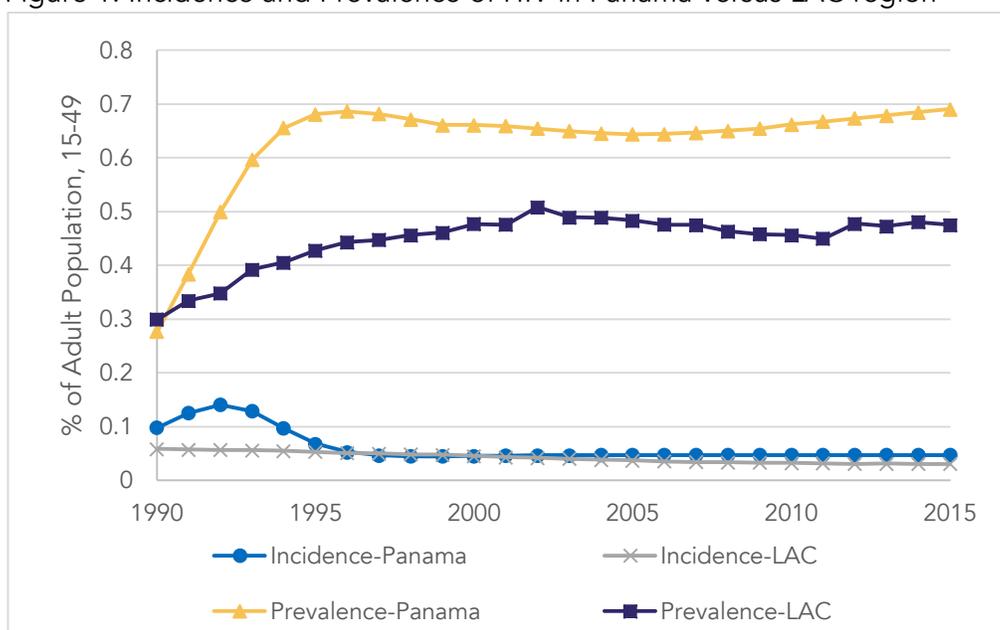
For the current grant, the country also agreed to significantly increase its role in funding HIV/AIDS prevention and treatment activities, in particular for most-at-risk populations. The country showed its intention to increase the domestic public resources to HIV response from 65 to 86 US\$ million. As part of this commitment, the government also agreed to support free rapid HIV testing in MINSA facilities for most-at-risk populations (roughly US\$357,000); to fund the opening of two new CLAMs, including operating costs and capacity building (roughly US\$522,000); and to fund additional ART and VL/CD4 testing for key populations diagnosed with HIV (roughly US\$1.248 million). Thus, the willingness-to-pay commitment for HIV over the three-year grant totals approximately US\$2.1 million.

3. Epidemiological Situation

3.1 HIV

HIV prevalence rates have remained relatively stable for the past 20 years, fluctuating between 0.64 percent and 0.69 percent. Since 2005, prevalence has been rising slowly, defying the trend across LAC, where rates have been generally declining since 2002, and are considerably lower in absolute terms, as shown in Figure 1. Panama’s HIV incidence rate has remained at about 0.05 percent for the past 20 years, slightly above the LAC rate of 0.03 percent. Throughout the 1990s, estimated AIDS-related deaths increased by a factor of ten, from 60 in 1990 to a peak of 624 in 1999; deaths have declined since, though with considerable oscillations. In 2015, there were an estimated 456 AIDS-related deaths.

Figure 1: Incidence and Prevalence of HIV in Panama versus LAC region



Sources: The Global Fund Database (2016) and World Bank Databank (2017)

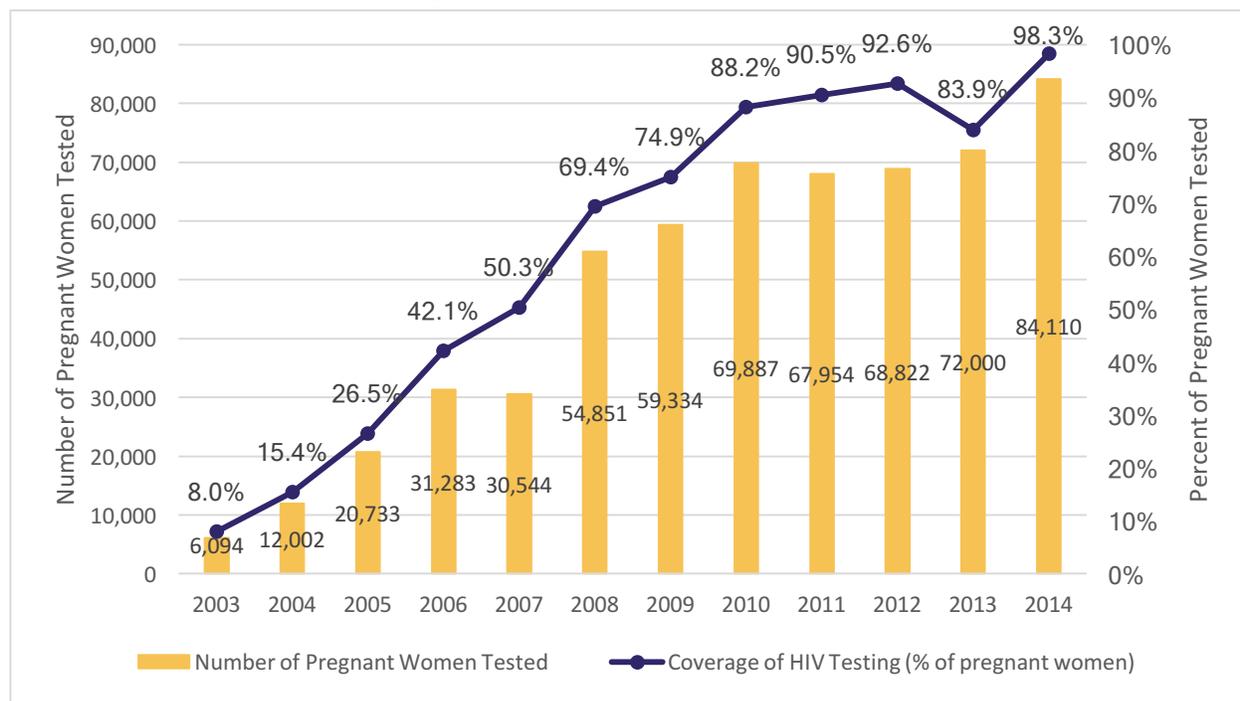
In 2015, 17,101 people were estimated to be living with HIV across Panama, and the incidence of new cases was greatest among those aged 25-44. However, youth aged 15-24 are considered an at-risk group for HIV; from 2001-2013, they made up 24 percent of HIV cases (The Global Fund, 2015c). These rates are likely fueled in part by a lack of awareness of the risk of sexually transmitted diseases, including HIV. Last year, the GCL (see more information in Section 7.1) published a study showing that HIV-related knowledge among youth between the ages of 14 and 18 is almost non-existent (GCL, 2016). Of 600 students surveyed in 10 schools in the district of Panama, 98 percent had limited knowledge of HIV transmission and prevention. Sexual and reproductive health is a delicate topic and often excluded from the curriculum. Only 17 percent of the teenagers said they learned about HIV in school. There is a clear need for improved population education on risk, prevention and treatment to dampen the rising infection rates among youth

in Panama. In addition to variation across age groups, there is a major gender gap. The ratio of HIV and AIDS cases in men to women was 3:1 from 1984 through mid-2016 (MINSA, 2016c). Nevertheless, HIV rates among women have risen over the past 25 years, from 2.4 per 100,000 people in 1993 to 8.0 in 2013; this increase parallels the rise in national prevalence over that same period.

One explanation for the lower levels of AIDS among women is the GoP’s successful prioritization of testing among pregnant women to reduce mother-to-child transmission. HIV testing among pregnant women was over 98 percent in 2014, up from 8 percent in 2003, and of those pregnant women diagnosed with HIV, 96 percent were on ART, as shown in Figure 2. These figures for testing and treatment adherence are significantly higher than those of the general population, due in part to the frequency of interactions pregnant women have with the health system during pre- and post-natal care. In 2014, HIV prevalence among pregnant women was estimated at 0.2 percent.

As a result of these concerted efforts, vertical transmission has been declining. In 2014, 181 of 182 children born to HIV-positive mothers received ART to prevent mother-to-child transmission, and the vertical transmission rate was 4.4 percent. The National Strategic Plan for HIV includes a specific goal to reduce this rate to 1.0 percent by 2019.

Figure 2: Increases in HIV Testing of Pregnant Women, 2003-2014



Source: MINSA (2016e)

In Panama, the key populations for HIV include MSM, sex workers and trans populations. The paucity of up-to-date data regarding the size of and HIV prevalence among some KPs, in addition to challenges associated with collection of such data (e.g. MSM and trans populations self-identifying as general

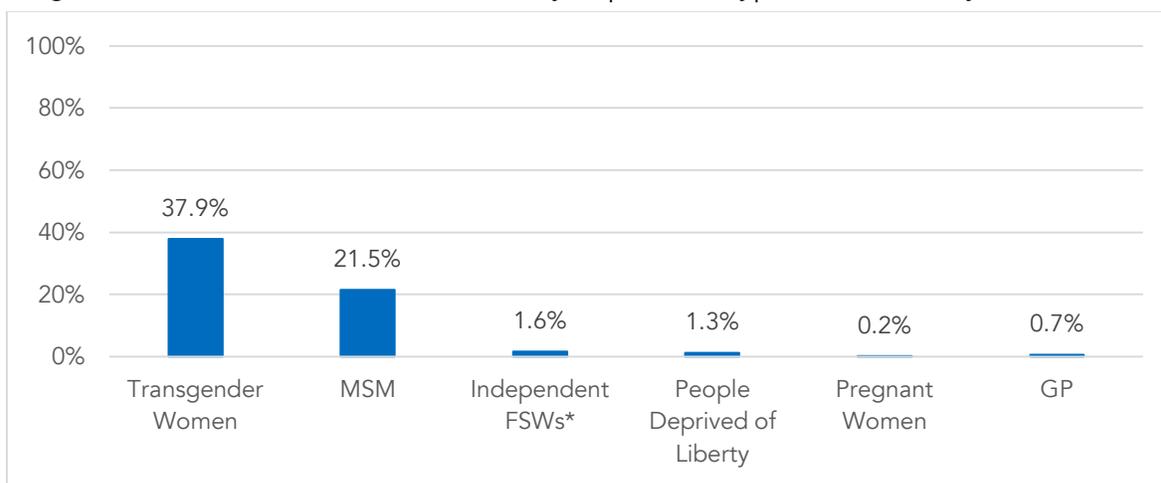
population in order to avoid stigma/discrimination) complicate analysis. However, some useful information is available. One study estimating key population sizes for 2014 placed the number of MSM at 15,842, transgender women at 888, and FSWs at 5,217, respectively (Miller 2014). In 2015, the National HIV Program produced different estimates using the Goals methodology: it calculated the MSM population at 31,000, of whom 10,392—over one-third—were estimated to be living with HIV. It also estimated that there were 1,464 FSWs living with HIV. Table 3 below summarizes the population size estimates for these populations, as well as people deprived of liberty (PDL) and indigenous persons.

Table 3: Key Population Size Estimates

Population	Source Year	Population Size Estimate	Source
MSM	2014	15,842	Miller (2014)
	2015	31,000	Programa Nacional de ITS, VIH y Hepatitis Virales
Trans Women	2014	888	Miller (2014)
Sex Workers	2014	5,217	Miller (2014)
PDL	2016	17,535	MINSA (2017b)
Indigenous Population	2010 (Projection: 2020)	438,309 (537,652)	INEC (2014)

Finally, existing data on HIV prevalence, while significantly outdated in some instances, show that HIV is much better controlled among FSWs than MSM or transgender women, potentially offering insight into successful prevention and outreach strategies¹. Figure 3 below shows estimated prevalence of HIV by population type highlighting the striking differences between these groups².

Figure 3: Estimated Prevalence of HIV, by Population Type (most recent year available)³



Source: Gorgas, IBBS (2010, 2011); Departamento de Epidemiologia, MINSA (2014); MINSA (2015e)

¹ Prevention programs delivered by MINSA targeting FSWs have been in existence for decades.

² We note that the figures are different to the approved Performance Framework which uses VICITS (acronym of the Spanish term Vigilancia Centinela de las Infecciones de Transmision Sexual) data notification while these numbers are estimates.

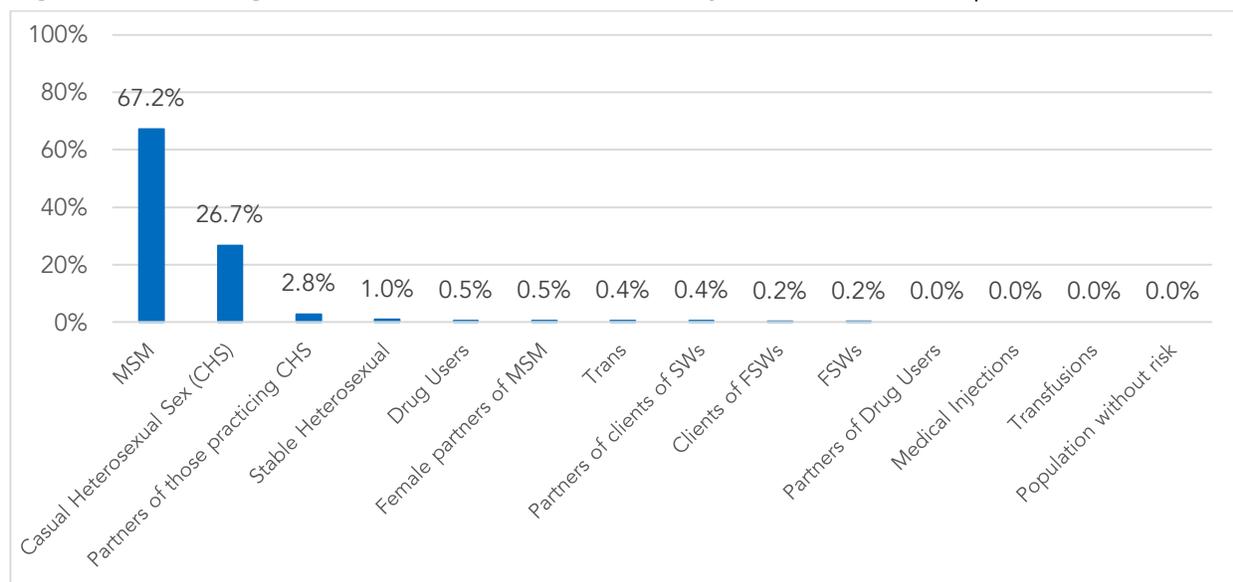
³ Given infrequency of HIV prevalence studies among KPs, data is from most recent year available, as follows: Transgender women, 2011; MSM, 2011; Independent FSWs, 2010; PDL, 2015; Pregnant women, 2014; General population, 2016.

*Sex work is regulated in Panama and registered sex workers are required to carry an ID card and, depending on their place of work, submit to HIV and STI testing at regular intervals. HIV prevalence among regulated FSWs is estimated at 0.2 percent (The Global Fund, 2015c).

In addition to the above key populations, people deprived of liberty also experience elevated HIV prevalence rates. In 2015, prevalence in prisons was 1.3 percent (corresponding to 209 PLHIV); this is a noticeable increase from 0.79 percent in 2010. The prison epidemic is largely concentrated in La Joya and La Joyita prison facilities: there were 169 people deprived of liberty living with HIV or AIDS between these two facilities in 2015, out of 9,734 PDL. Limited availability of condoms in prisons could be contributing to elevated prevalence among this population.

A specific breakdown of new cases by population type is not available for 2015. The 2013 data shown in Figure 4 reveal that MSM represented over two-thirds, those practicing casual heterosexual sex represented 27 percent, and the partners of those practicing casual heterosexual sex represented 3 percent, of new cases (see Figure 4). As noted above, issues of self-identification of population types could potentially skew these data and so they should be interpreted with care. Nevertheless, they suggest that MSM comprise a considerable proportion of new infections, indicating need for greater preventative efforts targeted at this population.

Figure 4: Percentage Distribution of New HIV Cases by Transmission Group, 2013

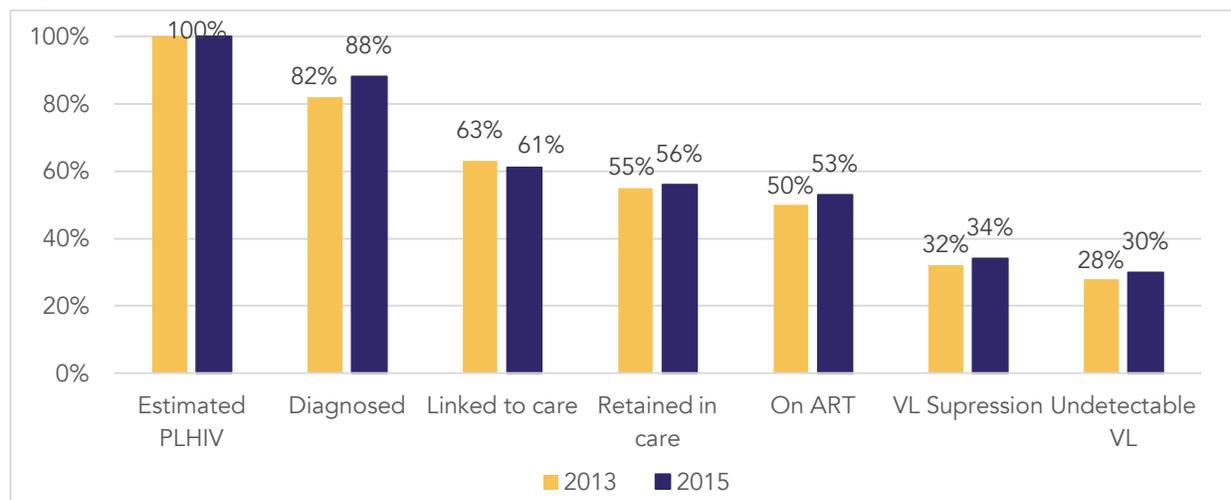


Source: MINSa (2015c)

Metropolitana, Colón and San Miguelito recorded the highest percentage of HIV cases from 2001-2012 (see Appendix Table A3.1). Over this period, the location of infection was not reported for 12.3 percent of new cases, indicating gaps in data collection that can hinder analysis and planning. There are also known regional hot-spots of transmission, such as Isla de Colón where sex work and drug usage are widespread.

Panama began compiling data regarding the HIV treatment cascade in 2013. Figure 5 compares the outcomes from 2013 and 2015. While the percentage of diagnosed PLHIV linked to care dropped by 2 percent, there were minor improvements over the rest of the pillars.

Figure 5: HIV Treatment Cascade, 2013 and 2015

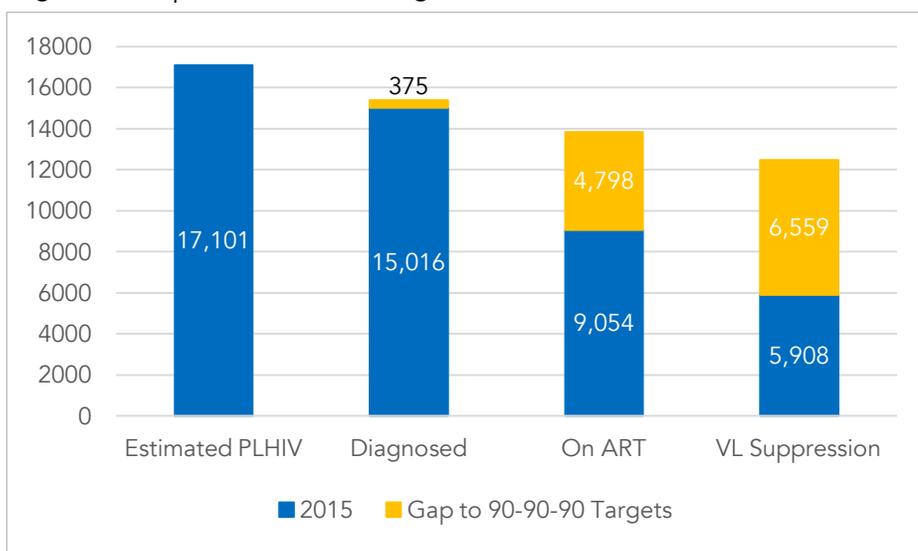


Source: MINSa (2016d)

Panama is on the cusp of reaching the first of the 90-90-90 targets, successfully diagnosing 87.8 percent of the estimated PLHIV (15,016 of 17,101), making the gap to the first target just 2.4 percent. The gaps to the second and third targets are considerably higher, however, at 34.6 percent and 52.6 percent, respectively. Figure 6 illustrates the gaps numerically. Further, these national figures obscure some of the regional variations in the data, as well as some areas still in need of significant improvement⁴. For example, treatment outcomes vary significantly across the country. In 2015, the percentage of PLHIV on ART with viral load suppression ranged from 24 percent to 80 percent, depending on the ART clinic attended (MINSa 2016d). Additionally, while diagnostic rates are impressive, 46 percent of those diagnosed receive a late diagnosis, indicating that there is still significant work to be done to expand early diagnosis. While a treatment cascade for 2016 is unavailable, the M&E technical unit of the HIV program notes that 10,887 PLHIV were on ART as of June 2016 (MINSa, 2017i).

⁴ More detail on the regional variations can be found in “Informe Nacional De Cascada Del Continuo De La Atención En VIH Y Medición Del Indicador De Sobrevida En Panamá, Año 2015”. The information is presented by HIV clinic.

Figure 6: Gaps to 90-90-90 Targets



Source: Adapted from MINSAs (2016d)

Improvements in the cascade can be attributed in part to increases in the number of clinics offering ART, provision of testing and ARVs free-of-charge, projects to improve the accuracy of estimation of drug supplies in order to reduce stock-outs, adoption of rapid testing as the norm and collaboration with international organizations, including the Global Fund, to increase testing among KPs.

Challenges remain, however, as illustrated by gaps toward reaching the 90-90-90 goals. A persistent challenge affecting health outcomes beyond just HIV is limited access to health facilities in some regions, particularly indigenous *comarcas*. Health workers at the primary care level often fail to offer and promote HIV testing during regular consultations, limiting testing. Stigma and discrimination continue to be barriers to successfully linking and retaining patients in treatment. For example, not all individuals give their correct telephone number to clinics and it is reported that some do not want to follow-up with a confirmatory test due to shock or denial of their HIV-positive diagnosis. Inflexible clinic hours can also prevent key populations from seeking follow-up care. On the programmatic side, insufficient drug supplies are a significant and persistent challenge. In 2014, 100 percent of facilities dispensing ART experienced at least one interruption in their drug supply, and 51 percent of patients on ART received interrupted, modified or incomplete treatment over the previous 12 months due to lack of drug availability (MINSAs, 2015c).

Finally, there are issues with the quality of the cascade data. Information systems are not standardized across clinics, and within some clinics databases for the pharmacy, laboratory and medical care are neither systematized nor integrated. Additionally, some patients move from one clinic to another during the treatment process; others utilize lab services offered by CSS but receive drugs from MINSAs; still others receive care from the private sector, but use MINSAs laboratory services for measuring their viral load – and none of these out-of-clinic services are recorded for the patient as records are clinic rather than

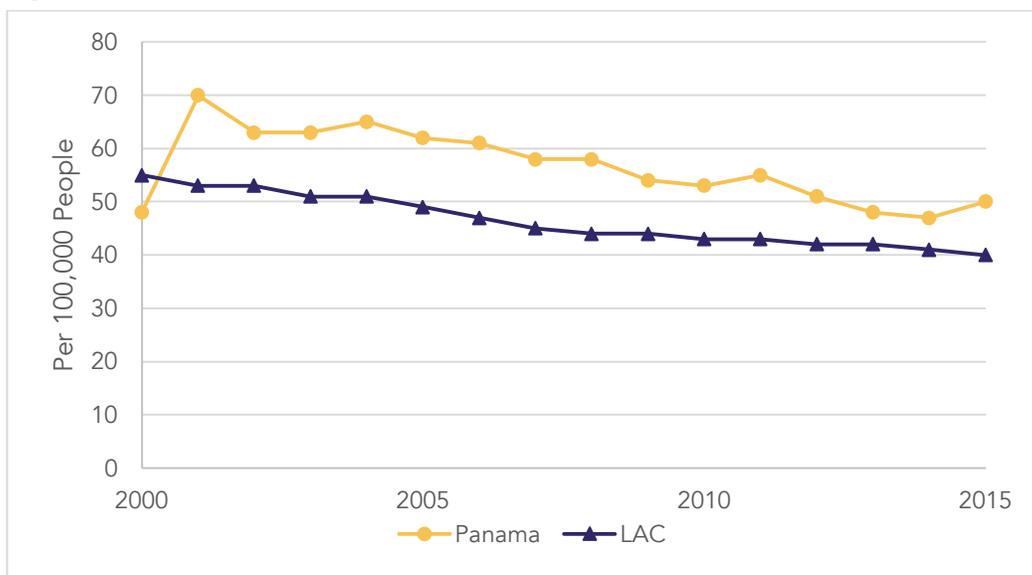
patient based. Some of these patients seeking care across systems and providers may not be registered in national databases (MINSAs, 2016d).

While Panama has not implemented Optima to assess allocative efficiency in the HIV response, it does employ Spectrum (including Goals) and the Epidemic Projection Package, the core tools supported by UNAIDS and used by countries to generate national HIV estimates and related indicators. Updated Goals estimates are expected to become available in June 2017. Panama has also used the Modes of Transmission (MoT) Model to determine transmission patterns, especially among vulnerable groups, and provide data for decision-making. The MoT analysis completed in 2014 revealed that new HIV cases were primarily concentrated in MSM and, to a lesser extent, those practicing casual heterosexual sex and their partners and trans populations, while sex workers and their clients contributed less to HIV incidence than the global average.

3.2 Tuberculosis

After peaking in 2001, TB incidence rates declined over the next 14 years from 70 cases per 100,000 population to 50 cases in 2015. The incidence rate for 2015 marks a slight increase from 2013 and 2014, 48 and 47 cases per 100,000 population, respectively. Panama's TB incidence rate exceeds the LAC regional average considerably, as shown in Figure 7. In 2015, TB incidence in LAC was just 40 cases per 100,000 population. Over the past 15 years, Panama suffered from above-average TB rates but has experienced a faster rate of decline than the region as a whole. Nonetheless it persists in leading the region in TB incidence. In 2016, a total of 1,580 cases were diagnosed.

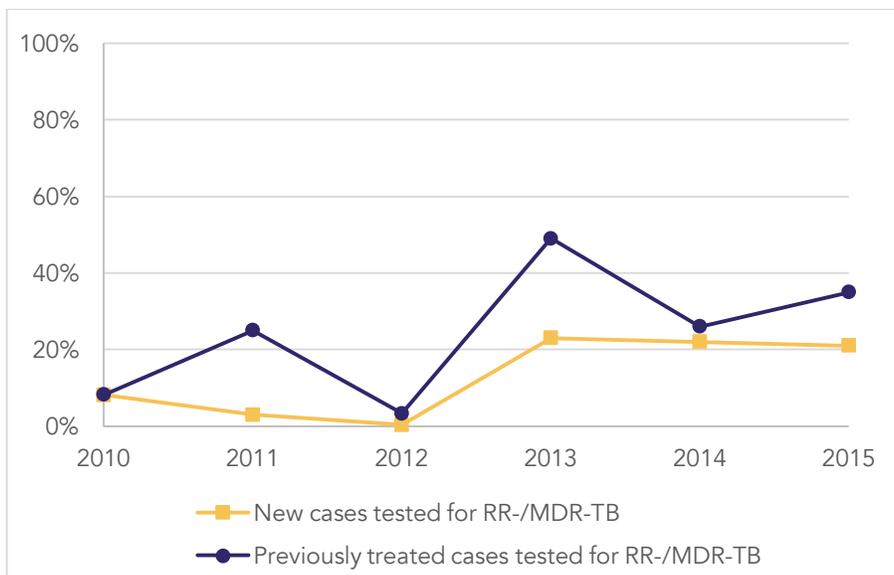
Figure 7: TB Incidence Rate, 2000-2015



Source: World Bank DataBank (2017)

Testing for RR/MDR-TB remains low, as shown in Figure 8, making it difficult to precisely gauge the scope of the drug resistant-TB burden. In 2015 alone, PNCT estimates that it diagnosed only 58 percent of MDR-TB cases (34 of an estimated 59), meaning roughly 42 percent of persons with living MDR-TB went undiagnosed (MINSAs, 2017j). For the same year, the WHO estimates that there were 63 cases of RR/MDR-TB among notified pulmonary cases and that the incidence rate is 2.3 per 100,000 population (WHO, 2016b). Three percent of new TB cases and 12 percent of previously treated cases are estimated to have MDR/RR-TB (WHO, 2016b).

Figure 8: RR/MDR-TB Testing in New and Previously Treated TB Cases, 2010-2015



Source: WHO 2017

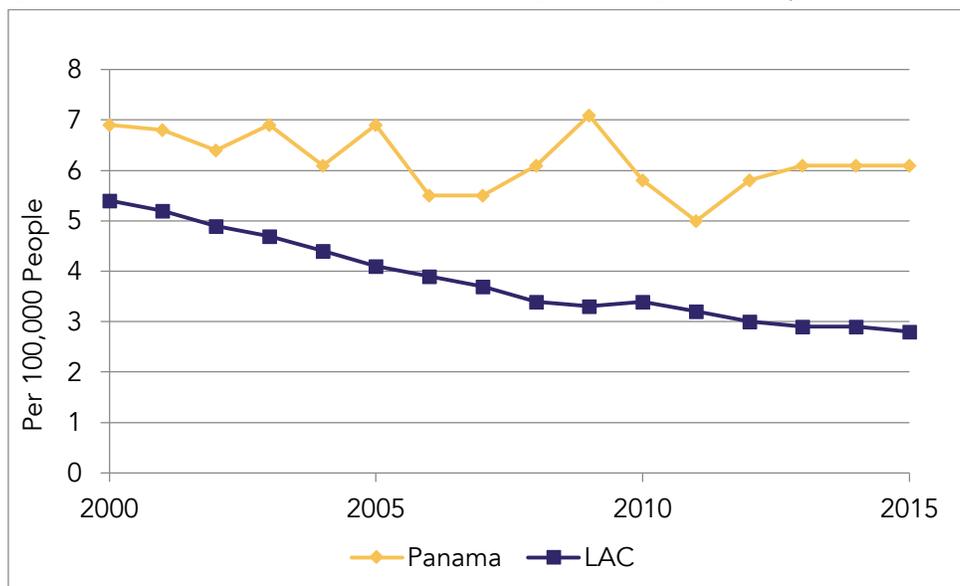
Panama has achieved considerable gains in the treatment of TB. Treatment coverage was estimated at 80 percent in 2015. The treatment success rate improved by almost 20 percentage points from 2000 to 2014, up from 60 percent to 79 percent. This is above the LAC average of 75 percent (World Bank Databank 2017). Nevertheless, a sizeable gap remains to reach 100 percent treatment success, which can in part be attributed to high levels of treatment dropout. Treatment outcomes vary considerably by region—in 2015, treatment success ranged from 66.7 percent in Los Santos to 100 percent in Herrera and Darién—indicating uneven access to or utilization of TB services across the country (MINSAs, 2017g). The treatment outcomes for the country as a whole and by region for 2015 can be found in Figure A3.1 in Appendix 3.

Improvements in the treatment of drug-sensitive TB have not carried over to other forms, and the National TB Program estimates treatment success of MDR-TB at just 50 percent, due largely to significant challenges with treatment abandonment. Outdated treatment protocols contributed to the rise of drug-resistance in the country; Panama was also one of the last countries to update its treatment standards in the region.

Trends in TB death rates are an additional cause for concern. From 2000 through 2015, death rates were volatile, with minimal net improvement. Death rates decreased by just 0.8, from 6.9 to 6.1 per 100,000

population. The figures are even more alarming when compared with the LAC region as a whole. As indicated in Figure 9, the regional death rate among HIV-negative individuals has been steadily declining for the past 15 years and was 2.8 in 2015. Only Haiti, Guyana, the Dominican Republic and Peru have higher TB mortality rates in the region. The mortality rate for MDR-TB is particularly concerning; the Panama TB and HIV Concept Note for the ongoing GF grant places it at 29 percent.

Figure 9: Estimated TB Death Rate (Among HIV-negative People), 2000-2015



Source: World Bank Databank (2017)

Based on the data collected by the National TB Program, Panama had mixed success achieving the Millennium Development Goals (MDGs) related to TB: while the country successfully reduced TB incidence from 1990 to 2015, it failed to reach the targets of halving TB prevalence and mortality.

TB does not affect all populations equally. Notably, there is a significant gender disparity, with estimated incidence twice as high in men as in women. Additionally, there are strong geographic variations (see Appendix, Table A2). TB rates are double or triple the national average in the regions of Guna Yala, Ngäbe Buglé and Bocas del Toro. These regions are rural, with large indigenous populations, high levels of poverty and extreme poverty, highly mobile populations, and most with poor access to health services. Colón and Metropolitana also suffer from significantly elevated incidence with urban migration contributing to higher rates.

People deprived of liberty comprise another key population for TB. In 2013, the incidence rate for all forms of TB in the country’s two main prison facilities—La Joya and La Joyita—was 643.7 cases per 100,000, or 17 times the national rate due to crowded conditions and limited access to health services. However, gains are being achieved: the number of TB cases in all prisons fell from a peak of 119 in 2015 to 88 in 2016, though this is still significantly higher than the 22 cases recorded in 2010.

3.3 HIV/TB Co-Infection

HIV/TB co-infection is a concern in Panama, reflected by the submission of a joint TB and HIV Concept Note to the Global Fund for Panama's most recent grant. Data on the size of this population is difficult to ascertain given low levels of TB testing among HIV-positive patients: according to the Concept Note for the ongoing HIV/TB grant, only 19 percent of HIV patients with respiratory symptoms are screened for TB, reflecting the national trend of generally low-levels of testing for TB among those presenting respiratory symptoms.

HIV testing among those with TB is significantly more systematized: the WHO estimated that in 2015, 89 percent of new and relapse TB cases knew their HIV status, of whom 14 percent were HIV-positive. Of those co-infected patients, the WHO estimates that 94 percent were on ART. However, a separate analysis completed after a WHO/PAHO external monitoring mission of the national TB program in January, 2014, found that HIV tests were carried out in 95 percent of TB patients, but only 45 percent of those diagnosed with HIV were receiving ART. Finally, PNCT recorded 195 TB-positive cases for HIV in 2015 out of an estimated 230, corresponding to a diagnosis gap of about 15 percent. Clearly, major discrepancies in the data exist, posing a problem in devising strategies to successfully tackle co-morbidity. In terms of uptake of preventative measures, in 2012—the most recent year for which data was available—an estimated 86 percent of HIV/TB patients received co-trimoxazole preventive therapy (CPT), up from 42 percent in 2009 (MINSa, 2017g).

All available data point to a gap in co-testing, treatment and prevention. MINSa has been promoting coordination between the two disease programs to increase collaborative activities, but the efforts have clearly fallen short.

4. Enabling Environment, Human Rights and Gender

4.1 Enabling environment

Urban areas outside Panama City are not adequately covered with tailored HIV services. The Panamanian population is heavily concentrated in urban areas, with 51 percent of the population residing in the Metropolitana region. As such, most of the government and community response to HIV is concentrated in this area as well. However, community representatives report that other urban developments including Colón, other tourist development centers, and indigenous districts experience high levels of sex work (both male and female) and drug use, and have unique needs related to the migration of populations. These areas also suffer from more limited access to HIV testing, which significantly raises the barrier to entering care. These regions require more targeted approaches tailored to their contexts, and while data are scarce, anecdotal reports indicate that they are not receiving adequate coverage of services under current efforts.

Stigma and discrimination related to HIV is not comprehensively addressed, particularly for key populations. There is no anti-discrimination law which applies to society at-large (for more about the AIDS Act, which applies only within the confines of Ministry of Health services, please see below). Recently, there have been commendable efforts to introduce a new, comprehensive HIV law, through extensive consultation with civil society partners. However, there are problematic elements of discrimination currently contained within the draft law, including mandatory premarital testing. In order for the proposed law to be truly comprehensive in guarding against stigma and discrimination, it will need to be further aligned with international best practices and recommendations, and should include protective elements for key populations at-risk for acquiring HIV, in addition to protections for people living with HIV.

At the ministerial level, while the *AIDS Act* assures access to universal coverage and guards against discrimination against people living with HIV (PLHIV) in the health care setting, stigma and discrimination are still widely documented in HIV – through the Stigma Index (REDLA+, 2014), and as reported by CSOs. The most significant issue related to access to care is confidentiality, particularly in smaller healthcare centers (e.g. outside of Panama City) where individuals cannot access care anonymously. There are no effective systems in place to address breaches of confidentiality or other stigmatizing or discriminatory practices; while there are anecdotal reports of some offending healthcare workers being reassigned to new clinics, there are no sanctions on either individuals or facilities for their violations. In addition, the *AIDS Act* does not provide for protection against discrimination based on other factors associated with increased risk for HIV, including sexual orientation or gender identity. This leaves many MSM and transgender people vulnerable to discrimination which, though not strictly related to their HIV status, may strongly impact access to prevention, testing, care and treatment for HIV. Unfortunately, so far neither the government nor civil society have made any systematic efforts to address this issue.

Stigma related to TB is more closely linked with TB being perceived as a disease of poverty. This may lead to avoidance of seeking health services, and also leads to low motivation to address TB morbidity and mortality, despite mortality rates being amongst the highest in the region (see Section 3.2). This problem even extends to health-related CSOs, which have low motivation to work on TB; many respondents indicated that low motivation is linked to the mutually reinforcing issues of stigma and a lack of financing for the TB response.

4.2 Human rights and gender

Key populations experience violence and barriers to accessing healthcare services in general, including HIV-related services. There is no mechanism in place to systematically document or address these violations. Only limited targeted services are available for key populations to address HIV, and quality and coverage vary by population.

Sex work is legal and regulated in Panama, providing some scope of rights protection (Carrington-Betts and Betts, 2010). Health regulations, as well as municipal and migration regulations, require that SW who work in close premises (e.g. not street-based) are subject to compulsory testing for HIV and syphilis on a quarterly basis; employers are responsible for assuring compliance with these regulations, and the details of testing are logged in their Health Card. Employers are also responsible to enforce health regulations for the significant population of non-citizen SW, who are required to provide health records from their country of origin. When a SW holding Panamanian citizenship tests positive for HIV, her Health Card is withdrawn and she is no longer authorized to perform sex work; according to key informants interviewed, a non-citizen who tests positive has her work permit revoked and is subject to deportation.

According to civil society informants, street-based female sex workers are issued a different Health Card and testing is voluntary, not compulsory, but costs for testing and other health screenings are borne by the individual and may be either undesirable or cost-prohibitive (Dresler et al, 2010). There are no equivalent regulations for male SW, nor are there specific programming targeting this population. No data are currently available to describe any current challenges or limitations in accessing care.

Transgender people have the highest recorded incidence of HIV of any subgroup in Panama. Transgender people experience high levels of violence and discrimination, and no legislation or regulations exist to protect them from these negative effects. There is no legislation in place to address gender identity changes, leaving individuals with gender that diverges from their biological sex vulnerable to discrimination at any place that requires identification, including healthcare, educational, employment and social services settings. This leads to many individuals engaging in sex work as one of the only viable employment options; however, they are likely to do so in an unofficial capacity, outside of the health regulations governing other sex workers, and therefore exacerbating vulnerability to illegal detention, physical and sexual violence, and extortion.

Gay men and other men who have sex with men (MSM) have access to relatively more programming from a mobilized civil society, with targeted outreach and educational campaigns to promote timely detection

of HIV, distribution of prevention commodities (condoms, lubricants), and some utilization of social networks and other digital applications to spread positive health messaging. Prevention programming is implemented in many places where sexual encounter occur, including cinemas, baths and saunas; however, condoms are limited and when CSO-provided condoms are not available, the cost of condoms (up to US\$5 per condom, as verified by three separate key informants) is prohibitive and discouraging. In addition, despite education and prevention campaigns, risky sexual practices including barebacking are still reported to be prevalent. There is some overlap with transgender populations here, especially in terms of sex work clientele and recreational drug use, and there are no targeted risk prevention or reduction strategies for these scenarios.

Migratory populations, including migrant laborers, are well-supported by the national HIV treatment plan, as all people living with HIV have the right to access treatment, regardless of citizenship. From a rights-based perspective, this is a positive development; however, CSOs warn that it also leads to significant migration, especially from nearby Venezuela which is in the middle of a healthcare crisis, adding significant stress to the Panamanian HIV response system. Migration also has a significant influence on epidemiology; a brief review of popular gay dating applications reveals a significant number of SWs and MSMs originating from Colombia and Venezuela, which means that HIV responses and enabling environments in these countries have an indirect impact on Panama's epidemic as well.

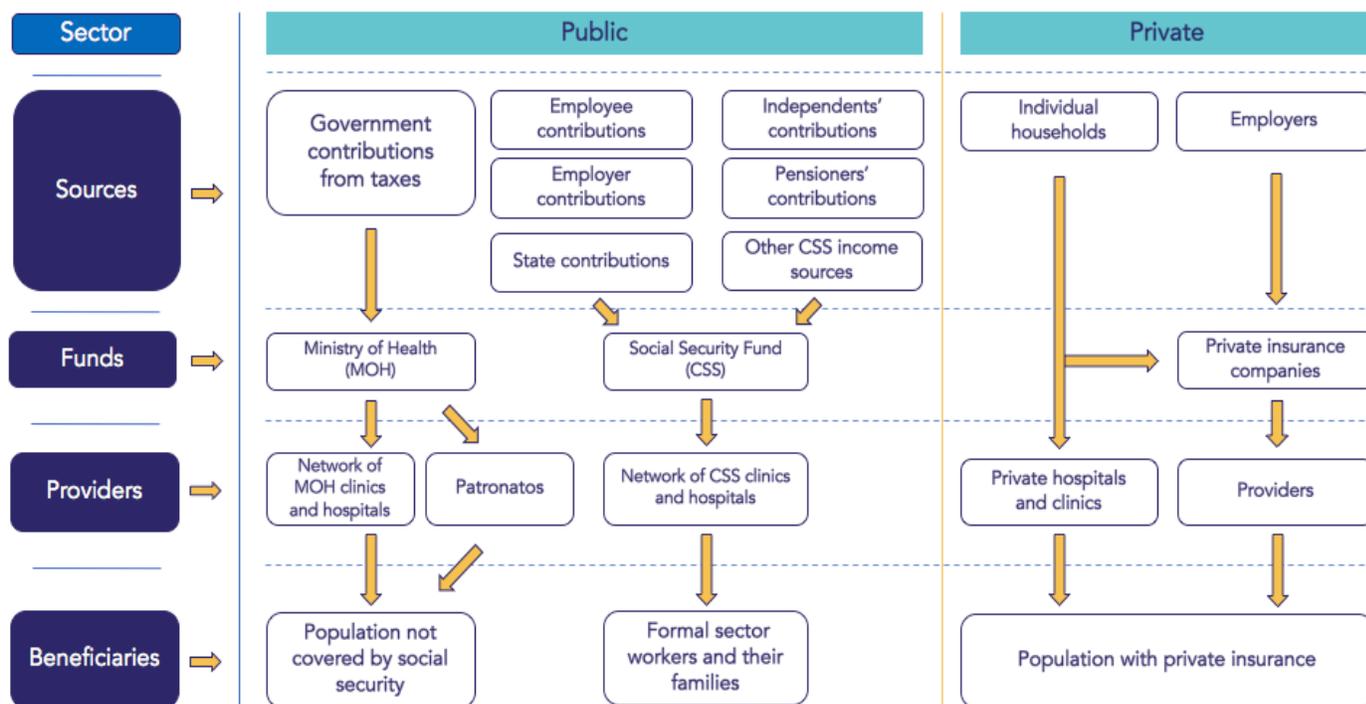
5. Health System Overview

5.1 The Panamanian health system

The Panamanian health system is characterized by high levels of fragmentation as the public health system is split into two separate public systems, as shown in Figure 10. Depending on employment rates, the coverage rates have been between 73 percent and 83 percent over the last couple of years, as summarized in Panel A of Figure 11. In 2015, 75 percent of the population were enrolled in CSS. CSS was created in 1941 and is financed through contributions by salaried employees and their employers. The high proportion of the population is due to CSS’s eligibility that allows dependents to be enrolled as well. In addition to health services, CSS operates the compulsory public pensions, disability, and workplace insurance system. CSS is an autonomous entity and runs its own network of hospitals and clinics where it provides services for its beneficiaries.

The rest of the population accesses healthcare services through MINSAs, the Ministry of Health, which operates a separate network of hospitals and clinics. MINSAs is financed through general revenues. Theoretically, MINSAs only covers the portion of the population that does not benefit from CSS coverage; in practice it is available to all Panamanians since MINSAs cannot deny service to anyone seeking care. The third pillar of the Panamanian health sector is the private sector which serves an estimated 6 percent of the population (World Bank 2015a).

Figure 10: The Panamanian Health System



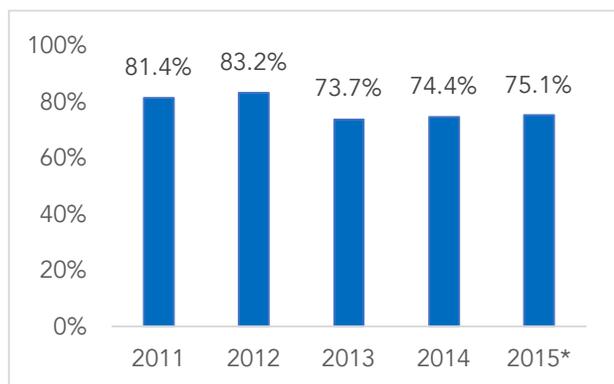
Source: Adapted from World Bank (2015a)

Figure 10, therefore, only provides a schematic overview as the boundaries between the three beneficiary groups get blurred by significant overlap in health service utilization. While the National Statistics Institute estimates that 75 percent of the population was covered by CSS in 2015, as shown in Panel A of Figure 11, actual coverage is remarkably different. According to MINSAs estimates for 2015, CSS effectively served only 51 percent. MINSAs, in contrast, should be covering 16 percent of the population but actually provided services to 49 percent of the population. There are agreements between MINSAs and CSS that allow for cross-subsidization making it possible for patients to access either institutions' facilities regardless of coverage (Clark 2014).

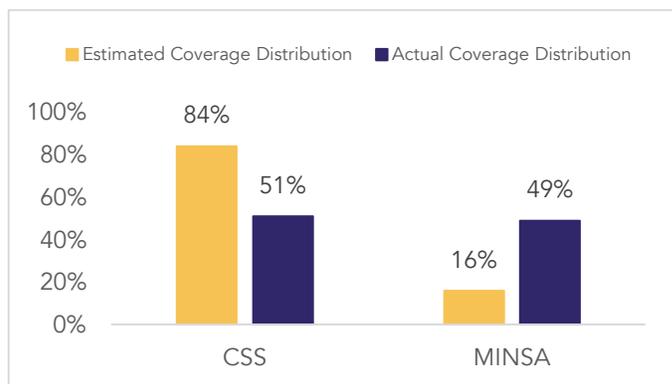
It is estimated that about half of the CSS beneficiaries utilize services provided by MINSAs, including for TB and HIV care. CSS beneficiaries opt to go to MINSAs facilities to obtain lower prices on drugs or to access services that would otherwise not be available to them. For example, 15 of the 17 ART clinics in the country are operated by MINSAs meaning it has much broader reach among HIV patients. Given that treatment is available at no cost, these centers draw patients from across the population. The percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services. For example, testing the viral load in a private lab costs about US\$400, making it attractive to instead use this service at a MINSAs facility where it can be had for free every four months.

Figure 11: Coverage Distribution between MINSAs and CSS

Panel A: CSS Beneficiaries as % of total population



Panel B: MINSAs estimates of effective coverage distribution in 2015



Source: Instituto Nacional de Estadística y Censo (INEC) and MINSAs (2015b)
*Statistics for 2015 are preliminary and may be updated by INEC in the future.

The parallel organization of service provision and financing is problematic for a country with a population of only 3.9 million as it creates significant waste in the health system. The cost sharing agreements neither seem to adequately reflect actually incurred cost by the respective provider, nor do they introduce incentives to achieve better coordination or lower costs. For example, for a smear microscopy performed for non-beneficiaries, CSS charges MINSAs US\$5. This type of intra-institutional agreement is singular to

the health system and is not registered or monitored by the *Ministerio de Economía y Finanzas* (MEF) or MINSAs internal or external auditors. There is a precedent for co-financing agreements; other areas in which MINSAs and CSS cooperate include dialysis and vaccines. Formalizing cross-utilization and subsidy agreements could help both institutions gain a better understanding of their actual expenditures and reciprocated benefits.

Attempts to unify the health system are launched periodically, and for a brief period in the 1980s MINSAs and CSS actually worked jointly, but recent efforts have not yet been brought to completion. Currently, *Mesa de Diálogo/Comisión de Diagnóstico* is tasked with reducing duplication and inefficiencies in the health system and to map out a merger of MINSAs and the health services segment of CSS. The first phase of this undertaking was recently completed, and the first implementation steps are planned for 2019. Full integration of the two public providers is expected to at least take another ten years. Panama is receiving technical support from UN for this health reform.

The Panamanian health system is further divided into 16 health regions; however, public management continues to be highly centralized. Provincial governments have limited control, decision-making power or ability to coordinate.

5.2 Institutional Environment for the HIV and TB responses

In addition to MINSAs and CSS implementation of the HIV and TB responses also requires the participation of several other entities. Since there are invariably many actors involved in the response, this section only highlights the functions of a few core institutions.

The Gorgas Central Laboratory (GCL) shares the stewardship role with MINSAs in the area of health sector research. The Ministry of Economy and Finance (MEF) assigns the annual budget to MINSAs and resolves requests for budget modifications or extraordinary allocations as discussed in section 6.2 in more detail. Civil society organizations, NGOs, organizations of key populations and affected populations also play a critical role as discussed in Section 8. International partners, such as PEPFAR, PAHO, USAID, UNAIDS and others, provide financial and technical assistance. The Global Fund is currently the only donor contributing financially to the TB program; the HIV program, however, receives international funding from multiples sources as highlighted in section 6.3.

For the HIV response, the *Comisión Nacional para la Prevención y Control del VIH* (CONAVIH) is responsible for promoting, supporting and coordinating the necessary actions for the implementation of national programs, policies and multi-sectoral projects in collaboration with the HIV program of MINSAs. CONAVIH was created in 2008 based on Executive Decree No. 7⁵. It is chaired by the first lady of Panama and has its

⁵ The fifteen members of CONAVIH, as stipulated by Executive Decree No.7 of 2008, are: The First Lady, the respective ministers of MINGOB, MINSAs, Ministerio de Educación, Ministerio de Desarrollo Social, MEF, Ministerio de Trabajo y Desarrollo Laboral; the respective directors of: CSS, GCL, two NGOs of PLHIV, two NGOs that are part of the Strategic Alliance and Public Advocacy

own budget line receiving US\$ 1.6 million for the 2016 fiscal year. With these funds CONAVIH provides services to KP, such as operating CLAMs and providing testing in CLAMs. HIV drugs and follow-up tests are covered by MINSA funds. No comparable body exists for the TB response.

The Country Coordinating Mechanism (CCM) is the decision-making body for all matters related to GF grants. It has played an important role coordinating the GF grant implementation and, according to its members, has been an effective center of inter-organizational exchange. It serves as a space for dialogue and technical support and as such is highly valued by its members. The CCM has further fulfilled the role of an early-warning system if an initiative or project does not work on the ground.

Discussions about the future role of the CCM are in nascent stages. If members decide to keep this body alive after GF exit, they need to carve out funding options and define their specific activities and functions to avoid duplication with other fora such as CONAVIH. If the CCM were to be dissolved, one option would be to give CONAVIH additional funding and add seats for civil society. To address the issue of competition for inclusion into this body, CONAVIH could adopt the Mexican model where civil society participants rotate on a regular basis ensuring participation of all interested parties. Regardless of the future governance mechanisms chosen, CSOs can contribute to the agenda, and therefore could continue to have designated roles in the future arrangement. As in many countries, it would also be helpful to further prepare CSOs for the role of representing a range of constituent organizations, and not simply their own organizational interests.

5.3 National programs to address HIV and TB

Both the TB and HIV program are grouped under the *Sub-Dirección General de Salud de la Población*. The HIV program, however, is de facto autonomous as it is run out of the Gorgas Central Laboratory (GCL) with its own budget and staff. Discussions are under way to merge STD, HIV, TB and Hepatitis under one sub-directorate to foster improved collaboration across these programs. CSOs are supportive of MINSA's initiative to integrate HIV and TB. MINSA leadership is confident that this process will move forward, but the timeframe is undetermined as of now, therefore, benefits of a closer collaboration of the TB and HIV programs may not materialize soon.

Tuberculosis

The National TB program receives limited allocations (see Section 6.3 below) and draws predominantly on other sub-directorates of MINSA to carry out activities. At central level, there are three staff members dedicated to the TB response full time. In addition, each of the 16 health regions has a doctor-nurse team serving as a regional coordinator of the National Tuberculosis Control Program, but they also have other

on HIV/AIDS; the presidents of: the General Congresses of the indigenous peoples of Panama, CONEP, Ecumenical Council of Panama, and the Ombudsman Office.

responsibilities. Given its limited resources and staff the TB program does not have much autonomy, but rather relies on the cross-organizational support from different MINSA units.

The National Strategic Plan for TB 2014-2016 contains the cross-cutting principles of respect for human rights (with the objective of eliminating exclusion based on age, gender, cultural background or health status), universal access and coverage, equity and social participation, and also includes specific objectives related to identified key populations. Other notable aspects are its inclusion of HIV-TB collaborative activities and promotion of incorporation of feedback from monitoring and evaluation activities, as well as better coordination between MINSA and CSS. A planning matrix detailing specific activities, indicators, measurable goals and responsible agencies is included, though the costing information is neither robust nor disaggregated by year. The national strategic plan for 2017-2021 is currently under development and is expected to include cost estimates of activities.

At the core of Panama's TB program is the implementation of DOTS and the End TB strategy, both of which are internationally recommended approaches. DOTS strategy implementation started in 1999 and was expanded to all public health facilities by 2005. Currently, DOTS is administered free-of-charge at primary care facilities to all patients regardless of insurance coverage. The broad coverage of DOTS is one of the main achievements of the TB program. TB diagnosis and care is free of charge.

Over the last few years, the TB program has implemented important improvements, including the update of outdated *Norma Nacional de TB* (published in 1999) based on WHO guidelines and accompanying capacity building of medical personnel. Additional protocols and technical guides, with an emphasis on MDR-TB and HIV-TB co-infection, were developed as well. Panama recently started implementing a computerized TB module within the epidemiological surveillance system (see Section 7.4 below) that will improve quality of data and facilitate analysis.

While the plans lay out the ideal, implementation deviates markedly from them. Some program deficiencies persist such as the sub-optimal epidemiological indicators (as presented in Section 3.2 above). Most concerning is the high number of cases that remain undetected or are only detected late. According to the latest estimates, there are 5,000 TB cases in the country, of which only 1,500 are detected. The country has tried to improve the poor detection of respiratory symptoms with the help of promoters; the active search for TB needs to be amplified and outreach performance has to increase. There are currently 15 peer promoters, however, they are financed through GF funds and it is unclear whether these positions will be absorbed upon GF exit.

Late detection is equally prevalent, almost two-thirds of TB cases are diagnosed in hospitals where patients arrive with advanced illness. Primary care facilities could play a much more prominent role in diagnosis.

Diagnosis is further hindered by delays in the transportation and the delivery of results of lab samples. Some delays occur due to geographic difficulties – limited accessibility in rural and coastal regions – however, a sizeable number of samples are not analyzed promptly even after they have arrived at the lab.

Overall, the deficiencies of the national laboratory network seem to limit the performance of the TB program.

While tackling HIV-TB co-morbidity is highlighted as one of the main intervention areas in the national strategic plan, efforts in HIV-TB prevention and coordination are seriously lagging. TB is still not perceived as critical co-morbidity of HIV. The lack of integrated HIV and TB monitoring means that only 19 percent of HIV patients with respiratory symptoms are screened for TB. While HIV testing among notified TB patients is almost universal (95 percent), not even half of co-infected patients receive ART.

TB continues to have a low political profile, and there is insufficient advocacy on behalf of civil society and inadequate oversight of performance by MINSA and CSS. While MINSA staff are committed to TB control actions, they are constrained by systemic health system issues that complicate an already difficult effort.

HIV

The National Multisectoral Strategic Plan for HIV 2014-2019 was developed in consultation with diverse stakeholders from relevant government agencies, international organizations, CSOs and the private sector. Human rights, gender and inclusion are cross-cutting themes, as is monitoring and evaluation. The three main focus areas of the Plan are: i) Strengthening the national HIV response (improving the enabling environment, improving knowledge of HIV, implementing a research plan and strengthening surveillance); ii) Prevention (with a focus on mother-to-child transmission and key populations); and iii) Improving care quality, access and coverage (reducing HIV-TB co-infection rates, improving diagnosis and treatment adherence and ensuring availability of strategic supplies). The plan promotes improved coordination between the different government and non-governmental entities involved in the response, and a greater role for the private sector. The plan is costed and lists specific monitoring indicators.

Currently, HIV testing and treatment is free for adolescents and members of key populations in all public health-care facilities. Starting 2018, the entire population will have the same access to public health facilities as stipulated by Executive Decree No. 214 of May 2016. Since 2013, Panama has implemented the Treatment 2.0 Strategy promoted by PAHO/WHO and UNAIDS with a strong focus on prevention, including treatment as a prevention for KPs. In 2014, Panama is the first Central American country to embrace treatment as prevention and is committed to reaching the 90-90-90 targets having adopted the Fast-Track Targets in 2015.

Administrative challenges in purchasing HIV supplies have led to recurrent stock-outs over the last couple of years putting reliable access to treatment in danger (see Section 7.2).

6. Health Financing Transition

6.1 Macroeconomic and fiscal overview

Panama has one of the most open economies in the region and is well integrated into the global economy. The Panama Canal is one of the major world trade routes, and the country has profited enormously from the growth of global trade. Revenues from the Canal represent about 10 percent of total government revenues. It has also strategically positioned itself as a financial hub and trade center, attracting billions of foreign direct and private investments every year and making it the most competitive economy in Central America (World Bank 2015b).

Panama's average economic performance exceeded regional outcomes over the last decade, and it has been one of the fastest growing economies worldwide. During 2010-2015, Panama's growth rate of 7.5 percent was more than double that of the LAC region of 2.8 percent. Growth has been accompanied by progressive distributional changes leading to declines in inequality. According to the World Bank, the poor, women, and the unskilled have benefited disproportionately from growth. However, pockets of abysmal poverty persist, and the indigenous territories are particularly lagging (World Bank 2015b).

The average unemployment rate was slightly lower for Panama at 6.1 percent than LAC overall at 6.9 percent. Inflation at 3.9 percent was below the regional average of 4.7 percent. Considering that Panama's level of government revenue, expenditure, and debt is on par with its peers—with its debt burden considerably lower than the LAC average—it is in a relatively stable fiscal position for the region. Full dollarization, prudent fiscal policy, and a healthy banking sector contribute to Panama's macroeconomic stability. Analysis by the Economist Intelligence Unit suggests that Panama will continue to experience some of the fastest growth in the LAC region over the next four years, despite a predicted economic slowdown for this period. Its performance will be boosted by toll revenue from the expanded Panama Canal and infrastructure investment (EIU 2016).

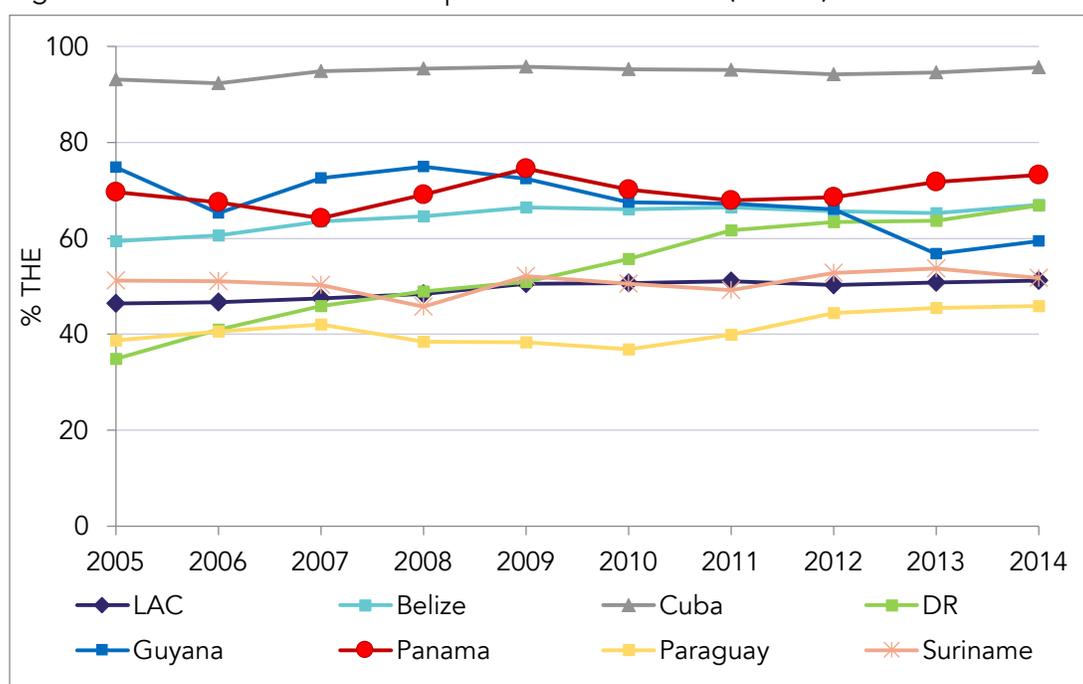
A 2002 social and fiscal responsibility law mandates fiscal deficit ceilings to help maintain fiscal prudence with possible implications for social spending. However, the law is not enforced rigorously; the current government is unlikely to achieve its goal of balancing the budget by the end of its term due to spending on public works and social programs (e.g. increased school scholarships, improved pension provision for uninsured individuals). Still, by 2020 the deficit is expected to drop below 1 percent, below the 1.5 percent ceiling mandated by the country's fiscal responsibility law (EIU 2016).

6.2 Health spending and public financial management

This section reviews health spending patterns across the public and private sectors, and then turns to the effectiveness of budget execution and financial management.

Panama spends considerably on healthcare in both the public and private sectors. Public spending represents a large proportion of overall expenditures on healthcare in Panama reaching almost three-quarters of the total, a significant proportion when compared to other countries in the region, as shown in Figure 12. Regionally, Panama also has the highest GDP and health spending per capita (World Bank). These indicators have been steadily rising over the past decade. As a percentage of government expenditure, Panama spent 14.6 percent in 2014, more than other countries in the region, and surpassed only by Cuba (World Bank 2016).

Figure 12: Government Health Expenditure 2005-2014 (% THE)

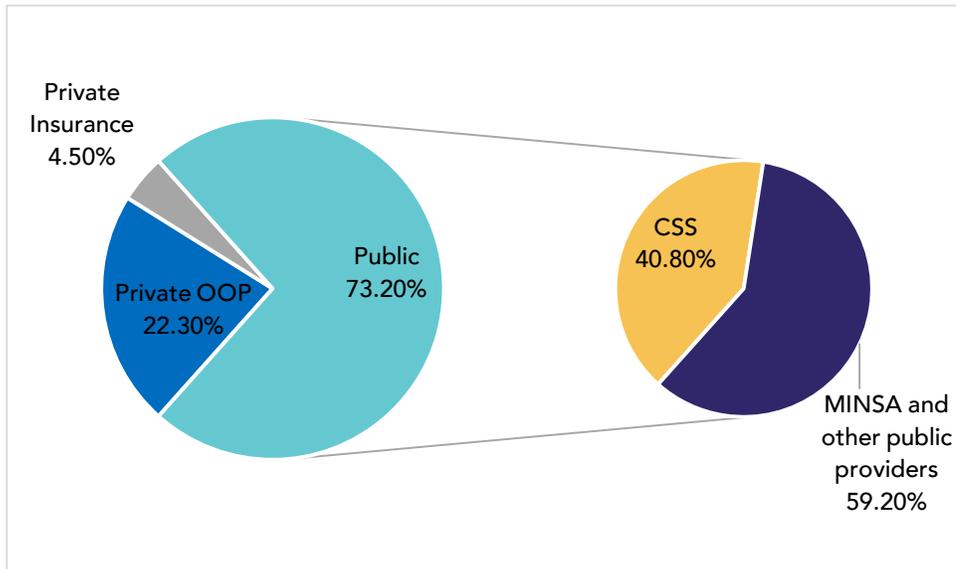


Source: World Bank DataBank (2017)

National Health Accounts provide a broad overview of Panama’s health financing landscape and allow comparisons of spending by different groups.⁶ Figure 13 shows the breakdown for public and private spending shares, and then provides a similar breakdown for public sector spending. MINSA expenditures are close to 60 percent of public sector spending, with the rest financed by CSS. The private sector is dominated by out of pocket payments at 22.3 percent of Total Health Expenditure, with private insurance covering a small segment of the spending and population.

⁶ While valuable trend data they should be taken with caution as much of the data is generated by algorithms rather than from actual data from surveys.

Figure 13: Public and Private Breakdown - Total Health Expenditure, 2014

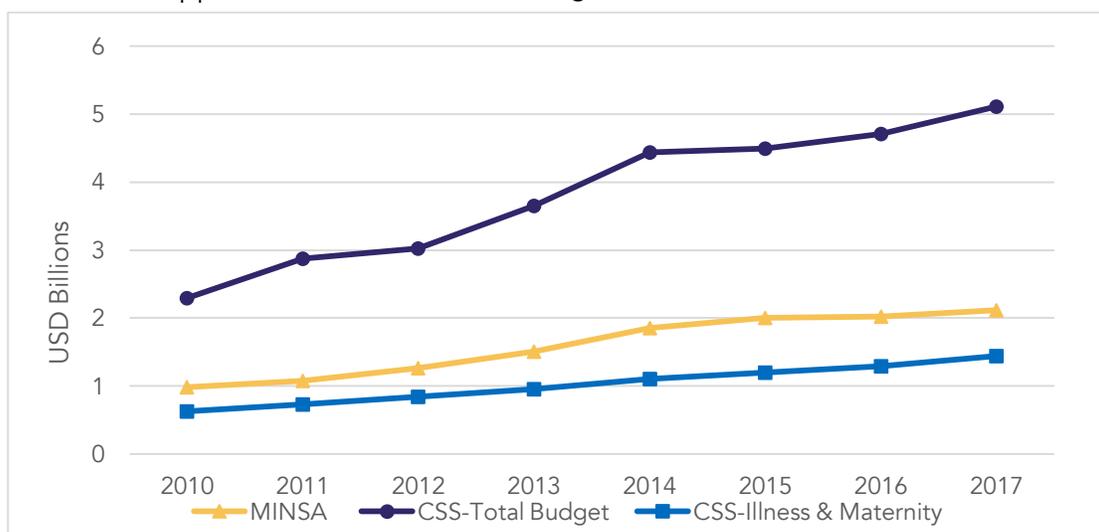


Source: WHO National Health Accounts (2017)

The trends in budgets for MINSA and CSS is provided in Figure 14, and Figure 15 shows trends in budget execution, meaning the extent to which budget allocations are actually spent. MINSA's budget has more than doubled since 2008. The largest increases have been in human resources, mainly to keep pace with increasing levels of inflation, but salary laws and labor union agreements have also played a role. However, new technical and administrative positions were created to staff new health facilities that were opened in the last two years. Inflation has also caused spending on medicines and surgical supplies to rise considerably. MINSA's budget execution rate is high compared to other government bodies, meaning that they are spending their operating budget. The budget execution rate for MINSA investments is reportedly below 50 percent due to rigidities in the operating environment and inevitable delays in construction.

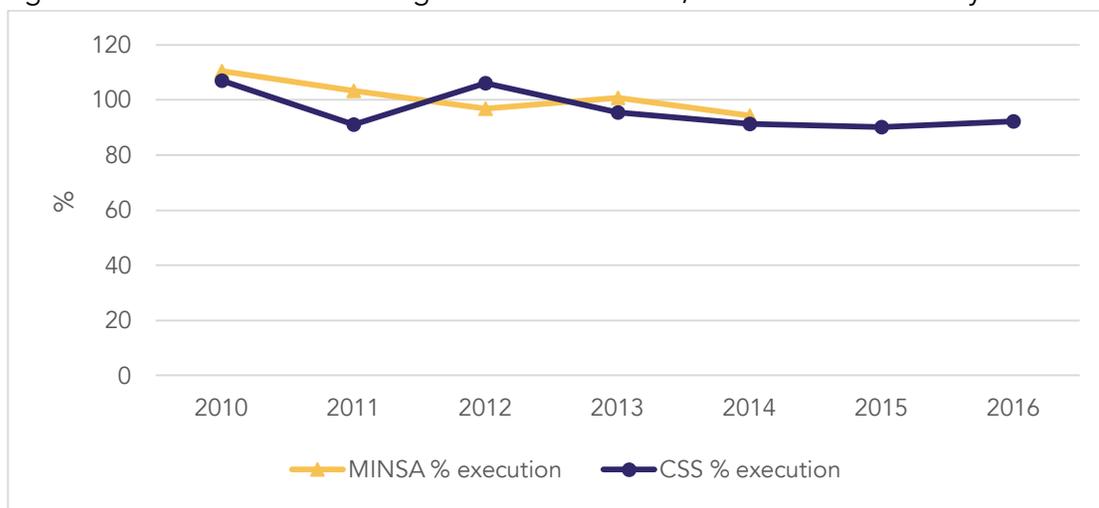
The Social Security Fund is the institution with the largest budget within the Panamanian State as it includes both pensions and healthcare for employed workers and their dependents; Figure 14 shows the breakdown between pensions and healthcare, with the latter roughly double the healthcare budget. CSS is the largest employer of doctors, nurses, technical health and administrative personnel in the country (CSS 2014). As expected, CSS operational expenses are largely dominated by personnel expenses (e.g. fixed salaries, temporary staff salaries, overtime, bonuses, etc.) and material and supply purchases. The staff budget was nearly executed in full, but there were gaps between the modified budget and execution rates of the other portions of the operational budget.

Figure 14: Annual Approved MINSA and CSS Budgets⁷, 2010-2017



Source: MEF (2017)

Figure 15: MINSA and CSS Budget Execution Rates⁸, 2010 to most recent year available



Source: MINSA (2015a) and CSS Financial and Budget Information (2017)

The focus of countries and donors when assessing commitment to health is inevitably on the level of budget allocation for health. While important, budget allocation for health is only part of the story and can often be eclipsed in importance by how or if those funds are spent. The World Bank's Public Expenditure and Financial Management (PEFA) assessment allows a comparison of countries' budget effectiveness and efficiency, that is, how well they execute their budgets. While PEFA is measured at a national level across all sectors, it reflects entrenched problems that directly affect the public health

⁷ Note: Budget figures for MINSA and CSS include both recurrent budgets and investments. The CSS total budget includes: financial and infrastructural investments; early retirement plans; administrative costs; illness and maternity; disability, old age and death; workplace injuries; and others.

⁸ Note: Budget figures for MINSA and CSS include both recurrent budgets and investments. Execution rates were calculated using initial approved budgets as recorded in annual budget laws, as opposed to revised budgets.

sector. Some of these public financial management factors can be mitigated at the sector level while others cannot, reflecting the rigidities and uneven budget performance that limit efficiency in budget management and in overall sector performance.

The latest PEFA assessment for Panama (2013) identified several challenges in public financial management (PFM), including deficits in budget planning and execution, low budget reliability, procurement rules and procedures, transparency of public records, and a missing framework for transfers to sub-national governments. The relevant PEFA categories and their scores (a scale of A to D) are listed in Table 4.

Table 4: Highlights of 2013 PEFA Assessment for Panama

A. Credibility of the budget		PEFA Rating
Composition of the deviations from the budget expenditure compared to approved original budget		B+
Revenue outturn		D
B. Key features of all stages: scope and transparency		
Government operations not included in budget reports		D
Supervision of aggregate fiscal risk caused by other public sector entities		C
C. Budget cycle		
Orderly character and participation in the annual budget process		C+
Multiannual perspective on fiscal planning, expenditure and budgeting		C
Effectiveness of payroll controls		C+
Procurement		D+
Effectiveness of internal controls on non-salary expenditures		C+
Effectiveness of internal audit		D+
Availability of information on the resources received by the units performing the services		A
Quality and timeliness of budget reports for the current year		D+
Scope, nature and follow-up of the external audit		D

Source: World Bank (2013)

The budget formulation and implementation process in Panama lacks clear rules, creating inconsistencies and weakening the objectives of the budget process. Specifically, the number of budgetary modifications tends to be high, preventing a precise estimate of the availability of resources for sectors. Administrative delays further undermine timely implementation resulting in large disparities between approved and executed budgets. The lack of sectoral costing policies impedes linking the multi-year budget with sector or institutional expenditure projections. Without costs, efficiency measures are not possible. Such limitations result in reliance on “historical” (or last year’s) budgets to define future funding, thereby locking individual sectors into the same relative budget levels over time and preventing shifts in funding to respond to new, important and innovative opportunities in various sectors.

The unpredictability of the budget makes it difficult to realistically define activities to be carried out during the budget year. For example, if planned funding for action plans is not granted, implementation will necessarily be temporarily halted or abandoned completely. Reductions in transfers force implementing agencies to improvise a new program by redefining activities to align with reduced funds. A budget executed in this way ceases to be a strategic instrument of administration and planning for the public sector, becoming a simple tool for recording commitments and transfers. Budget planning exercises are being introduced, using some basic tools to project needs, but these do not yet have costing linked to them, and it is not yet linked to budget formulation processes.

The lack of transparency in public procurement stems from processes that are neither based on Procurement Plans nor always recorded and published in the PANAMACOMPRAS electronic procurement system as mandated by the country's regulatory framework.

Fiscal reports do not provide complete information on government revenues and expenditures and hence prevent effective monitoring of budget execution at the national and sectoral levels. Transfers to sub-national governments lack clear and transparent rules. The amounts to be transferred by the government to each municipality are unpredictable, making the preparation of the municipal budget something uncertain or merely nominal. Yet, for most municipalities these transfers represent their main, and possibly only, source of income.

Good PFM is a prerequisite for efficient public service delivery and weaknesses in PFM performance have negative influences on the performance and outcomes in all sectors, including health. While not solely a health sector responsibility, there is a need for performance-based budgeting including modernizing financial planning (something that is already being tested), debt management and fiscal risks from unanticipated disasters. Simply improving fiscal management could free up resources for priority or neglected areas, like HIV and TB. The World Bank (2015b) points out that there is currently a mismatch between the increasing sophistication of Panama's economy and the effectiveness of its public financial and budgetary institutions. Challenges are most marked in the transparency, efficiency and the adequacy of the regulatory framework.

These factors will have a bearing on transition and the ability of MINSA and CSS to respond to HIV and TB demands. This is more of a cautionary note than a significant problem, but it cannot be ignored in planning for the future of these programs.

6.3 Financing of the HIV and TB Response

Tuberculosis

There are no external funding sources for TB other than the Global Fund. Domestic sources, consisting of social health insurance and government revenue, fund the response. For 2016, government funding

towards TB is anticipated to be US\$1,846,949. The remaining 30 percent of the total budget for TB that year are provided by the Global Fund.

Table 5: Anticipated Sources of TB Funding for Fiscal Year 2016⁹

Funding Source	Planned Funding (US\$)
Government (including loans)	1,846,949
Global Fund	768,500
USAID	
Other Sources	
Total	2,615,449

Source: MINSA (2017g)

Currently, the PNCTB is funded at an insufficient level to achieve the entirety of its goals as outlined in the National Strategic Plan. Table 6 below summarizes the gaps as identified by the TB program for the 2016 fiscal year. The gap is largest for drug-resistant TB program cost and operational research and surveys. Of the total planned budget of US\$ 2,615,449, the government provides US\$1,846,949 and the Global Fund US\$768,500. The Global Fund co-financing requirement for the 2016-2018 period stipulated additional national resources to hire additional personnel for the TB program. So far, this requirement has not been met. Given the high drug costs currently incurred by the program, there is an opportunity for savings from buying cheaper drugs as discussed in Section 7.2.

Table 6: Budget for TB Program for Fiscal Year 2016

Component	Needed Budget (in US\$)	Planned Budget (in US\$)	Gap (in US\$)
Infrastructure, Equipment and Lab Supplies	383,500	260,784	122,716
Personnel (Central Unit and Regional, Sub-regional Coordinators)	683,400	639,600	43,800
Drug-sensitive TB Drugs	1,017,258	1,017,258	0
Drug-resistant TB Drugs	78,430	78,430	0
Drug-sensitive TB Program Costs	124,630	505,794	-381,156
Drug-resistant TB Program Costs	270,000	26,360	243,640
HIV-TB Collaborative Activities	125,000	86,223	38,777
Patient Support	20,000	1,000	19,000
Operational Research and Surveys	190,000	0	190,000
Other	85,000	0	85,000
Total	2,977,226	2,615,449	361,777

Source: MINSA (2017g)

HIV

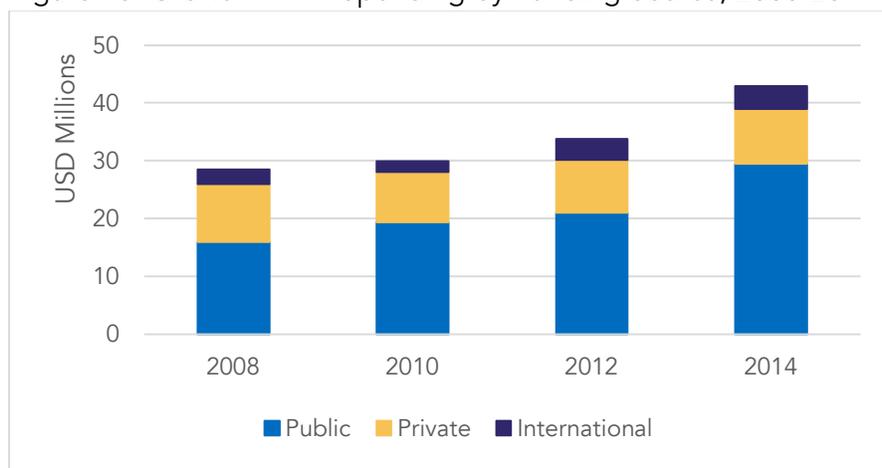
⁹ The information contained in Table 5 does not align with the financial gap table submitted to the GF along with the Concept Note. This discrepancy arises due to the fact that projections were used to prepare the Concept Note. These projections turned out reflect the real data quite closely.

MINSAs and the MEF are the only government agencies that have budgets assigned for HIV. CSS, and all other government agencies, use funds for the HIV response but do not have a separate budget line item. Medición de Gasto en VIH/SIDA (MEGAS) reports have been completed biannually in Panama since 2006, following an initial report that jointly covered 2004 and 2005. These reports offer a detailed snapshot of the state of HIV financing specifically, including all sources of funding and spending by programmatic area and population type. The following USAID/PASCA analysis is based on 2014 MEGAS data.

From 2008 through 2014, the public sector continuously increased spending on HIV/AIDS, from approximately US\$15.9 million to US\$29.5 million. Further, by 2014 the public sector shouldered a significantly higher share of total HIV spending when compared to the private sector and international organizations: 69 percent of the total response, up from 56 percent in 2008; the private sector’s share dropped from 35 percent to 22 percent over the same period, while the international organizations contributed 9 percent in both 2008 and 2014, although their share fluctuated in this period.

In 2014, US\$42,918,587¹⁰ was spent on the national HIV response. The bulk of the HIV response (69 percent) was funded through domestic public resources, and public allocation almost doubled between 2008 and 2014 showing robust government commitment to absorb programmatic costs and scale-up the response. While international contributions have increased in absolute terms, they comprised 9 percent of total HIV spending in both 2008 and 2014, highlighting the dramatic increases in overall funding. Meanwhile, the private sector share has been steadily dropping, from 35 percent in 2008 to 22 percent in 2014 (see Figure 16).

Figure 16: Growth in HIV Spending by Funding Source, 2008-2014¹¹



Source: MINSAs (2016e)

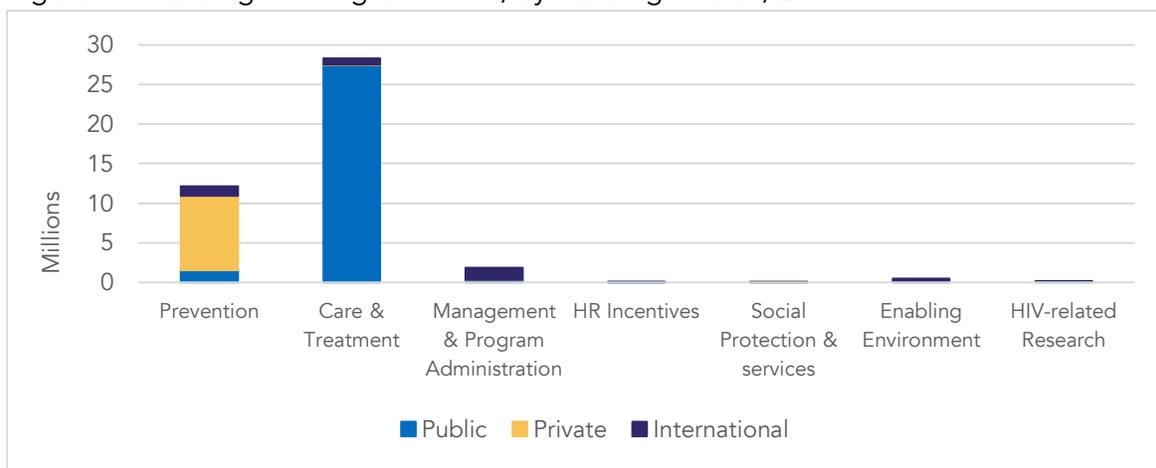
In 2014, spending was dominated by care and treatment at US\$28,261,543 and, to a lesser extent, prevention at US\$12,136,646 (see Figure 17). Domestic public resources funded 97 percent of care and treatment activities. Prevention was primarily funded by domestic private resources, reflecting private

¹⁰ This figure differs from the information contained in the financial gap table because the MEGAS 2014 report was finalized after submission of the documents for the Concept Note, for which estimates were used.

¹¹ Note: Figures for 2008, 2010 and 2012 were inflated to 2014 real terms.

spending on condoms. By comparison, spending on other areas—management and program administration, human resources incentives, social protection and services, enabling environment and HIV-related research—was minimal and to a large extent funded by international resources.

Figure 17: Funding for Program Areas, by Funding Source, 2014



Source: MINSA (2016e)

As shown in Table 7, HIV spending in Panama is predominantly driven by public sources. Private funding for HIV is dominated by household spending. International contributions to the HIV response make up only 9 percent of the total. Their focus is almost entirely on populations at higher risk of HIV infection.

The Global Fund is responsible for 22.8 percent of international funding and 2.13 percent of the total national spending on the HIV response. US agencies, currently shouldering almost half of international support to the HIV response, are also in the process of modifying the focus of their support. Given that this occurs in parallel with GF transition, it would be important for Panama to carefully plan and manage both processes and exploit any possible synergies.

Table 7: Detailed Sources of Spending on HIV/AIDS, 2014

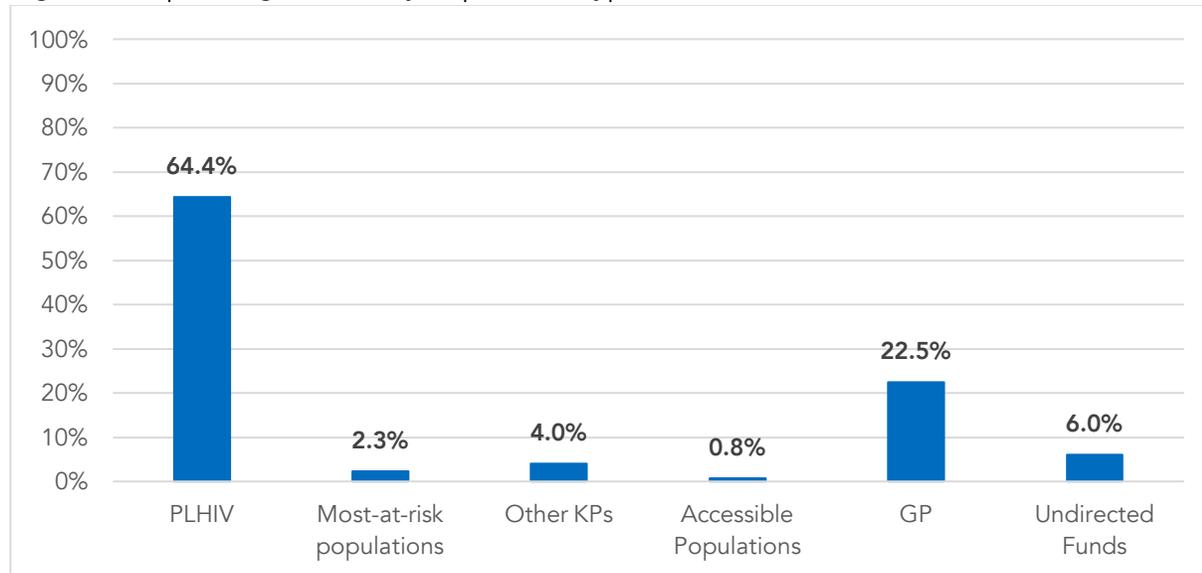
Funding Source—General	Details—Specific	Total (US\$)	%
Public	Total Public	29,476,743	69%
	Central Government Revenue	17,320,544	58.8%
	Local/Municipal Government Revenue	20,000	0.1%
	Employers' Social Security Contributions	5,476,004	18.5%
	Employees' Social Security Contributions	4,259,114	14.4%
	Government Transfers to Social Security	2,385,642	8.1%
	Other Public Funds (Source Unknown)	15,439	0.1%
Private	Total Private	9,429,251	22%
	Non-Profit Institutions (Different from Social Security)	683,683	7.3%
	Household Funds	8,618,875	91.4%

	Private Sources of Financing (Source Unknown)	80,281	0.9%
	For-Profit Institutions and Corporations	46,412	0.5%
International	Total International	4,012,594	9%
	UNAIDS	117,241	2.9%
	Global Fund	915,399	22.8%
	Other International Non-Profit Organizations & Foundations (Source Unknown)	921,580	23.0%
	US Government (primarily through PEPFAR)	1,912,909	47.7%
	UNFPA	80,384	2.0%
	WHO/PAHO	65,082	1.6%
Total		42,918,587	100%

Source: MINSA (2016e)

Figure 18 shows the break-down by population type. In 2014, over 64 percent of HIV spending was directed towards PLHIV, reflecting high expenditure on care and treatment. Most-at-risk populations (which include FSWs and their clients, trans populations and MSM) and other key populations (indigenous populations, people deprived of liberty, truck drivers, blood recipients and babies born to mothers with HIV) received 2.3 percent and 4.0 percent of HIV funds, respectively.

Figure 18: Spending on HIV, by Population Type¹², 2014



Source: MINSA (2016e)

¹² Note: Most-at-risk populations: FSWs and their clients, trans populations and MSM; Other key populations: indigenous populations, people deprived of liberty, truck drivers, blood recipients and babies born to mothers with HIV; Accessible populations: People working in dispensaries, secondary school students, police and other uniformed service members (not military) and factory workers.

MEGAS reports have proven valuable in the past, having helped policymakers optimize spending in blood banks as well as on the prevention of mother-to-child transmission. Based on analysis of 2014 spending, the most recent MEGAS report recommends increased public investment in prevention. Despite their usefulness to disease programming, however, resource tracking and production of these reports is not institutionalized in the National HIV Program or MINSAs/CSS activities, and as a result they rely on considerable external support from agencies including UNAIDS and USAID. The MEGAS 2014 highlights this risk, as well as the difficulties of obtaining reliable data due to existing accounting practices at MINSAs and CSS that do not permit the separation of HIV spending from other health spending. Lack of comprehensive coverage data is another limitation and is hindered by the non-response rate of some providers to MEGAS information requests.

6.4 Future financing of the health sector

Despite rising funding levels in the public health programs of MINSAs and CSS, performances in general, and specifically in TB, have not been noteworthy. The pace of institutional change has lagged behind the rapid growth in national income. Institutions change more slowly than financial shifts in general, but it leaves MINSAs and CSS in difficult circumstances. Part of the difficulty is related to the problems identified above in budget and financial management, procurement, monitoring and accountability. Lack of flexibility in budgetary processes and execution delays improvements in performance and makes change difficult. Given the myriad challenges that have been outlined here, greater flexibility to adapt and modernize how services are financed and delivered will be key to improving efficiency, performance and outcomes at the MINSAs and CSS level. These are all tied to fixing the problems with financing. Funding is essential, but it needs to be managed well and spent where returns are highest both across the government and in the public health bodies. This is the fundamental challenge facing Panama and its public health sector.

Under the current scenario, it is likely that MINSAs will be able to attain adequate funding from the MEF for its agenda. Given national priorities and revenue projections, MINSAs budgets will likely keep pace with inflation and benefit from continued increases in national income. MEF and the Ministry of Planning understand the importance of communicable disease management and the need to adequately fund those programs. Hence both MINSAs and the HIV and TB programs retain priority in the national agenda.

If savings obtained through procurement reforms in MINSAs are used to improve service delivery performance, outreach and training it would touch on many of the challenges faced by the HIV and TB programs, especially those relating to reaching KPs, improving health worker responsiveness and monitoring outcomes. This is not guaranteed, but again is part of an institutional modernization agenda. In a similar vein, if better data and research (see Section 7.4) can be generated and harnessed, improvements in efficiency will effectively translate into additional resources, but this assumes greater autonomy and some way to ensure accountability in public sector performance. Some of this could be achieved within MINSAs, but would require a specific initiative to do so. It deserves some attention, as it would generate savings, but it would also build capacity for modernizing processes within the ministry.

To reach KP better, MINSA is considering contracting out HIV prevention services to CSOs. MINSA has worked closely with PROBIDSIDA since 2008, but this NGO is currently the only direct recipient of government funds. MINSA has also worked closely with non-governmental service providers under international loan agreements. For example, the World Bank's Results-Based Financing (RBF) program *Health Protection for Vulnerable Populations* has drawn on 48 external organizations to deliver a basic package of health services to rural, non-indigenous populations. The program is described in Box 3. These experiences provide valuable lessons learned and as discussed in Section 8.2 formalizing them into a civil society contracting system could be an innovative financing and delivery mechanism.

Box 3: Engaging Non-Governmental Providers in Service Delivery – Panama's Experience with the PSPV Program

In 2008, GoP launched a results-based financing program Health Protection for Vulnerable Populations (PSPV) financed by the World Bank. The program was designed to improve health services to the rural, non-indigenous poor and included TB services. Packages of defined health services were delivered to rural areas, using basic health units (UBA) as intermediaries. UBAs could be either government or non-governmental providers.

A major component of PSPV was the verification of results. A portion of the payment made to UBA every four months was dependent on the achievement of ten service provision indicators, incentivizing good performance. The UBA's responsibility was to enroll individuals in the program and reach out to defined rural populations. A third party was used to verify that the beneficiaries were properly registered, and that coverage and service provision were adequate. The UBA were also financially penalized for non-compliance with protocols, delays in service provision and other issues (Perazzo et al, 2015).

Processes and institutional arrangements under this program provide a useful starting point for the elaboration of a CS contracting mechanism (see section 8).

The slow process of the MINSA/CSS merger could be accelerated by better understanding the net benefits, and implicit and explicit cross subsidies, between MINSA and CSS for infectious diseases. That information would provide a basis for revised payment agreements between MINSA and CSS. Currently, MINSA is shouldering the bulk of the national TB and HIV responses, but it isn't clear how the value of the services provided by MINSA relates to the transfers CSS makes to MINSA.

7. Service Delivery, Procurement, Human Resources and Information Systems

7.1 Service delivery

Service delivery quality and performance will determine how well HIV and TB will be addressed in the short and long term. While they have separate programs, they already rely heavily on the existing healthcare delivery system in both MINSA and CSS.

While there is not much information available on service delivery, it is apparent that hospitals play an outsized role in the Panamanian health sector. Panama, as in many other countries, sees overcrowding in hospital emergency rooms and an underutilization of primary care. There are 18 MINSA and 15 CSS Hospitals in the country. Four of the hospitals are operated as *patronatos*, publicly owned facilities but with autonomy in internal management. They are better managed and have a reputation for higher quality. Panama's premier reference hospital, Santo Tomás in Panama City, has *patronato* status and also has its own generated revenue that permits further independence.

Difficulties in the health system persist in both referrals and continuity of care after discharge. Coordination of care between hospitals and health centers is poor overall. For example, it is worrisome that a large number of TB patients enter the health system at the tertiary level and receive late diagnoses as they present when their symptoms are severe. Currently, there are no incentives to use the appropriate level of care. Some countries encourage usage of lower levels of care by using a referral system that rewards patients for using primary care providers first. Examples include giving patients access to secondary or tertiary services without waiting in line, imposing fines on patients who do not require emergency hospitals care, or exempting patients from other requirements at hospital entry. The bureaucratic separation of hospitals and primary care undermines efforts to encourage use of lower level facilities. Hospitals can provide leadership in linking services across levels of care. Given the lack of incentives for patients, hospitals will need to take on the referral issue if a tiered referral system is going to work.

HIV services are decentralized to 17 HIV clinics (2 of which operated by CSS) offering ART as well as CD4, Viral Load and DNA PCR testing to all PLHIV. In addition, there are 6 "Friendly Clinics" (*Clinicas Amigables*) targeting key populations, namely, MSM, transgender women, sex workers, by providing a stigma-free environment for counseling, testing and treatment. The Friendly Clinics are a service delivery innovation introduced in 2012 as a major part of the HIV strategy. They operate out of primary healthcare centers and are usually open once a week for walk-ins during and outside of normal clinic hours to accommodate the needs of KP. They offer prevention, diagnosis and treatment of STIs and HIV among KPs. The government pays for these clinics in full, but gets donor support for the use of peer promoters. Running these clinics costs about US\$ 700 per day. Some run below capacity, others are oversubscribed. Researchers at the Universidad del Valle in Guatemala are analyzing the effectiveness of the clinics under

a PEPFAR-funded study, and may provide the financial justification to continue offering this targeted service.

Gaps remain towards achieving UHC and major inequities persist. Rural and indigenous populations generally have less access to health services due to remote locations. Language and culture barriers also exist, especially in the *comarcas*. Poor or no infrastructure and human resources capacity in rural settings also pose an important challenge. Further, migration flows into urban centers strain their infrastructure and resources. The laboratory network and the prison program also constitute significant bottlenecks for effective service delivery (see below).

Laboratory network

Timely diagnosis of test results is a prerequisite for both a successful TB and HIV response and a country's lab system plays a critical role in ensuring swift results and linkage to care. Panama's Central Laboratory, the *Instituto Conmemorativo Gorgas de Estudios de la Salud* (GCL), coordinates with MINSA but is under independent leadership. It has been autonomous since 2003 and acts as a World Bank-PAHO reference laboratory for HIV for the Central American region. While the lab is internationally recognized for its path-breaking research, it is less effective in overseeing the country's lab network. Panama has 60 laboratories at the national level, including the 31 labs in hospitals and one lab in La Joyita prison. There are 43 first level and 14 second level laboratories as well as 3 private ones. GCL is the only third level laboratory.

All labs but one (in Guna Yala) fail to yield the expected outcomes due to multiple operative and administrative difficulties. Issues include the late arrival of diagnostics due to an inefficient mechanism for transport samples, while lab samples are sometimes lost or not analyzed due to damages. Panama has currently 14 public GeneXpert machines, five of which were procured through the Global Fund grant. Usage data indicates that the machines are currently not used at capacity, putting the sustainability of these machines into question¹³. After its last visit to Panama the Green Light Committee expressed concerns about laboratory management, quality control and biosafety. The committee also noted that there were insufficient human resources across the lab network.

Currently, there is no national laboratory strategic plan to address these problems. These issues are partially the result of staffing problems as lab technicians generally prefer to work for CSS. While CSS and MINSA have the same pay scale, they compensate for overtime differently, skewing the HR supply towards CSS. There appears to be a scarcity of labs performing BK in the Metropolitana region where 17 health centers are located but which is served by one lab alone. Collaboration with the private sector is limited, exacerbating this bottleneck.

Prison program

The program for People deprived of liberty (PDL) faces several difficulties. MINSA and *Ministerio de Gobierno* (MINGOB) share the responsibility of providing TB and HIV related services to people deprived

¹³ Maintenance of the equipment for two years is already included in the purchase price and the government has committed to take over the maintenance from the third year.

of liberty. MINSA provides human resources and all medical inputs, whereas MINGOB provides security and logistics associated with PDL visits to health centers. Communication between the two ministries has been an issue in the past, both on administrative and logistical levels. For example, due to coordination gaps, hospitals are occasionally not notified in time about PDL transferred over for treatment. TB patients can only be isolated in La Nueva Joya, resulting in overcrowding and unwillingness of the prison management to receive more individuals. This is a concern as DOTS can only be performed in isolation, once PDL are back in a group settings, direct observations are no longer possible.

Access to care and coordination of care is poor. Prison facilities lack medical personnel that are assigned for 24 hours. Instead, care is provided by a nurse-practitioner in the mornings, combined with bi-weekly doctors' visits. There are no incentives for medical personnel to work in prisons; there is no extra pay to compensate for difficult work conditions but rather, added personal costs as doctors travel to facilities on their own dime. Diagnostics are often delayed because transportation has to be coordinated between the two ministries. Hospitals complain that treating people deprived of liberty disrupts their operations as it requires special security and logistics. Further, released PDL are difficult to track for treatment. Prison nurses try to follow up with their patients who, once freed, often miss doctors' appointments and forgo care.

Of the total prison population – 17,535 prisoners – approximately 1,000 PDL are originally from Colombia, putting an additional strain on the program. The prison program works closely with the Colombian embassy to ensure access to treatment for these individuals. However, access to care seems to hinge on the personal commitment of family members that take medications to the prison facilities.

7.2 Procurement and supply chain management

Drug purchasing and distribution pose a significant challenge in Panama. Stock outs, high prices, ineffective supply chain management, and poor pooling of purchases are the root causes, but stem from a combination of complex internal bureaucratic requirements and planning difficulties. MINSA well understands the circumstances and is taking steps to address them, but the problems are broad and significant and are difficult to solve in the short term.

First, according to the National HIV Program, it seems that demand poses challenges for estimation given MINSA's responsibility for but difficulty to estimate needs from CSS, in-migration of HIV-positive individuals and emergence of resistance to available therapies. Greater reliance on modeling to project demand may prove useful to complement existing means of estimating future drug needs based on past use. It is worth noting that current modeling for quantification are robust and could certainly address the challenges identified in quantification. Both HIV and TB programs might therefore consider requesting some technical assistance in that area. MINSA is already collaborating with the Centre for Excellence in HIV/AIDS in Vancouver, Canada to enhance its procurement planning capacity.

Second, procurement processes are onerous and time consuming. Misalignment of internal purchasing procedures with the administrative schedule of the Ministry appear to be a major cause for delays. A WHO/PAHO (2014) Monitoring Mission found that the process for procuring and delivering TB drugs comprised roughly 28 steps. Several departments within MINSa are involved in the procurement process. MINSa's procurement is centralized, i.e. the requests of all 16 health regions are consolidated and procured jointly. The *Dirección de Provisión de Servicios de Salud* receives requests from the different executing programs, it then passes requests to the *Departamento para la Provisión de Suministros Sanitarios* that prioritizes the products and passes the list to the *Departamento de Compras, Dirección de Administración*. There have been discussions to unify the procurement process and to strengthen the capacity at a central level. A proposal to streamline the existing system of public procurement was submitted to the Minister of Health and is pending approval.

Another impediment to speedy procurement of essential drugs is Law 1¹⁴ that stipulates drug approval procedures. Currently, all drugs purchased for the Panamanian market need to be approved by the *Dirección de Farmacia y Drogas*, even if they have undergone a rigorous approval procedure in another country with advanced and credible approval mechanisms. Currently, 8 of the 23 drugs used by the TB program cannot be procured through PAHO's Strategic Fund because they do not meet the strict requirements imposed by Law 1. The law is currently being reviewed and updates to approval processes, such as accepting all drugs approved by the US, EU, Brazil, and other countries with reliable regulations, which could allow MINSa and CSS to purchase drugs more quickly.

Third, high drug prices are a serious problem and are key to the sustainability of the HIV and TB responses. Due to its high-income classification Panama purchases ARVs at higher prices than most Latin American countries. It is participating in a very concentrated market with few responsible providers. Additionally, MINSa and CSS purchase drugs separately which reduces the volume of purchases and drives up costs. UNAIDS (2014) indicates that CSS pays more for ARVs than MINSa. There have been discussions to combine drug and supply purchases of CSS and MINSa to take advantage of economies of scale; however, these discussions are currently stalled. MINSa lacks jurisdiction over CSS and therefore cannot oblige CSS to partake in a pooled mechanism. Progress may require higher level intervention and encouragement.

Fourth, supply chain management further delays distribution of drugs to users, with delays and problems in warehousing and in reaching points of service. Even though Panama has been using a new information system since 2010 for inventory control, alerting officials about upcoming drug supply bottlenecks, stock-outs occur frequently (Avila, 2017; Morán, 2017). Problems with drug storage, related to temperature and humidity, persist. The National Pharmacy administering the central drug storage (*Almacén Nacional de Insumos Sanitarios*) can improve distribution and rational use. While less well understood, strengthening supply chains will bolster the effectiveness of both TB and HIV programs. Savings on drug purchases is only part of the challenge ensuring timely delivery to providers is obviously critical.

¹⁴ Ley Nacional de Adquisición de Medicamentos

In preparation for transition, improvements in both procurement processes and supply chain management are necessary. Panama has already initiated important steps such as reviewing its burdensome legislation and redesigning its protracted internal procurement process. Making the administrative and payment system more efficient is a good first step. In addition to this, drawing on alternative elements of pooled procurement could be a worthwhile option. Joint purchasing through COMISCA, PAHO and UNFPA would allow the country to access drugs and supplies at manufacturing cost. Panama could also participate in COMISCA's drug exchange platform, which allows countries running low on certain drugs to request them from others that have them in stock.

The National TB Program has a 3-year contract with international providers which will run till the end of 2017. This presents an opportunity to consider pooled procurement mechanisms to lower the prices of drugs. It is estimated that alternative purchasing methods could significantly reduce the costs for TB drugs. Similarly, according to the National HIV program, significant cost reductions for the HIV drugs could be obtained through PAHO Strategic Fund. An analysis was presented with the estimated figures to the Minister of Health and is under review.

For the upcoming years, the HIV program has already indicated it plans to buy from PAHO supplemented by purchases from local pharmaceutical companies. The reason for splitting the purchase between different suppliers is to lower the overall costs to the government and mitigate the risk of delays. PAHO can reduce the costs of drugs significantly and their accompanying technical assistance offers additional support to governments and strengthens the value of procuring through PAHO. However, long processing times of up to nine month reduce the ability to rely on them exclusively. Maintaining access to other commercial providers to fill unforeseeable gaps is therefore seen as necessary by the HIV Program as private companies tend to provide drugs with a quick turnaround. Spreading the risk across different providers can help ensure consistently adequate stocks of drugs even in cases where anticipated drug needs falls short of actual drug needs.

7.3 Human resources

The leadership of the HIV and TB programs stressed that insufficient personnel in health facilities and labs, especially in inaccessible regions, presented an obstacle to successfully implementing prevention and treatment activities. To address these shortages the health system has seen an overall increase in HR in all areas over the past years. The salary levels for MINSA and CSS personnel have increased to keep up with inflation. However, personnel shortages persist.

Given that the budget spent on HR already makes up the largest portion of the MINSA budget, it would be difficult to justify further budget increases for HR to MOF. Instead, ways to use existing staff more effectively can be considered. A perceived lack of human resources is caused to a large degree by the inadequate – geographic and technical – distribution of existing personnel. The geographic distribution of the health workforce is highly concentrated in urban areas due to difficulties recruiting staff for rural

areas. Financial incentives to attract public sector workers to work in rural areas could help mitigate the shortage.

Furthermore, better HR management could help alleviate the mismatch between skills needed and those filling the job. Hiring priorities are defined at the local level and communicated to the central level, the HR department of MINSA then makes decisions on staff deployment. Currently, staff are moved around based on non-technical criteria such as seniority. Updating existing guidelines with prerequisites for filling positions with qualified people could improve the overall performance of the health workforce. Relatedly, MINSA currently lacks a bonus system – it has no way to penalize or reward performance financially.

Given its tiered HR structure, MINSA has some flexibility in hiring and firing. The permanent appointments can take months to fill but temporary staff, with their contracts limited to 12-months, can be hired faster, often within a month. MINSA also uses short-term contracts to hire professional services for up to two months. It is contractually very difficult to dismiss permanent staff; in contrast, staff with short-term contracts can be easily replaced making it easier to address fluctuating HR needs.

MINSA competes for the same human resources as CSS. While both institutions offer remuneration based on the same pay scale, working conditions and timely payments for overtime are often the reason health personnel choose CSS over MINSA.

In preparation for transition, the HIV program stressed the need for funding and creating a position overseeing all monitoring and evaluation at the national level. This hire would help oversee the data collection process and ensure that information is harmonized across sources.

For the HIV program, peer promoters were hired with funds from the GF to help improve treatment adherence through home visits. There are currently 15 peer promoters, however, they are financed through GF funds and it is unclear whether these positions will be absorbed upon GF exit. To further assist with transition, Global Fund-funded peer promoters can be hired on short-term contracts under existing hiring rules. While MINSA currently has no rules for the contraction of peer promoters, there are rules for health promoters: these include minimum requirements including for academic and technical training and are the same across regions. Each health region requests their contracts separately from the central level given that each has its own minimum operating budget defined based on to their needs. Since the peer promoters would have to be separately requested by the different health regions, a continuation of these positions depends on local political will.

7.4 Monitoring, evaluation and research

As highlighted in the 2016 PEPFAR Sustainability Index and Dashboard (SID), Panama made strides toward improved collection of strategic information, both with regards to performance evaluation and epidemiological data. A National Monitoring and Evaluation (M&E) Committee exists and links with government health sectors including those involved in specific disease responses, such as TB and

HIV/AIDS, and there is a national M&E plan. However, challenges remain as evidenced for example by the information gaps regarding the treatment cascade highlighted in Section 3.1.

The information system for epidemiological surveillance in Panama is called *Sistema de Vigilancia de Salud* (SISVIG). MINSA developed this web platform for automated registration of surveillance data in collaboration with CDC and began implementation in 2010. The platform seeks to combine data generated by the Ministry of Health, the Social Security Fund and the private sector. This constitutes an important improvement compared to previous years where data collection was scattered across providers. SISVIG contains weekly updates on notifiable items per the country's sanitary code, such as on mortality in hospitals and morgues, and also has separate HIV and TB modules.

HIV indicators are tracked in SISVIG-MONITARV and TB indicators in SISVIG-TB. These modules allow for the registration of the diagnosis, treatment, follow-up and discharge of the TB and HIV patients, broken down by geographic areas and specific populations. Unfortunately, SISVIG does not collect information on transgender identity for either TB or HIV; it does, however, include all different indigenous groups. The activities outlined in the National TB plan are linked to specific indicators captured in the SISVIG system.

Some key implementation issues remain, specifically issues of connectivity and underutilization of the reporting system. In remote areas of the country only 50 percent use the system while the others resort to paper-based reporting. Not surprisingly, the paper-based results lead to significant delays in reporting and action. Since cellphone coverage is much more widespread than internet connectivity, one innovative way to overcome this challenge would be to transmit the information collected on paper via cellphones and then integrate the information electronically into SISVIG at the central level.

It is also problematic that information on TB and HIV is collected separately. While SISVIG-TB has a module on activities related to HIV-TB, the information collected is not systematically merged with the information collected by the HIV program. The lack of integration between HIV and TB programs in data collection exacerbates already separate programming. The integration of TB and HIV should be reflected in monitoring as well. Furthermore, there is a lack of integration of reporting by the private sector and CSOs.

Despite best efforts at data collection modernization, there are inconsistencies in the information between the PNCTB, SISVIG, and the Central Lab (WHO/PAHO, 2016). Labs do not have access to SISVIG, but use separate data monitoring systems, and the lab network lacks an effective online IT system, which together contribute to delays in diagnosis and the onset of treatment. Integration of these data systems is necessary to ensure timely data and intervention, and to avoid contradicting data that now plague the system.

With inadequate and uncertain data that inhibits effective monitoring, evaluation is almost nonexistent, to the detriment of the HIV and TB programs. Evidence on what has worked will be important to strategies going forward. For examples, surveys in high-risk areas to understand the shortcomings in current efforts,

and an evaluation of the role and effectiveness of peer promoters in reaching high risk individuals would seem particularly valuable.

The situation is similar with research. This report has suffered from the absence of good studies of key elements of the health system and its effectiveness, and of how well the objectives of HIV and TB have been met through the overall delivery system. Part of this is due to the fact that research funds are limited as shown in Section 6.3.

M&E can be strengthened in both the government and civil society. Neither have meaningful evidence of their impact or usefulness, nor do they have any sense of costs. Current indicators are predominantly input or process-related and there is a lack of close coordination with M&E of the prevention programs funded by the donors. To strengthen the disease responses, the focus is best placed on results and impacts. Moreover, weak analysis of existing efforts makes data-driven decision-making impossible and therefore decisions must rely on assumptions and anecdotes.

8. Civil Society Organizations

8.1 Current state of civil society strengthening

Civil society is active in the HIV response, but is highly fractured. While community-driven organizations are committed to the HIV response across all key populations, no functional national networks of organizations, either for PLHIV or for the HIV response as a whole, exist. Significant in-fighting and competition, driven both by personalities and limited availability of funds, has been documented between organizations serving the same populations. While this is not unusual, it is limiting civil society's ability to conduct effective advocacy, to be represented effectively in decision-making processes, and to collaborate on effective program implementation or monitoring. Without a significant change in this inter-organizational dynamic, it is unlikely that Panama's HIV-related civil society can effectively survive the exit of the Global Fund or gain a greater foothold as a full partner in planning, implementation and monitoring of the national HIV response.

Table 8: List of CSOs serving key populations

CSO	GP	Pregnant Women	MSM	FSW	Trans	Indigenous	PLHIV	Children	Drug Users
PROBIDSIDA	X	X					X		
Asociación Viviendo Positivamente							X		
Grupo Génesis Panamá Positive	X	X	X			X	X		
Equipo Multidisciplinario para Educación en SSR	X	X		X			X		
Asociación Panameña de Personas Trans					X				
Hombres y Mujeres Nuevos de Panamá			X						
Mujeres con Dignidad y Derechos de Panamá				X					
Mujeres Luchando por una Nueva Vida				X					
Asociación Nuevos Horizontes			X		X				
Cruz Roja	X								
Hogares Crea									X
PASMO	X		X	X					
Observatorio Ciudadano							X		
AID FOR AIDS						X		X	
APLAFA	X	X	X	X			X		
CHEBS	X						X		

Source: MINSa (2015c)

Civil society is currently empowered to interact with planning the HIV response, but not as active decision-makers. CSOs are actively involved within CONAVIH, through which they may share perspectives and recommendations. However, as defined in the decree creating the Commission, CSOs are included in CONAVIH at the invitation of the person presiding over the Commission, who according to the decree, is the First Lady of the country. As a result, not all affected populations are mandated for inclusion. In addition, the lack of cooperation between CSOs, as described above, means that CSOs serving as representatives to CONAVIH are likely to represent only their own interests, rather than representing all people from their key population. The most problematic aspect of the current arrangement is the lack of a decision making authority: CSOs may advise CONAVIH, but do not have a vote on any decisions. As Panama makes a decision on the future of the CCM and its long-term interaction with either CONAVIH or any other integrated HIV-TB decision-making body, the issue of transparent election of CSOs and empowerment of these members to vote should be an important concern.

There is still a significant need for community systems strengthening to be addressed before a Global Fund exit. The Global Fund and USAID/PEPFAR made investments in the technical capacity of these organizations to implement outreach models and provide other services. Significant improvements have been achieved, however there is still a need to further strengthen their organizational capacity. CSOs note they face difficulties in project management, some of it related to Global Fund management models. However, there is an acknowledgement that if CSOs are to transition to implementing government social contracts, there will still be significant need for capacity building to assure that organizations can effectively apply for funding, and plan, implement and monitor their work in a professional manner under any new mechanism. This capacity building will need to be done alongside efforts to instill a sense of unity and cooperation between organizations, empowering them with conflict-resolution skills and facilitate joint advocacy and action. An effort to link Panamanian partners to regional networks and foster regional exchange – beyond the neighboring countries of Colombia and Costa Rica, which have quite different circumstances – may benefit this effort.

The TB response has limited involvement from civil society, and current models do not appear sustainable following the exit of Global Fund support. While contracting former TB patients as promoters is believed to be an effective model, particularly in indigenous areas, this model has some significant limitations from a sustainability perspective. Promoters are contracted as individuals, and in relative isolation from each other, which does not allow for cross-pollination of experiences and ideas from one area to the next, nor for building long-term dedication to cause and morale. In addition, these promoters are currently fully funded by Global Fund funding, and there has been no attempt to institutionalize this model. There may be opportunities for further organization and development of these cadres of promoters through integration with HIV service organizations.

8.2 Sustainability and resilience of civil society beyond transition

To reach KP better, MINSA is considering contracting out HIV prevention services to CSOs. MINSA has worked closely with PROBIDSIDA since 2008, but this CSO is currently the only direct recipient of

government funds, and provides a full range of medical services; this model differs significantly from some of the necessary community-based outreach interventions which stand to lose support when Global Fund funds cease.

MINSAs have also worked closely with non-governmental service providers in other sectors under international loan agreements. For example, the World Bank's Results-Based Financing (RBF) program *Health Protection for Vulnerable Populations* has drawn on 48 external organizations to deliver a basic package of health services to rural, non-indigenous populations (Perazzo 2015). These experiences provide valuable lessons learned and as discussed in Section 8.2 formalizing them into a civil society contracting system could be an innovative financing and delivery mechanism.

As such, development of a broadened social contracting system for provision on HIV services, including prevention, for key populations is both possible and necessary. There are no legislative barriers preventing this from happening. Further, there is now political will with the national HIV program to create such a system to ensure the sustainability of the civil society response to HIV (and potentially to build it in response to TB); however, some doubts within other sectors of government, including within MINSAs, may need to be overcome to assure long-term sustainability. Implementing a social contracting system to scale will require significant technical assistance and exchange with countries of the region which have a history of successfully implementing such models. A more detailed analysis of the circumstances related to social contracting are provided in Appendix 5.

In addition to addressing social contracting, CSOs urgently need assistance in sustainability planning. While sustainability should necessarily include social contracting, it is not realistic to expect that all CSOs will be able to or should want to be solely reliant on government resources; in fact, several CSOs interviewed expressed concerns about this level of reliance. This is in line with international norms, as globally CSOs tend to avoid full reliance on government resources because it limits their ability to advocate for changes that require government action, and also leaves them vulnerable to dramatic changes in state budgets and priorities. Panama does not currently have any effective models of social enterprise or business planning within its HIV civil society response; yet, as a tourist destination and a fiscal hub for the region there are tremendous opportunities for private partnerships and utilization of the local economy to help diversify funding for CSOs.

9. Conclusions and Recommendations

The recently communicated Global Fund allocation to Panama for HIV/TB equivalent to US\$2.7 million for HIV/TB is expected to be the last one. This transition readiness assessment identifies positive elements as well as areas of risk in the level of preparation of the country to face this transition. It also includes suggestions on interventions recommended to be included in the transition work plan to be developed as the basis for the funding request for the transition grant.

1. National financing for HIV and TB is relatively assured, the challenge is ensuring MINSAs savings can be reprogrammed within the sector. High level support for public goods from both the MEF and MOP offer important underpinnings for both programs. The government also has the legal right to contract out services to private entities, which makes support to CSOs for key populations a feasible alternative, and one that officials view as important to the HIV program. The government transitioned smoothly to financing immunization programs; it already finances 69 percent of the HIV program, and the MINSAs delivery system currently manages most aspects of the program. Ensuring effective HIV and TB programs remains the challenge. A number of issues are raised below in this regard. A major concern emanates from the national budgeting system and the built-in rigidities that provide few incentives for efficiency or savings. Allowing MINSAs to reprogram savings will be key to encouraging lower cost options and adopting other improvements in service delivery.

2. The TB program faces multiple challenges including identifying possible patients, obtaining test samples, realizing laboratory testing and diagnosis in a timely fashion, and ensuring completion of a full treatment regime for patients, particularly among indigenous groups and those outside the ambit of primary care clinics. Areas of consideration for strengthening TB performance include: (i) outreach to high risk communities through broadening community health worker (CHW) numbers, linking their efforts to those of the primary care clinics, and engaging CSOs to better identify at-risk individuals; (ii) improving clinic management of samples; (iii) upgrading laboratory services (see below); and (iv) tracking patients on treatment. The latter could benefit from greater use of CHWs, CSOs and of recruiting local leaders to support patients during treatment; harnessing cellphones to offer reminders for patients can be highly beneficial for those patients with such devices. This, however, requires that primary care units have cellphones as well.

Transition work plan opportunities: Identifying and evaluating current good practice in any of these areas; testing outreach options; upgrading training of primary care providers and outreach workers.

3. The Gorgas Central Laboratory is key to diagnosing and tracking both HIV and TB, but has fallen short for both diseases. GCL has demonstrated weaknesses as a reference laboratory, and in supervising the laboratory system overall, the latter is part of its regulatory and oversight function in the Panama laboratory system. Efforts to strengthen the leadership, management and performance of GCL are critical to the effective operation of the TB and HIV programs, and will produce benefits beyond these diseases. Important areas to consider are (i) improving internal management; (ii) bolstering the interface with the

rest of the system through outreach and establishing feasible processes; (iii) taking on the responsibilities of a functioning reference laboratory to support the smaller laboratories and provide them with training and processes to effectively operate a national laboratory system; (iv) integration of data systems, i.e. use of SISVIG to report diagnoses; and (v) exploring collaborations with private laboratories to avoid backlogs of undiagnosed samples.

Transition work plan opportunities: Provide data and analysis of specific weaknesses to diagnose priority areas for upgrading; aligning the management information systems of the TB program and of the laboratory system to communicate seamlessly; testing incentives to strengthen the laboratory system and its interface with the lower level laboratories; testing use of private laboratories as a back up for GCL.

4. The cost of drugs inhibits accessibility and affordability of both prevention and treatment, and distribution remains a challenge. MINSAs efforts to improve flexibility in drug procurement through revisions in Law 1 are ongoing and will be critical to lowering the overall speed of drug approvals and permit lower cost drug purchases. Extending the current joint MINSAs-CSS procurement of vaccines suggests the potential benefits of extending this arrangement across all pharmaceutical purchasing of the two institutions, which would benefit from higher volumes. It would also bring the two institutions closer together in operating their systems. Harnessing the PAHO Strategic Fund, something already under discussion, will specifically lower costs of HIV and TB treatment. These ongoing initiatives are encouraging and align with our assessment of priority reforms in drug procurement. Finally, further exploring a possible Central American joint purchasing arrangement (COMISCA) to provide a backup supply of drugs from a regional pool would ensure continuous availability of vital pharmaceuticals.

Supply chain of drugs and reagents faces difficulties with frequent stock-outs and gaps in coverage. Given the efforts at improved management and the seriousness of the supply shortfall for promoting drug resistance, radical solutions may be appropriate. Outsourcing such services would relieve the burden on MINSAs and ensure professional management of drug supply chains, and reduce bureaucratic burdens on front-line providers. However, the rigidity of the budget system may undermine the ability to outsource. Nonetheless outsourcing offers an alternative to public sector efforts that struggle with distribution and in doing so jeopardize treatment, and potentially prevention of HIV transmission. Uncertainty of supplies further undermines the ability to plan and to use resources sensibly.

Transition work plan opportunities: Testing alternative supply chain arrangements and evaluating the impacts to guide policy; trying new ways of allowing front-line workers to (re)order drugs such as use of cellphones when connectivity is a problem; establishing a follow-up system to ensure responsive supply chain management.

5. Data and Information for policy and programs are weak. Data systems are inadequate despite efforts at standardizing reporting for HIV and TB, although each of these programs has its own data system. Data estimates of incidence both overall and especially for high risk groups provide inconsistent measures across sources, undermining efforts to inform policy and build cost effective programs. Despite best efforts at data collection modernization, there are inconsistencies in the information between the PNCT,

SISVIG, and the Central Lab (WHO/PAHO 2016). Labs do not have access to SISVIG, but use separate data monitoring systems, and the lab network lacks an effective online IT system, which together contribute to delays in diagnosis and the onset of treatment. Integration of these data systems is necessary to ensure timely data and intervention, and to avoid contradictory data that now plague the system.

Similarly, research on effectiveness and efficiency of public and CSO efforts is largely absent. Going forward, effectiveness and affordability will be key, hence the need to ensure robust data and information to guide policy and program decisions in HIV and TB. A number of data and research options could strengthen the current arrangements: (i) regular, standardized surveys of incidence and prevalence across risk groups and in the general population; (ii) better training of health staff in prioritizing reporting of infectious diseases; (iii) providing health staff, particularly in outlying areas with uncertain connectivity, alternative timely reporting options, such as sending photos of completed forms via cellphone; and (iv) research on the relative costs and impact of alternative public and CSO outreach initiatives. Using results from studies of impact across programs can provide the evidence for bolstering the returns on public investment in HIV/TB prevention and treatment.

Transition work plan opportunities: Data and research are possible areas for strengthening under the transition grant from the GF as better data offers a useful agenda for transition, and research on multiple fronts could better inform performance as well as the transition process.

6. The HIV/TB program for persons deprived of liberty is not working effectively and deserves attention to better align intentions, program investments and processes. Identified problems include adequacy of space, transport, security, data and patient compliance. Given the high rates of infection in this population, controlling both HIV and TB will entail focused efforts. The program deserves to be rethought and revamped. The current contortions and perverse incentives in managing these diseases among PDL make sensible decision making and project management difficult, if not impossible. A more rational structure and better designed processes could streamline operations, reduce costs and raise the working conditions of public workers, including medical staff, police and prison officials. A good example is the distorted incentives in reporting TB infection. Currently admitting a TB infection results in a transfer to a new location. Incentives that encourage reporting of (possible) infection are preferable if the disease is to be contained. Difficulty in managing PDL health is common, but with HIV and TB the implications are serious for other PDL and the general population. A better designed program that considers efficient and safe processes, and at the same time reduces risks for all concerned, would improve on current arrangements.

Transition work plan opportunities: Collecting specific information and data to map the shortcomings of the current system; from that mapping providing advice on how to improve performance at key points along the chain of prevention, testing, counseling, and treatment.

7. Merging MINSAs and the CSS public healthcare systems is an issue that has resurfaced after many years and is now on the current agenda. The pediatric hospital and those facilities serving rural populations work jointly to serve those populations. Merging the two systems would reduce duplication, and allow a

single strategy in TB and HIV, with combined programs and joint funding. Currently the subsidy incidence is not clear and responsibility is diffuse.

Transition work plan opportunities: Study of the services provided, the estimated costs and the value of those benefits and spending between MINSA and CSS; proposed costs to the institution purchasing services from the other. This also provides information on ways to merge functions between the two institutions.

8. Managing HIV and TB jointly could produce savings and synergies. The HIV and TB programs are managed separately, although the co-infection rate is high and there are natural synergies. The government has plans to merge HIV, TB and hepatitis, and doing so could improve coverage, and generate savings from joint programming. Joint oversight could also stimulate greater efforts on prevention if they are addressed together rather than as separate activities. We encourage this planned merger.

Transition work plan opportunities: Support steps to structure a new, integrated arrangement for managing the co-morbidities.

9. Assessing the options for continuation of the CCM's contribution to the national disease responses. With the Global Fund support gradually ending, the future of the CCM is uncertain. The CCM has been effective in assuring that service delivery CSOs and individuals representing key populations have a formal voice in decision-making within the HIV and TB response. If stakeholders decide to maintain this body after GF exit, funding options need to be identified. If the CCM were to be dissolved, one option would be to give CONAVIH additional funding and add seats for civil society. To address the issue of competition for inclusion into this body, CONAVIH could adopt the Mexican model where civil society participants rotate on a regular basis ensuring participation of all interested parties.

Transition work plan opportunities: Assessing different options for future role of CCM and identifying alternative sources of funding.

10. Strengthening prevention efforts, including civil society's role to support national efforts in meeting global targets for HIV and TB. While joint management of HIV and TB may produce positive benefits in terms of programmatic costs, it will also be critical to maintain and strengthen prevention efforts. Implementation of existing strategies for health, dignity and positive prevention, as well as further articulation of a specific, evidence-based prevention strategy nationally, will be critical for preserving the integrity of the HIV response. We strongly recommend that civil society be intimately involved in both the design and implementation of such a strategy, through an enhanced role in decision-making in national bodies as well as engagement in social contracting (as further discussed below).

Transition work plan opportunities: Suggest development of an evidence-based national prevention strategy as a pre-requisite for transition funding, and support civil society involvement in its design.

11. Piloting of social contracting. Given the political will available to assist in funding non-state actors to implement health interventions, it is ideal to lay the foundation for a sustainable social contracting program. This entails:

- i. Developing and budgeting a specific prevention plan (based on scientific evidence) which includes provision of services by CSOs;
- ii. Strengthening community systems, including skills development, training on specific issues and conflict resolution processes;
- iii. Bolstering the mechanism for social contracting within MINSA, based on the experience of MINSA in outsourcing under the World Bank's RBF project "Protection in Health for Vulnerable Populations";
- iv. Strengthening government technical capacity for issuing tenders, conducting transparent selection, monitoring and supervision of projects;
- v. Piloting the process for 18 months or longer;
- vi. Developing final national technical guides in accordance with international recommendations.

Transition work plan opportunities: It is recommended that the CCM and the Country Team work jointly to explore opportunities to introduce a funding model similar to that being explored in Montenegro, whereby any further grant funds for CSOs from Global Fund are awarded to the government specifically to be run through the social contracting mechanism.

12. Continued strengthening of civil society community systems, both in terms of technical capacity and capacity for greater coordination. In order to support the implementation of an enhanced combination prevention strategy and the social contracting mechanism noted above, it will be necessary to greatly expand the capacity of HIV civil society for cooperation and joint program implementation with the government, as well as build their technical capacity for program management under the new funding paradigm. This will require extended mentorship and support from external actors, and may also be supplemented by strengthening linkages to regional networks. There is urgent need for sustainability planning for CSOs, beyond the ability to apply for social contracts for service delivery from the Panamanian government. It is recommended that that funding partners active in the region, including both USAID/PEPFAR and the Robert Carr Civil Society Networks Fund, be engaged in identifying funding opportunities for supporting this work.

Transition work plan opportunities: Supporting capacity building on critical areas for CSO sustainability. In addition to the country grant support could be sought through the Global Fund Community, Rights and Gender Special Initiative, including through regional grants.

13. Committing to anti-discrimination actions, led by the government in close coordination with civil society, to improve the environment for KP and encourage utilization of testing and services. Ultimately, efforts to expand reach to the most marginalized key populations, and to stabilize and reverse the HIV epidemic in order to comply with UNAIDS' global commitment to end AIDS by 2030 will not be achieved without reduction of stigma, discrimination, and violence against key populations. This is critical to be

addressed both within the healthcare setting, where the current system does not adequately support equitable access to care nor does it provide any redress for violations, and outside the healthcare system, where systematic discrimination and violence experienced by SW, MSM and transgender people create barriers or disincentives to accessing services. The work of civil society partners such as REDCA+ in documenting and denouncing human rights violations both for PLHIV and key populations should be amplified and replicated as part of this process – but it must necessarily be met by government support to address violations identified.

Transition work plan opportunities: Supporting appropriate legislative changes to protect against discrimination; consider importance of empowering civil society to advocate on this issue in a united front, for long-term impact.

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11. Appendix

Data Requests for Country

Section 3.1

- What are the requirements for a patient to receive care at an ART clinic, especially any referral requirements or need to be accompanied (by a health professional, peer promoter, etc.)?

Section 5.2

- What does the CONAVIH budget include (e.g. what does it fund)?

Section 6.3

- What were the actual funding sources for TB for FY2016? Table 5 (Anticipated Funding Sources) in the report does not align with the TB funding gap table provided by the country for the Global Fund Concept Note.
- What was national expenditure on HIV in 2014? There is a discrepancy between the data in the MEGAS 2014 report and the HIV funding gap table provided by the country for the Global Fund Concept Note.

Section 7.3

- What are the existing hiring rules for peer promoters? Why must they be requested separately by the different health regions rather than centrally?

Appendix 1. List of Stakeholders consulted

- Ministerio de Salud, including the Ministro de Salud
- Mecanismo Coordinación de Panamá
- Fondo Mundial
- PNUD
- Laboratorio Central de Referencia Programa de Control de la Tuberculosis
- Programa Nacional de ITS/VIH/SIDA
- Grupo Jacobs
- Organización Mundial para la Salud (OMS)
- Caja de Seguridad Social
- Hospital Santo Tomas
- OPS
- ONUSIDA
- UNFPA
- USAID – PASCA
- USAID - Delivery
- PEPFAR
- Dirección General de Salud
- Dirección de Epidemiología
- Dirección de Planificación de Salud
- Ministerio de Economía y Finanzas, including the Viceministro de Economía y Finanzas
- Ministerio del Gobierno – Programa de Salud Penitenciaria
- Dirección de Finanzas
- Dirección de Recursos Humanos
- Dirección de compras y suministros de Salud
- Asociación Hombres y Mujeres Nuevos de Panamá
- Asociación Nuevos Horizontes
- Asociación Panameña de Personas TRANS
- Asociación Viviendo Positivamente
- Activistas Independientes
- Asociación Cambiando Vidas
- Asociación contra Enfermedades Respiratorias Contagiosas prevenibles como la Tuberculosis
- Asociación Nueva Vida
- Centro de Desarrollo Juvenil Comunitario
- Consejo de Mujeres Indígenas de Panamá
- Consorcio Clave 3
- Grupo Génesis Panamá +
- ICW Latina
- Jóvenes Positivos de Panamá
- Consejo Nacional Juventud de Panamá
- Mujeres con Dignidad y Derecho de Panamá
- Mujeres Independientes Luchando por sus Derechos
- Observatorio Ciudadano DDHH y VIH Panamá
- ONU Mujeres

Appendix 2: Current HIV/TB Grant

Table A2.1: Projected Budget Summary by Module, Current HIV/TB Grant 2016-2018

Module	Amount Allocated (US\$)			
	Year 1	Year 2	Year 3	Total
Prevention: MSM, Transgender	\$548,989 [20.9%]	\$641,034 [27.3%]	\$759,214 [34.5%]	\$1,949,237 [27.2%]
Prevention: Sex workers & Clients	\$186,979 [7.1%]	\$219,346 [9.4%]	\$270,719 [12.3%]	\$677,044 [9.4%]
Treatment, Care and Support	\$28,355 [1.1%]	\$28,591 [1.2%]	\$28,880 [1.3%]	\$85,826 [1.2%]
TB Prevention and Care	\$666,277 [25.3%]	\$513,154 [21.9%]	\$454,192 [20.7%]	\$1,633,622 [22.8%]
HIV/TB	\$86,223 [3.3%]	\$76,979 [3.3%]	\$54,421 [2.5%]	\$217,623 [3.0%]
MDR-TB Care Packet	\$16,000 [0.6%]	\$17,500 [0.7%]	\$10,000 [0.4%]	\$43,500 [0.6%]
Procurement and Supply Chain Management	\$6,750 [0.3%]	\$4,500 [0.2%]	\$4,500 [0.2%]	\$15,750 [0.2%]
Monitoring and Evaluation	\$397,355 [15.1%]	\$161,000 [6.9%]	\$66,000 [3.0%]	\$624,355 [8.7%]
Elimination of Legal Barriers to Access	\$168,600 [6.4%]	\$127,600 [5.4%]	\$77,600 [3.5%]	\$373,800 [5.2%]
Strengthening Community Systems	\$103,811 [4.0%]	\$103,900 [4.4%]	\$86,800 [4.0%]	\$294,511 [4.1%]
Program Management	\$419,662 [15.9%]	\$453,560 [19.3%]	\$386,234 [17.6%]	\$1,259,455 [17.6%]
Total	\$2,629,000	\$2,347,164	\$2,198,559	\$7,174,723

Source: The Global Fund (2015d)

Table A2.2: Projected Budget Summary by Cost Category, Current HIV/TB Grant 2016-2018

Cost Grouping	Year 1	Year 2	Year 3	Total
1.0 Human Resources (HR)	\$779,436 [29.6%]	\$834,988 [35.5%]	\$915,399 [41.6%]	\$2,529,823 [35.3%]
2.0 Travel related costs (TRC)	\$489,576 [18.6%]	\$465,418 [19.8%]	\$447,299 [20.4%]	\$1,402,293 [19.5%]
3.0 External Professional services (EPS)	\$342,505 [13.0%]	\$185,400 [7.9%]	\$97,900 [4.5%]	\$625,805 [9.7%]
4.0 Health Products - Pharmaceutical Products (HPPP)	\$0 [0%]	\$0 [0%]	\$0 [0%]	\$0 [0%]
5.0 Health Products - Non-Pharmaceuticals (HPNP)	\$136,186 [5.2%]	\$158,475 [6.8%]	\$184,950 [8.4%]	\$479,612 [6.7%]
6.0 Health Products - Equipment (HPE)	\$126,029 [4.8%]	\$62,800 [2.7%]	\$7,900 [0.4%]	\$196,729 [2.7%]
7.0 Procurement and Supply-Chain Management costs (PSM)	\$52,443 [2.0%]	\$36,667 [1.6%]	\$36,990 [1.7%]	\$126,100 [1.8%]
8.0 Infrastructure (INF)	\$0 [0%]	\$0 [0%]	\$0 [0%]	\$0 [0%]
9.0 Non-health equipment (NHP)	\$179,538 [6.8%]	\$9,547 [0.4%]	\$9,760 [0.4%]	\$198,845 [2.8%]
10.0 Communication Material and Publications (CMP)	\$121,566 [4.6%]	\$99,541 [4.2%]	\$82,214 [3.7%]	\$303,321 [4.2%]
11.0 Programme Administration costs (PA)	\$239,550 [9.1%]	\$343,888 [14.7%]	\$293,147 [13.3%]	\$876,585 [12.2%]
12.0 Living support to client/ target population (LSCTP)	\$82,170 [3.1%]	\$100,440 [4.3%]	\$123,000 [5.60%]	\$305,610 [4.3%]
13.0 Results-based financing (RBF)	\$80,000 [3.0%]	\$50,000 [2.1%]	\$0 [0%]	\$130,000 [1.8%]
Total	\$2,629,000	\$2,347,164	\$2,198,559	\$7,174,723

Source: The Global Fund (2015d)

Table A2.3: Breakdown of Principal Recipient and Sub-Recipients under Current HIV/TB Grant 2016-2018

PR/Sub-Recipient	Amount allocated (US\$)
PR: UNDP	\$4,295,333
MINSAs	\$1,645,321
SR1:	\$978,320
SR2:	\$255,750

Source: The Global Fund (2015d)

Notably, GF monies for this grant do not contribute to the purchasing of pharmaceuticals (first or second line drugs for TB; ARVs or viral load or CD4 testing for HIV/AIDS). They do, however, support drug susceptibility testing and laboratory supplies for TB and MDR-TB diagnosis (including GeneXpert machines), as well as strengthening of procurement and supply chain management.

Table A2.4: GF Funding for Essential Services for HIV and TB: Percent Contribution and 3 Year Funding Projections

	Number of People Covered	Annual Average Investment	Percent Contribution	3 Year Funding Projection
<i>HIV</i>				
ART	0	\$0	0%	\$0
VL	0	\$0	0%	\$0
CD4	0	\$0	0%	\$0
<i>TB</i>				
Lab TB & MDR-TB Diagnosis	NA	\$73,125	80%	\$219,375
First Line Drugs	0	0	0%	\$0
Second Line Drugs	0	0	0%	\$0

Source: GF Essential Services Allocation (LAC)

Appendix 3: Additional Epidemiological Data

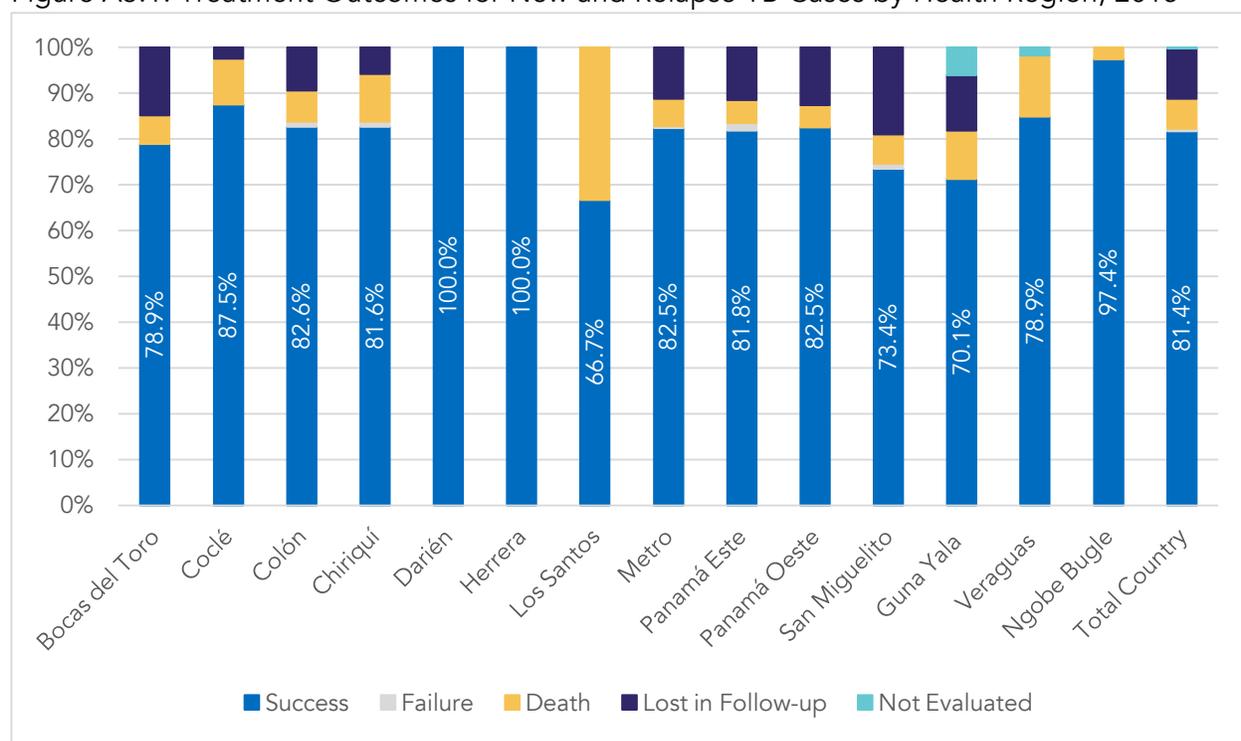
Table A3.1: Total Number of Men and Women Infected by HIV from 2001-2012, by Region*

Region	Male	Female	% of Total
National	4,439	3,035	100%
Panamá Metro	1,340	912	30.1%
Colón	461	601	14.2%
San Miguelito	572	485	14.1%
Panamá Oeste	518	293	10.9%
Chiriquí	245	122	4.9%
Panamá Este	152	48	2.7%
Coclé	111	77	2.5%
Guna Yala	96	51	1.9%
Veraguas	68	38	1.4%
Herrera	63	36	1.3%
Ngäbe Buglé	59	31	1.2%
Bocas del Toro	37	38	1.0%
Los Santos	51	16	0.9%
Darién	13	17	0.4%
Region Unspecified	653	270	12.3%

Source: Pérez (2014)

*Cases are registered as male or female, despite gender being non-binary.

Figure A3.1: Treatment Outcomes for New and Relapse TB Cases by Health Region, 2015



Source: MINSa (2017g)

Table A3.2: Cases and Incidence of TB by Health Region, 2015-2016 (Incidence per 100,000 people)

Region	2015		2016*	
	Number of Cases	Rate	Number of Cases	Rate
National	1,679	42.2**	1,408	34.9
Guna Yala	53	125.0	47	108.6
Bocas del Toro	198	126.5	180	111.8
Colón	163	58.9	137	48.7
Panamá Este	139	102.8	95	69.2
Ngäbe Buglé	117	59.1	104	51.2
Metropolitana	391	50.6	332	42.1
Panamá Oeste	168	30.4	156	27.6
San Miguelito	240	39.5	183	29.6
Darién	15	22.7	22	32.8
Chiriquí	91	20.2	98	21.6
Herrera	12	10.2	13	11.0
Veraguas	44	18.0	20	8.2
Coclé	43	16.7	17	6.6
Los Santos	5	5.3	4	4.2

Source: Departamento de Epidemiología, SISVIG

*Data for 2016 is preliminary and subject to change.

**Note: Incidence data for 2015 does not match that referenced in the main body of the report, which is sourced from the World Bank.

Appendix 4: Panama PEFA Results 2013

A. Credibility of the budget		
ID-1	Aggregate expenditure outturn	A
ID-2	Composition of the deviations from the budget expenditure compared to approved original budget	B+
ID-3	Revenue outturn	D
ID-4	Balance and tracking of late-payments	NR
B. Key features of all stages: scope and transparency		
ID-5	Budget Classification	B
ID-6	Budget documentation	B
ID-7	Government operations not included in budget reports.	D
ID-8	Transfers to subnational governments	C
ID-9	Supervision of aggregate fiscal risk caused by other public sector entities	C
ID-10	Public access to fiscal Information	A
C. Budget cycle		
ID-11	Orderly character and participation in the annual budget process	C+
ID-12	Multiannual perspective on fiscal planning, expenditure and budgeting	C
ID-13	Transparency on the obligations and liabilities of the taxpayer	C
ID-14	Effectiveness of taxpayer registration tracking and estimation of the tax base	D
ID-15	Effective tax collection	NR
ID-16	Certainty in the availability of funds to commit expenses	D+
ID-17	Registration and management of cash, debt and guarantees	NR
ID-18	Effectiveness of payroll controls	C+
ID-19	Procurement	D+
ID-20	Effectiveness of internal controls on non-salary expenditures	C+
ID-21	Effectiveness of internal audit	D+
ID-22	Opportunity and frequency of the conciliation of accounts	C+
ID-23	Availability of information on the resources received by the units performing the services	A
ID-24	Quality and timeliness of budget reports for the current year	D+
ID-25	Quality and timeliness of the annual financial statements	D+
ID-26	Scope, nature and follow-up of the external audit	D
ID-27	Legislative scrutiny of the annual budget	C+
ID-28	Legislative scrutiny of the external auditors' reports	D+
D. Donor Institutions Practices		
D-1	Predictability of direct budget support	D+
D-2	Financial information provided by donors for budgeting and reporting on aid for projects and programs	A
D-3	Proportion of total aid administered through the use of national procedures	C

Appendix 5: Overview of Analysis of Social Contracting

No.	Question	Analysis/Recommendations
1		
1a	<p>What is going well in terms of government funding of CSOs? What precedents are in place for social contracting or similar mechanisms? What are the possibilities for replication or scale-up?</p>	<p>There is a legal framework which theoretically allows the government to fund CSOs working on HIV and TB. The government has a process of transferring resources to CSOs under other ministries (e.g. in the Ministry of Social Development), and there is some limited experience within MINSA of contracting CSOs for rural health outreach as part of a specific World Bank initiative for Results Based Financing. Therefore, MINSA can build on this experience by adding HIV and TB, based on their own definitions and needs, or learn the process to implement within their own ministry.</p> <p>There is manifest political will of MINSA, the HIV program is already considering the possibility to provide some small funding to CSO to provide certain services in specific locations. However, there is also some opposition as in some areas of the Government CSO works is expected to be done in a volunteer basis and There are agencies with technical capacities to support the process of implementing social contracting.</p> <p>At the local level, some possibilities may also exist to support CSOs or key population initiative groups through municipal funds or through the local clinics, based on agreements of outreach or support groups.</p>
2	What specific barriers have been found to full and/or effective implementation of social contracting?	
2a	By category:	
	o Legal	There are no legal barriers to social contracting.
	o Structural (administrative, bureaucracy, lack of momentum/inertia)	There is a delay in the processes of approval of legal status of organizations which work with or have membership of trans people, sex workers and/or gay men, thereby limiting these organizations' abilities to access any social contracting mechanisms. This is thought to be due to conservatism and homophobia.

	o Political will	<p>There has been little political will prior to discussions on Global Fund transition; however there is now expressed political will to move social contracting forward, so this barrier may be overcome.</p> <p>However, there is also some opposition as in some areas of the government. Some expect that CSO work should be done strictly on a volunteer basis. This mentality will need to be overridden and efforts will need to be made to prove the quantifiable public health value of CSO interventions, in order to assure long-term sustainability of social contracting.</p>
	o Technical/capacity	<p>There is currently limited technical capacity at MINSAs for the development of public tenders for HIV or TB services, as well as for the proposal selection processes, supervision, technical assistance, monitoring and evaluation of projects. While there is some limited experience in transferring financing to an external entity through the funding of PROBIDSIDA, this process was not a transparent, open tender; and previous World Bank experience with RBF does not seem to have translated to any capacity within the HIV response. While both of these existing experiences may provide some lessons to build on, there is still need for systematic technical capacity building.</p> <p>Additionally, there is a lack of community systems capacity to enable them to perform efficiently, both in effective strategies and in project design, management, monitoring and evaluation, as well as in accountability.</p>
	o Resources (financing, human resources, etc.)	<p>To date, there has been no inclusion of contracting CSOs in the HIV budget; however with appropriate political will, this may change.</p> <p>There are no staff in charge of internal resource allocation processes to finance the provision of services and implementation of preventive projects by CSOs and to identify and there is no defined budget of domestic resources for the same purpose.</p>
2b	Are there specific populations which are affected more than others by these barriers?	<p>All key populations are affected by these barriers, due to the concentrated epidemic dynamics, historic absence of adequate prevention services targeted towards these populations implemented by the government, and discrimination within and outside of the HIV and TB fields. Delays in registering new CSOs, in particular, highlights the impact of discrimination against MSM, trans, SW populations.</p>

2c	Which parties are involved in these barriers? Who needs to be targeted for change?	<p>In order to address discrimination within the process of registering organizations, personnel in charge of legal processes would need to be targeted.</p> <p>In order to assure that funds are adequately allocated, decision-makers with influence on budget-making will need to be engaged to assure that funds are available.</p> <p>In order to develop and appropriate mechanism and build capacity at MINSA, officials from administrative, legal and technical areas of HIV and TB programs will need to be targeted and supported.</p>
2d	What needs to change to remove those barriers?	<p>To achieve removal of barriers, it will be necessary for civil society to implement an advocacy strategy using examples and results of social contracting from other countries, in order to gain the support of General Director of Public Health. This will require the unification of the CSOs working together towards joint advocacy goals. In particular, this is likely to include:</p> <ul style="list-style-type: none"> -Sensitization of political and administrative staff to reduce stigma and discrimination that creates barriers for lawful formation and operation of CSOs; -Advocating for clear political leadership from CONAVIH and MINSA to support the involvement of CSOs, particularly those formed around and targeted key populations, as a continued part of the HIV response; -Campaigning for the creation and funding of a mechanism for social contracting.
2e	What assistance is needed to make those changes? Who needs this assistance?	<p>Technical support will be required for both HIV and TB programs to develop and implement this mechanism; as well as to assist civil society in developing capacity to apply for, implement and monitor contracts from the government. It is also likely that some technical assistance will be needed to build CSO capacity for joint advocacy work, to assure that there is adequate civil society participation in the social contracting development and funding processes.</p>
<p>3 What recommendations can be made to improve social contracting?</p>		

3a	What concrete changes should be made?	<p>Political will appears to be available, and to achieve social contracting it is simply a matter of moving to a stage of action, completing the steps outlined below.</p> <p>In the meantime, the government should work closely with civil society leaders to address underlying social attitudes driving stigma and discrimination. In the short term, this would help remove the unnecessary barriers to registration and operation for CSOs which would ultimately be critical partners in social contracting. In the long term, reduction of stigma and discrimination would lead to greater service coverage for SW, trans, and MSM populations, as well as PLHIV.</p>
3b	What could be the motivations for the government to make these changes?*	<p>The government of Panama is committed to fulfilling national and international commitments, including the Sustainable Development Goals and the UNAIDS 90-90-90 targets, among others. There is stated will to do so through social participation, implementation of strategies and cost-effective services. The government can achieve these commitments by having a concentrated HIV epidemic and harnessing the comparative advantages of CSOs for reaching key populations, peer education, implementation of combined prevention strategies, health, dignity and positive prevention focus.</p> <p>In the short term, Panama can eradicate mother-to-child transmission; in the medium term, the country could ensure that AIDS is not a public health problem, and ensure universal access to prevention and care to HIV and TB. The participation of the community sector in the response would facilitate the achievement of these goals, both through the implementation of strategies to reduce stigma and discrimination, as well as through the implementation of preventive projects to avoid new infections and strategies that facilitate adherence to treatments. The ultimate benefits would be improved health of PLHIV, a decrease in the possibility of HIV transmission, and improved access to TB treatment - all achieved in a cost-effective manner through the contracting of civil society.</p>

3c	What could be the motivations for civil society to make these changes?*	<p>Civil society can fulfill its raison d'être by contributing to the response to the national HIV and TB, through its meaningful participation, advocacy, social monitoring and working with its communities. Working through government resources should not only add an additional level of sustainability to services, but should also achieve reduction of stigma and discrimination and promote the inclusion of disadvantaged populations through the exercise of human rights, their protection and promotion.</p> <p>The involvement of the community sector in reaching these goals allows them to influence the definition of key strategies, and at the same time allows them to expand their social capital and financial sustainability. Furthermore, the opportunity to receive government funding will further develop skills and experience in service delivery and project implementation, which may make it easier for them to further diversify their options and find resources in other areas.</p>
4	What activities will be required to implement the recommended changes? How should those activities be prioritized? How will progress be monitored and evaluated?	<ol style="list-style-type: none"> 1. Strengthen community systems (including skills development, training on specific issues and conflict resolution processes); 2. Develop and budget a specific prevention plan (based on scientific evidence) which includes provision of services by CSOs, in the short term to cover emerging needs and to pilot the SC mechanism and in the medium term as part of the next NSP. 3. Development a mechanism for social contracting within the Ministry of Health, based on the experience of other ministries in Panama and Ministries of Health in other countries; 4. Build government technical capacities for issuing tenders, conducting transparent selection monitoring, supervision and evaluating projects; 5. Pilot the process and make the necessary adjustments; 6. Develop National technical guides in accordance with international recommendations, for example a National Prevention Guide, Guide to VCT strategies, Guide to STI care, among others.
4a	Which activities should be prioritized over the next year?	<p>Steps 1 should begin the next year and extended at least for the next 3 years; step 2 is divided, the short-term goal is for the 1st year; step 3 and 4 should begin the first year.</p>

4b	Which activities will need to be done over the next 1-3 years?	<p>In order to develop social contracting as part of the national response to achieve a sustainable one, step 1, 2, 3 and 4 should be continued and step 4 and the piloting process (Step 5) may extend beyond the next year; once this is complete, evaluation of piloting should be conducted. Adjustments should be made to the mechanism in order to develop final guidance and any necessary regulations. Continued strengthening will be needed both for government officials overseeing social contracting, as well for CSOs implementing. This will need to be done in a broader context of CSS and reconciliation of competition within the civil society sector.</p> <p>If it has not already occurred, the launch of the national prevention plan, as part of the NSP, should be initiated, including actions to reduce stigma and discrimination.</p>
4c	Which activities will need to be done over the next 3-6 years?	<p>In order to make social contracting effective, it is necessary to maintain different efforts: There is likely to be continuous need for capacity building for community systems, which will take investment from external and internal resources over time.</p> <p>A mid-term evaluation of the national prevention plan should be conducted during this timeframe, and result in recommendations for adjustment and strengthening, including elements related to social contracting.</p> <p>Other priorities for this time period will likely include: inclusion of new technologies for prevention and coverage of timely detection of HIV, early initiation of HIV treatment, prevention and treatment of TB, use of PreP in populations at increased risk, adherence to treatment and extent of viral suppression in the greatest number of people. Continued prevention and care of other STIs.</p>
4d	Which activities will need a longer timeline (+6 years)?	<p>Combating stigma and discrimination, inclusion of disadvantaged populations, advocacy to strengthen the legislative framework (laws against discrimination, protection of sexual diversity and gender identity), reaching hard-to-reach populations, and national dialogue with communities will all be ongoing processes which need sustained commitment in the long term, to ensure that social contracting responds effectively to the national response to diseases.</p>

**For each party, consider: epidemiological and public health arguments, comparative advantages, efficiency gains (including budgetary arguments), cost-benefit analysis, how to address expected fears (loss of power, etc.).*