THE GLOBAL FUND

Grant Confirmation

Execution Version

1. This **Grant Confirmation** is made and entered into by **the Global Fund to Fight AIDS, Tuberculosis and Malaria** (the "Global Fund") and **Socios en Salud sucursal Peru** (the "Principal Recipient" or the "Grantee"), pursuant to the Framework Agreement, dated as of 28 May 2015, as amended and supplemented from time to time (the "Framework Agreement"), between the Global Fund and the Grantee, to implement the Program set forth herein. The Grant Confirmation is effective as of the earlier of the start date of the Implementation Period (as defined below) or the date of the Global Fund's signature below, and Program Activities shall not commence prior to the start date of the Implementation Period, unless otherwise agreed in writing by the Global Fund.

2. **Single Agreement**. This Grant Confirmation, together with the Integrated Grant Description attached hereto as Schedule I, sets forth the provisions (including, without limitation, policies, representations, covenants, Program Activities, Program budget, performance framework, and related implementation arrangements) applicable to the Program, and forms part of the Grant Agreement. Each capitalized term used but not defined in this Grant Confirmation shall have the meaning ascribed to such term in the Framework Agreement (including the Global Fund Grant Regulations (as amended from time to time), available at https://www.theglobalfund.org/media/5682/core_grant_regulations_en.pdf). In the event of any inconsistency between this Grant Confirmation and the Framework Agreement (including the Global Fund Grant Regulations (as amended from time to time)), the provisions of this Grant Confirmation shall govern unless expressly provided for otherwise in the Framework Agreement.

MINISTERIO DE SALUD OFICINA DE ASESORÍA JURÍDICA J. DEDIOS

3. **Grant Information**. The Global Fund and the Grantee hereby confirm the following:

3.1	Host Country or Region:	Republic of Peru
3.2	Disease Component:	HIV/AIDS, Tuberculosis
3.3	Program Title:	Reduce the burden of HIV and TB in Peru by ensuring access to quality and timely comprehensive health services
3.4	Grant Name:	PER-C-SES
3.5	GA Number:	4728
3.6	Grant Funds:	Up to the amount of USD 20,837,900 or its equivalent in other currencies
3.7	Implementation Period:	From 1 January 2026 to 31 December 2028 (inclusive)

3.8	Principal Recipient:	Socios en Salud sucursal Peru Av. Javier Prado Este 492 15001 Lima Republic of Peru Attention: Dr. Leonid Lecca Garcia Executive Director Email: llecca_ses@pih.org
3.9	Fiscal Year:	1 January to 31 December
3.10	Local Fund Agent:	PricewaterhouseCoopers Asesores Gerenciales S.A.S. Calle 100 No. 11 a 35 FL 8 110221 Bogotá Republic of Colombia Attention: Juan Malagon Team Leader Telephone: +5716684999 Facsimile: +571 218 8544 Email: juan.malagon@co.pwc.com
3.11	Global Fund contact:	The Global Fund to Fight AIDS, Tuberculosis and Malaria Global Health Campus, Chemin du Pommier 40 1218 Grand-Saconnex, Geneva, Switzerland Attention: Giulia Perrone Regional Manager Grant Management Division Telephone: +41-587911700 Facsimile: +41-445806820 Email: giulia.perrone@theglobalfund.org

4. **Policies**. The Grantee shall, and shall cause the Principal Recipient to, implement the Program in accordance with the Specific Plan for Strengthening the Prevention and Control of HIV, Syphilis, and Viral Hepatitis 2027–2031" to be approved in 2026 and the Tuberculosis Specific Plan (PETB) 2027–2029 to be approved in 2026 set forth in Schedule II and take all appropriate and necessary actions to comply throughout the Implementation Period with (1) the Global Fund Guidelines for Grant Budgeting (2023, as amended from time to time), (2) the Health Products Guide (2018, as amended from time to time), and (3) any other policies, procedures, regulations and guidelines, which the Global Fund may communicate in writing to the Grantee and the Principal Recipient, from time to time.

5. **Covenants**. The Global Fund and the Grantee further agree that:

5.1 **Co-Financing**

(1) In accordance with the Global Fund's Sustainability, Transition and Co-financing Policy (GF/B35/04) (the "STC Policy"), the commitment and disbursement of USD 5,209,475 (the "Co-Financing Incentive"), is subject to the Global Fund's

satisfaction with the Host Country's compliance with the requirement set out hereinafter ("Co-Financing Requirements"). The Principal Recipient acknowledges and agrees that the Global Fund may reduce Grant Funds during the current or any subsequent Implementation Period in the event the Host Country fails to: increase domestic funding of Global Fund-supported programs, with a focus on progressively absorbing the key costs of national disease plans, as identified in consultation with the Global Fund.

(2) In order to satisfy the Co-Financing Requirements, the Principal Recipient acknowledges and agrees that the Host Country shall, as set out in the Commitment Letter signed by the Government of Peru on 29 September 2025 (the "Commitment Letter"), unless otherwise agreed in writing with the Global Fund:

(a) fulfil a total minimum co-financing commitment of USD 712,560,000 from 2026-2028 (inclusive), comprising investments in:

i. HIV of USD 286,760,000 and
ii. TB of USD 425,800,000.

(b) fulfil the programmatic commitments as stipulated in Section 2 of the Commitment Letter; and

(c) provide to the Global Fund, by no later than 31st March of each year of the Implementation Period and the year following the end of the Implementation Period, evidence supporting achievement of the Co-Financing Requirements, including:

i. the approved budget for HIV / TB for the current year;
ii. the total expenditure for HIV / TB in the previous fiscal year; and
iii. the evidence on programmatic commitments in the previous fiscal year.

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5.2 The Program budget may be funded in part by Grant Funds disbursed under a previous Grant Agreement, which the Global Fund has approved to be used for the Program under the current Grant Agreement ("Previously Disbursed Grant Funds"), as well as additional Grant Funds up to the amount set forth in Section 3.6. hereof. Accordingly, the Global Fund may reduce the amount of Grant Funds set forth in Section 3.6. hereof by the amount of any Previously Disbursed Grant Funds. Previously Disbursed Grant Funds shall be governed by the terms of this Grant Agreement.

5.3 **Pooled Procurement Mechanism**

The procurement of Health Products shall be carried out through the Pooled Procurement Mechanism ("PPM") of the Global Fund, unless the Global Fund directs the Principal Recipient otherwise in writing. The Principal Recipient has all the necessary power and authority to execute, deliver and carry out its obligations under the wambo.org – PPM registration letter in the form approved by the Global Fund.

5.4 **Payment for Results modality:**

5.4.1 **Use of Grant Funds**. Grant Funds shall be accounted for and used solely for the implementation of the National Strategic Plan in accordance with the provisions of the Global Fund Grant Regulations (as amended from time to time) and the Global Fund Guidelines for Grant Budgeting (2023, as amended from time to time) to the extent not conflicting with those set forth in this Grant Confirmation.

5.4.2 **Disbursements**. Section 3.3(1) of the Global Fund Grant Regulations (as amended from time to time) shall not apply with respect to this Program and the following provisions shall apply instead:

(1) The first annual funding decision ("AFD") is determined in 2026, covering a prepayment for expected results under the correspondent disbursement linked indicator ("DLI") as contained in Schedule III of this Grant Agreement.

(2) Each following AFD will be determined to cover a pre-payment for expected results under the relevant DLIs and agreed Health Products procurement. An adjustment to each AFD may be made by the Global Fund based on the verification and validation of the results of the previous year of the Implementation Period.

(3) Disbursement methodology. Disbursements shall be made pursuant to the disbursement methodology set forth in Schedule III of this Grant Confirmation (the "Disbursement Methodology").

(4) Disbursement Requests. Notwithstanding the National Strategic Plan budget and the Disbursement Methodology or anything in this Grant Confirmation to the contrary, the timing and amount of any Disbursements shall be determined by the Global Fund at its sole discretion. The Global Fund will not make any Disbursement unless:

(a) the Principal Recipient has submitted to the Global Fund, in form and substance satisfactory to the Global Fund, a request for Disbursement, signed by a duly authorized signatory, at a time acceptable to the Global Fund;

(b) the Global Fund has determined at its sole discretion that funds sufficient to make the Disbursement are available to the Global Fund from its donors for such purpose at the time of the Disbursement;

(c) the Principal Recipient has fulfilled, in form and substance satisfactory to the Global Fund, all requirements for such Disbursement within relevant deadlines;

(d) the Principal Recipient has provided to the Global Fund all the relevant reports that were required prior to the date of the request for Disbursement; and

(e) the Principal Recipient has demonstrated that it has achieved programmatic results consistent with the targets for indicators set forth in the Grant Agreement.

5.4.3 **Verification of results**. Any Disbursement shall be subject to the achievement of the results that are reported by the Principal Recipient and verified by the Global Fund (or any third party verification agency as approved in writing by the Global Fund) using the methodology described in Schedule IV, which may be refined or amended from time to time by the Global Fund in consultation with the Principal Recipient and partners. The Principal Recipient shall support, collaborate and cooperate with third parties and the process through which results are verified. If during the verification of results the Global Fund identifies discrepancies concerning the results reported for any indicator, the Global Fund reserves the right to set the percentage of achievement of that particular indicator and/or consider the achievement of a particular indicator as zero.

Catastrophic results. In the event that the results reported by the Principal Recipient are deemed, at the sole discretion of the Global Fund, to be catastrophic, the Global Fund may elect to apply the remedies established in Article 10 of the Global Fund Grant Regulations (as amended from time to time) or may decide to disburse only a percentage of the achieved results to cover essential service delivery and targeted recovery costs, based on a prompt review of the reasons of the poor results, changes that will be made to the Program, total available Grant Funds for the Program and stocks of Health Products in the Host Country, as relevant.

5.4.4 **Fraud, theft or misuse**. If fraud, theft or misuse of public funds is identified and verified in the Principal Recipient's Program, the Principal Recipient shall be required to repay to the Global Fund an amount equal to the portion of the amount of funds lost to fraud, theft or misuse that is proportional to the Global Fund's contribution to the Program implementation, as applicable.

5.4.5 **Co-mingling**. With reference to Section 3.4(1)(d) of the Global Fund Grant Regulations (as amended from time to time), the Global Fund hereby agrees to the co-mingling of Grant Funds disbursed for the purposes of the Program with other funds.

5.4.6 **Use of interest**. Notwithstanding Section 3.4(2) of the Global Fund Grant Regulations (as amended from time to time), any interest accrued on Grant Funds may be used for Program purposes without the prior written approval of the Global Fund.

5.4.7 **Use of revenue**. Notwithstanding Section 3.4(3) of the Global Fund Grant Regulations (as amended from time to time), any revenues earned by the Principal Recipient or Sub-recipients from any Program Activities may be used for Program purposes without the prior written approval of the Global Fund.

5.4.8 **Gains or losses deriving from Treasury management**. The Principal Recipient bears full responsibility for the management of the risk of losses related to treasury management, including, but not restricted to, foreign exchange risk.

5.4.9 **Periodic and ad hoc reports**. Section 6.2(1) of the Global Fund Grant Regulations (as amended from time to time) shall not apply with respect to this Grant Agreement and the following provisions shall apply instead:

(1) The Principal Recipient shall provide to the Global Fund the reports specified in 5.4.9(2) – 5.4.9(4) below. In addition, the Principal Recipient shall provide to the Global Fund such other information and reports at such times as the Global Fund may request. From time to time, the Global Fund may provide to the Principal Recipient guidance on the acceptable frequency, form and content of the reports required under this Section. The Principal Recipient shall provide to the CCM a copy of all reports that the Principal Recipient submits to the Global Fund under the Grant Agreement.

(2) No later than 60 calendar days after the end of each Fiscal Year during the Implementation Period, the Principal Recipient shall provide to the Global Fund, in form and substance satisfactory to the Global Fund, an annual report for the preceding year of the Implementation Period, in which the Principal Recipient shall:

(a) Show the progress towards the achievement of key performance indicators as set forth in the Performance Framework included in Schedule I, by providing the relevant analysis of reported data and information on the measurement methods and data quality assurance mechanisms in place, as agreed in the "Monitoring and Evaluation Plan for TB and HIV" approved in writing by Global Fund, or as otherwise communicated in writing by the Global Fund, using the agreed reporting templates and mechanisms or as otherwise communicated in writing by the Global Fund;

(b) provide to the Global Fund an Annual Financial Report ("AFR"), for the previous year of the Implementation Period comparing the relevant portion of the summary budget set forth in Schedule I of this Grant Agreement, against the Global Fund confirmed amounts under the DLIs achieved and verified as expenditures for the period specified by the Global Fund; and

(c) show the progress towards the fulfilment of any requirements set forth in this Grant Confirmation and any relevant management actions.

(3) In the event that the Principal Recipient's annual expenditure is less than the amount corresponding to the achieved results under the relevant DLI, the Global Fund may in its sole discretion reduce any subsequent disbursements by the equivalent shortfall amount (the "Shortfall Amount") or request reimbursement by the Principal Recipient of the Shortfall Amount to the Global Fund and the Principal Recipient shall reimburse the Shortfall Amount to the Global Fund within 60 calendar days of the Global Fund's request.

(4) Any exception request to Section 5.4.9 of this Grant Confirmation shall be submitted in writing by the Principal Recipient, and approval of such deviations shall be at the sole discretion of the Global Fund.

5.4.10 **Audits**. Sections 7.2, 7.3 and 7.4 of the Global Fund Grant Regulations (as amended from time to time) shall not apply with respect to this Grant Agreement and the following provisions shall instead apply:

(1) Grant Funds may be used to pay for the services of an external auditor retained by the Global Fund for grant specific performance of the Program (the "External Auditor") and the Global Fund may disburse such Grant Funds directly to the External Auditor.

(2) The Principal Recipient consents to relevant audit arrangements and to the terms of reference of the External Auditor (as approved by the Global Fund) and agrees that such terms of reference may be amended from time to time.

(3) No later than 30 June 2027, 2028 and 2029, the Principal Recipient shall provide to the Global Fund, the annual audit report for each audit arranged by the Principal Recipient's auditor for the previous Fiscal Year.

(4) Within six months from the end of the Implementation Period, the Principal Recipient shall provide to the Global Fund, a grant-specific performance audit report, financed with Grant Funds, covering the entire Implementation Period.

(5) In addition to Section 7.6 of the Global Fund Grant Regulations (as amended from time to time), the Principal Recipient shall ensure that the Office of the Inspector General of the Global Fund will have explicit permission to access the working papers of the Auditor for assurance validation, including the annual audit plan and other relevant internal audit reports.

5.5 Unless otherwise notified by the Global Fund in writing, prior to the use of Grant Funds to finance the procurement of second-line anti-tuberculosis drugs and for each disbursement request that includes funds for the procurement of multi-drug resistant tuberculosis medicines, the Principal Recipient shall submit to the Global Fund and obtain the Global Fund's written approval of a written confirmation of the price estimate and quantities of the second-line anti-tuberculosis drugs that will be procured by the Principal Recipient from the Global Drug Facility's procurement agent.

5.6 The Principal Recipient acknowledges the obligation to reimburse to the Global Fund the amounts the Global Fund has determined as recoverable pursuant to the terms of the relevant grant agreements, and such reimbursement will be carried out in line with existing tax reimbursement mechanism in the country.

[*Signature Page Follows.*]

MINISTERIO DE SALUD
D.G. ASESORÍA JURÍDICA
J. DEDIOS

IN WITNESS WHEREOF, the Global Fund and the Grantee have caused this Grant Confirmation to be executed and delivered by their respective duly authorized representatives on their respective date of signature below.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

By: _____

Name: Mark Eldon-Edington

Title: Head, Grant Management Division

Date: 12/16/2025

Socios en Salud sucursal Peru

By: _____

Name: Leonid Lecca Garcia

Title: Executive Director

Date: 02/Dic/2025

Acknowledged by

By: _____

Name: Luis Napoleón Quiroz Avilés

Title: Chair, Country Coordinating Mechanism of Republic of Peru

Date: 12/Dic. 2025

By: _____

Name: Fara Zamudio Santos

Title: Civil Society Representative, Country Coordinating Mechanism of Republic of Peru

Date: 03/Dic/2025

Schedule I

Integrated Grant Description

A. PROGRAM DESCRIPTION

1. Background and Rationale for the Program

Peru has greatly advanced in the response to tuberculosis (TB) and HIV, with important progress in HIV testing, ART initiation, and significant increase of molecular rapid testing for TB. Despite this, there is important HIV transmission particularly among vulnerable and indigenous populations and the TB diagnostic gap persists in urban areas of Lima and Callao and in geographically dispersed regions. The country's health system is affected by high geographic dispersion, transportation difficulties, lack of infrastructure and equipment, shortage of trained health workers, and high costs associated with sample transport. These barriers limit access to timely and quality diagnosis and care, especially in Amazonian and rural areas. The Global Fund HIV/TB grant for the 2026–2028 period prioritizes the introduction of innovations, strengthening diagnostic capacity, decentralizing services, and improving community engagement. It includes catalytic interventions to generate evidence for sustainability and scale-up, aligned with national plans and technical standards.

In 2023, the TB case notification was 31,686, representing 54% of the WHO estimated in the same year (unchanged due to limited data). The proposal focuses on scaling up active TB detection and increasing the treatment success rates in DR-TB. AI-supported active case finding activities will target three specific populations: prisoners, populations in hotspots, and individuals at risk or symptomatic who attend health facilities. Further, an additional 11 service points will be strengthened with x-Ray and TB rapid molecular test platforms at the first level of care in prioritized regions. The grant also supports the introduction of national standardized DRTB pharmacovigilance mechanisms, capacity building, and strengthening the community responses for TB. Between 2019 and 2023, HIV incidence continued increasing in key groups and indigenous population. The proposal includes expansion of PrEP and PEP delivery models, including community PrEP, telemedicine-based PrEP/PEP, and facility-based services. It also supports the sustainability of interventions in the Awajún population and the implementation of mobile brigades to reach key populations with prevention packages. Additional priorities include improving surveillance mechanisms for HIV-related deaths.

Peru has adequate programmatic and financial data management systems in place to monitor, report, and verify programmatic and financial data. Additionally, the Ministry of Health has experience in results-based budgeting for domestically funded programs. This will be an opportunity to contribute to national efforts and apply lessons learned. The rationale for selecting the six disbursement-linked indicators (DLIs) is based on the country's epidemiological priorities. The DLIs aim to align grant funding with outcomes that are critical for reducing HIV transmission, improving HIV care, decreasing the TB diagnostic gap, and improving DRTB outcomes.

2. Goals, Strategies and Activities

A. Goals: to reduce the burden of HIV and TB in Peru by ensuring access to quality and timely comprehensive health services. Specific strategies and activities include:

B. Strategies:

- **Expand access to HIV and TB services** by decentralizing care, integrating services, and reaching vulnerable populations through community and primary health care systems.
- **Strengthen diagnostic and treatment capacity** using AI-assisted tools, rapid molecular tests, pediatric formulations, and new oral regimens for MDR-TB.
- **Empower health professionals and communities** through training, virtual campuses, community-led monitoring, and support for community-based organizations.
- **Leverage technology and data systems** to improve interoperability, case tracking, and pharmacovigilance through electronic health records and dashboards.
- **Promote equity and sustainability** via legal advocacy, social contracting, intercultural strategies, and targeted interventions for migrants, indigenous groups, and key populations.

C. Activities:

1. Decentralize and integrate HIV/TB services through primary health care, community outreach, and facility-based and mobile models, including key and vulnerable populations.
2. Enhance diagnostics and treatment using AI-assisted digital X-rays, rapid molecular tests, pediatric formulations, and new oral regimens for MDR-TB and HIV.
3. Strengthen health workforce capacity through virtual training, in-service education, and support for managing co-morbidities and pediatric care.
4. Expand prevention and screening with HIV self-tests, quadruple tests, PrEP/PEP, and TB preventive therapy for children, PLHIV, and prisoners.
5. Improve data systems and interoperability by integrating TB and HIV information systems, electronic health records, and pharmacovigilance tools.
6. Support community-led responses through community-based organizations, peer networks, mental health services, and community-led monitoring.
7. Promote equity and inclusion via targeted interventions for migrants and indigenous populations, legal and policy advocacy, and intercultural communication.
8. Ensure sustainability and accountability through social contracting, regional budget advocacy, and economic analysis for integration into national programs.

3. Target Group/Beneficiaries

- Transgender women, men who have sex with men, and sex workers
- Health workers
- Pediatric population
- Population deprived of liberty, indigenous communities, migrants and populations living in hotspots with very high TB transmission.
- People living with TB and HIV and their contacts
- Members of civil society, community-based organizations, community health workers, peer educators, counselors, and promoters from key populations.

B. PERFORMANCE FRAMEWORK

Please see attached.

C. SUMMARY BUDGET

Please see attached.

THE GLOBAL FUND

Performance Framework

Country	Peru
Grant Name	PER-C-SES
Implementation Period	01-Jan-2026 - 31-Dec-2028
Principal Recipient	Socios en Salud sucursal Peru

Reporting Periods	Start Date	01-Jan-2026	01-Jan-2027	01-Jan-2028
	End Date	31-Dec-2026	31-Dec-2027	31-Dec-2028
	PU includes DR?	Yes	Yes	No

Program Goals, Impact Indicators and targets

	Impact Indicator	Country	Baseline Value	Baseline Year and Source	Required Dissagregation
			N: D: P: %		
	Comments				

Program Objectives, Outcome Indicators and targets

	Outcome Indicator	Country	Baseline Value	Baseline Year and Source	Required Dissagregation
			N: D: P: %		
	Comments				

Coverage indicators and targets

CI Number	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Cumulation Type	Reverse Indicator	01-Jan-2026 31-Dec-2026	01-Jan-2027 31-Dec-2027	01-Jan-2028 31-Dec-2028
Differentiated HIV Testing Services											
1	HTS-3 Other 1. Number of individuals from vulnerable populations who have undergone an HIV test during the reporting period under key population-specific programs and know their results.	Country: Peru; Coverage: Geographic National, 100% of national program target	N: 146882 D: P: %	2024 Source: DPVIH/MINSA Year: 2024		Yes		No	N: 194491 D: P: %	N: 207132 D: P: %	N: 221865 D: P: %
	Comments										

Coverage indicators and targets

CI Number	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Cumulation Type	Reverse Indicator	01-Jan-2026 31-Dec-2026	01-Jan-2027 31-Dec-2027	01-Jan-2028 31-Dec-2028
1	Disbursement-Linked Indicator (DLI2): Number of people in vulnerable that have received an HIV test during the reporting period and know their results (reached with defined package of services) (HTS-3) Budget: 3,632,283 USD (21% of the budget allocated to payment for results) The estimated per capita cost for IVD2 is 8 USD for 2026, 7 USD for 2027, and 3 USD for 2028. Baseline: This indicator corresponds to the vulnerable HIV populations (men who have sex with men, transgender women, female sex workers, and indigenous population) who were screened in health facilities (fixed-site services), mobile outreach units (mobile services), and by CBOs/CCMs (community-based services) in 2024. The source of information is HISMINSA-DPVIH-MINSA. Assumptions for the targets: This indicator is derived from the number of people from vulnerable populations (MSM, TW, FSW, and indigenous population) who have undergone an HIV test during the reporting period (12 months of the year). The purpose is to evaluate the screening coverage among key populations who are potentially unaware of their serostatus, considering the differences in baseline diagnosis prevalence among the different population groups. For reporting the other HTS-3 indicator, a flexibility criterion was applied to consolidate the numbers (numerators) of screened individuals from the vulnerable populations (MSM, TW, FSW, and indigenous population). The numerator corresponds to the sum of the annual targets calculated for each population. The calculation of the indicator's numerators is recorded in the "HIV indicator calculation" tab of the RMF. The national strategy to achieve the targets for this indicator will focus on the accessible and differentiated expansion of this service by strengthening the provision at first-level care facilities (FLCF), implementing extramural and community services, and using technology through telemedicine and the ECHO methodology to train professionals. Mobile outreach units will be optimized, and a mobile service specifically targeting female sex workers (FSW) will be implemented, in addition to Amazonian mobile units for the indigenous population. Likewise, communication strategies aimed at men who have sex with men (MSM), transgender women (TW), and FSW will be generated, promoting combination prevention, and access to diagnosis will be expanded through the procurement of HIV self-tests and rapid quadruple tests for all service modalities. The country, through the HIV program (PR/DPVIH), will conduct continuous coverage monitoring. Any variation in population estimates will be reported in a timely manner. It should be noted that the established targets are subject to changes in WHO estimates. If significant changes occur, the indicator should be reviewed. Global Fund Contribution: The Global Fund's contribution consists of financing mobile outreach units for a period of two years, community-based services, and the procurement of HIV self-tests. MINSA guarantees screening tests for HIV, syphilis, and hepatitis, condoms and lubricants, diagnosis and treatment for STIs, Pre-ART exams, and antiretroviral treatment for reactive cases. Geographic Scope: Interventions targeting this indicator will be developed at the national level. Measurement Methods: Verification Source: HISMINSA-DPVIH/MINSA The source of information comes from the HISMINSA-DPVIH/MINSA module, a system that centralizes the records of people who have taken an HIV test nationwide. This platform integrates data obtained from the types of health service provision (fixed, mobile, and community-based), containing epidemiological variables such as: screening location, socialization setting, country, sex, age, and population group. Subsequently, the General Office of Information Technology (OGTI) processes these records through a standardized protocol that includes the generation of an anonymized database using unique codes and a review process by the DPVIH Program and the Principal Recipient (PR). This system ensures the quality and integrity of the data before analysis. Finally, the processed data are analyzed to quantify the total number of people from key populations who have taken an HIV test. These values constitute the numerator of the epidemiological indicator. For the PUDR, the total values of the indicator will be reported, as well as its breakdown by key population. Means of Verification: For the verification of information associated with DLI2, a structured verification process has been established in three stages: 1) Data Collection: Health personnel are responsible for the continuous recording of HIV screening services in the application. This information is recorded promptly in HISMINSA. 2) Quality Control: The Directorate of HIV Prevention and Control (DPVIH) assumes responsibility for ensuring data integrity and quality. This review is conducted quarterly, supervising the records contained in HISMINSA. 3) Verification: The Principal Recipient (PR) is ultimately responsible for verifying the information. This activity is carried out on a monthly/quarterly basis, through the analysis of the HISMINSA screening database provided by the program. The objective is to identify and resolve discrepancies, such as duplicates, omissions, or inconsistencies in the data.										
Treatment, care and support											
2	TCS-1.1 Percentage of people on ART among all people living with HIV at the end of the reporting period	Country: Peru; Coverage: Geographic National, 100% of national program target	N: 100061 D: 110000 P: 90.96%	2024 Source: DPVIH/MINSA Year: 2024	Gender	Yes		No	N: 110149 D: 118440 P: 93.00%	N: 116983 D: 124450 P: 94.00%	N: 121838 D: 128250 P: 95.00%
	Comments										
	Disbursement-Linked Indicator (DLI3): Number of people on ART among all people living with HIV at the end of the reporting period (TCS1.1) Budget: 3,071,190 USD (18% of the budget allocated to payment for results) The estimated per capita cost for IVD3 is 12 USD for 2026, 9 USD for 2027, and 6 USD for 2028. Baseline: In 2024, 100,061 PLHIV received antiretroviral treatment, considering the total number of PLHIV who know their diagnosis. The information source is SIHCE-DPVIH/MINSA. Objective Assumptions: For this indicator, the target is to reach 93% by 2026, 94% by 2027, and 95% by 2028 of PLHIV on ART relative to the pillar of diagnosed individuals, according to Spectrum-CDC 2024 estimates. This represents a percentage increase of one percentage point each year, moving closer to the global HIV elimination targets for 2030. The national strategy to achieve the targets for the indicator of people receiving ART is based on four main pillars: a) prevention of co-infection through training of first-level care health personnel and communication strategies on TB Preventive Treatment for PLHIV; b) timely diagnosis by strengthening and expanding multi-diagnostic platforms in Amazonian regions; c) HIV treatment and provision of differentiated services through decentralization and diversification of treatment with differentiated services at the first level of care, new pediatric regimens, and specific strategies for migrant populations; and d) improvement in advanced case management through the expansion of specialized protocols and strengthening of AIDS mortality registries in prioritized regions. The country, through the HIV Program (PR/DPVIH), will conduct continuous monitoring of coverage. Any variations in population estimates will be reported in a timely manner. It should be noted that the established targets are subject to changes in WHO estimates. If there are significant changes, the indicator should be revised. Global Fund Contribution: The Global Fund will contribute to the decentralization of ART to first-level care facilities by financing complementary hourly payments for health personnel who establish the service in new health facilities and initially provide care to PLHIV during differentiated hours. The payment will be for a defined period, and the service will be sustained by MINSA once funding concludes. ART medications are covered by the Ministry of Health. Geographical Scope: Interventions targeting this indicator will be developed at the national level. Measurement Methods: For this indicator, the numerator is obtained from the number of PLHIV on ART, and the denominator is the estimated population of PLHIV for the reporting year, according to Spectrum-UNAIDS 2024. Verification Source: SIHCE-DPVIH/MINSA. The information source comes from the SIHCE-DPVIH/MINSA module, a system that centralizes the records of people receiving antiretroviral treatment nationwide. This platform integrates data from MINSA, Non-Governmental Organizations (NGOs), Armed Forces (FF.AA.), Police Forces (FF.PP.), National Penitentiary Institute (INPE), and soon from Social Health Insurance (EsSalud). It contains epidemiological variables such as: region, sex, age, key population (MSM, TGW, FSW), and treatment regimen. Subsequently, the General Office of Information Technology (OGTI) processes these records through a standardized protocol that includes generating an anonymized database using unique codes and a review process by the DPVIH Program and the Principal Recipient (PR). This system ensures data quality and integrity before analysis. Finally, the processed data is analyzed to quantify the total number of PLHIV receiving ART. These values are used to calculate the epidemiological indicator. Means of Verification: A structured three-stage verification process has been established for information associated with DLI3: 1) Data Collection: Healthcare staff are responsible for the continuous recording of care related to Antiretroviral Treatment (ART) activities. This information is recorded promptly in the ART Module of the SIHCE TAR system. 2) Quality Control: The Directorate of HIV Prevention and Control (DPVIH) assumes responsibility for ensuring data integrity and quality. This review is conducted quarterly by supervising the records contained in the ART Module of the system. 3) Verification: The Principal Recipient (PR) is ultimately responsible for verifying the information. This activity is carried out on a monthly/quarterly basis by analyzing the SIHCE TAR database provided by the program. The objective is to identify and resolve discrepancies, such as duplicates, omissions, or inconsistencies in the data.										
Prevention package for men who have sex with men (MSM) and their sexual partners											
3	KP-1 Other 1. Number of individuals from vulnerable populations reached by HIV prevention programs: Defined package of services.	Country: Peru; Coverage: Geographic National, 100% of national program target	N: 125429 D: P: %	2024 Source: DPVIH/MINSA Year: 2024		Yes		No	N: 180614 D: P: %	N: 188877 D: P: %	N: 200922 D: P: %
	Comments										

THE GLOBAL FUND

Coverage indicators and targets

CI Number	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Cumulation Type	Reverse Indicator	01-Jan-2026 31-Dec-2026	01-Jan-2027 31-Dec-2027	01-Jan-2028 31-Dec-2028
3	Baseline: This indicator corresponds to key populations (men who have sex with men, transgender women, and female sex workers) who benefited from the HIV prevention package through fixed health facilities, mobile outreach units, and community-based services provided by CBOs/MCSOs in 2024. The information source is DPVIH-MINSA. Assumptions for goals: For reporting purposes under indicator KP-1 (other), a flexible reporting approach consolidates data across all three key populations (MSM, transgender women, and female sex workers). The numerator represents the sum of population-specific targets, with detailed methodology and calculations documented in the "HIV indicator calculations" section of the Performance Framework. The national strategy to achieve the targets for this indicator will focus on the accessible and differentiated expansion of this service by strengthening service provision at first-level care facilities (FLCF), implementing extramural and community-based services, and utilizing technology through telemedicine and the ECHO methodology to train professionals. Itinerant brigades will be optimized and a mobile service specifically targeted at female sex workers (FSW) will be implemented, in addition to Amazonian mobile brigades for indigenous populations. Furthermore, communication strategies targeting men who have sex with men (MSM), transgender women (TGW), and FSW will be developed to promote prevention, and access to diagnosis will be expanded through the acquisition of HIV self-tests and rapid quadruple tests for all care modalities. The country, through the HIV Program (RP/DPVIH), will conduct continuous monitoring of coverage. Any variation in population estimates will be reported in a timely manner. It should be noted that the established targets are subject to changes in WHO estimates. If significant changes occur, the indicator should be reviewed. Global Fund Contribution: The Global Fund provides financial support for three key components: mobile outreach team operations (two-year funding cycle), community-based service delivery, and procurement of HIV self-testing kits. MINSA guarantees delivery of the complete prevention package, which includes: HIV counseling and testing services, PrEP promotion and access, condom and lubricant distribution, STI diagnosis and treatment services, plus screening tests for HIV, syphilis, and hepatitis B and C. Geographic Scope: All interventions related to this indicator will be implemented at the national level, ensuring countrywide coverage. Measurement Methods: Verification Source: HISMINSA-DPVIH/MINSA. The primary data source is the HISMINSA-DPVIH/MINSA module, a national-level system that consolidates records of individuals receiving prevention services. This platform aggregates data from all service delivery models (fixed-site, mobile, and community-based) and includes key epidemiological variables: geographic region, health network (DIRIS/DIRESA/GERESA), age, sex, and population type (MSM, transgender women, female sex workers). Subsequently, the General Office of Information Technology (OGTI) processes these records through a standardized protocol involving two key steps: creation of an anonymized database using unique identifier codes, followed by a quality review process conducted by both the DPVIH Program and Principal Recipient (PR) teams. This rigorous system maintains data quality and integrity throughout the analysis process. Finally, the processed data undergo analysis to determine the total number of key population members who received prevention services. These final figures serve as the numerator for calculating the epidemiological indicator. For the PUDR, the total values of the indicator will be reported, as well as its breakdown by key population										
4	KP-6 Other 1. Number of vulnerable individuals who initiated PrEP at least once during the reporting period.	Country: Peru; Coverage: Geographic National, 100% of national program target	N: 4504 D: P: %	2024 Source: DPVIH/MINSA Year: 2024		Yes		No	N: 17427 D: P: %	N: 30231 D: P: %	N: 44843 D: P: %
	Comments										
	Disbursement-Linked Indicator (DLI1): Number of key populations who received any PrEP product at least once during the reporting period (KP6-other) Budget: 2,918,990 USD (17% of the budget allocated to payment for results) The estimated per capita cost for IVD1 is 53 USD for 2026, 38 USD for 2027, and 19 USD for 2028. Baseline: The Technical Health Standard for Combined Prevention by MINSA, which incorporates PrEP as a prevention strategy, was approved in June 2023. Efforts to secure PrEP medications enabled coverage for 4,096 men who have sex with men (MSM), 248 transgender women (TW), and 160 female sex workers (FSW) by the end of 2024, according to data from the DPVIH-MINSA information system. Assumptions for goals: In 2024, the DPVIH conducted an exercise to estimate the programmatic targets for PrEP using the PAHO QuantPrEP tool to measure implementation progress. The various parameters of the tool were loaded with data from prevalence studies among MSM and TGW conducted in 2019, Spectrum data, and prevalence study information from other countries in the region. PrEP implementation was carried out through a progressive expansion strategy differentiated by population: for MSM, an annual increase of 10% was established to cover 40% of the population in need of this service; for TGW, a gradual growth of 5% per year was applied to reach 30% coverage; while for FSW, a continuous scaling-up scheme was designed to achieve 50% coverage of the population requiring this preventive intervention. For this indicator, the numerator is obtained from the number of new MSM, TGW, and FSW users who initiated oral PrEP in the last 12 months. The targets are aligned with those proposed in the Prevention Roadmap. This indicator will be reported annually, with monthly monitoring by the DPVIH. The national strategy to achieve the targets for the PrEP coverage indicator will focus on the accessible and differentiated expansion of this service by strengthening service provision at first-level care facilities (FLCF), implementing extramural and community-based services, and utilizing technology through telemedicine and the ECHO methodology to train healthcare professionals. Itinerant brigades will be optimized and a mobile service specifically targeted at female sex workers (FSW) will be implemented, in addition to Amazonian mobile brigades for indigenous populations. Furthermore, communication strategies targeting men who have sex with men (MSM), transgender women (TGW), and FSW will be developed to promote combination prevention, and access to diagnosis will be expanded through the acquisition of HIV self-tests and rapid quadruple tests for all care modalities. The country, through the HIV Program (RP/DPVIH), will conduct continuous monitoring of coverage. Any variation in population estimates will be reported in a timely manner. It should be noted that the established targets are subject to changes in WHO estimates. If significant changes occur, the indicator should be reviewed. Global Fund Contribution: The DPVIH has developed an expansion plan supported by both national funding and Global Fund resources. The Global Fund's contribution specifically supports: expansion of PrEP services to new health facilities, implementation of Mobile PrEP and telemedicine services for PrEP/PEP, hiring of ECHO program facilitators, development of a communication strategy, and procurement of self-testing kits. MINSA guarantees the provision of PrEP medications, screening tests for HIV, syphilis and hepatitis, condoms and lubricants, laboratory testing, and antiretroviral treatment. Geographic scope: All interventions related to this indicator will be implemented nationwide across the country. Measurement Methods: Verification Source: SIHCE-DPVIH/MINSA (currently under implementation). The primary data source is the SIHCE-DPVIH/MINSA module, a national-level system that consolidates records of individuals receiving pre-exposure prophylaxis (PrEP). This platform integrates data from MINSA and partner NGOs, containing key epidemiological variables including: sex, age, ethnicity, population group (MSM, transgender women, female sex workers), country of origin, PrEP modality, seroconversion status, and treatment discontinuation information. Subsequently, the General Office of Information Technology (OGTI) processes these records through a standardized protocol consisting of two main components: generation of an anonymized database using unique identification codes, followed by a quality review process conducted by both the DPVIH Program and Principal Recipient (PR) teams. This system ensures rigorous data quality control and integrity maintenance prior to analysis. Finally, the processed data undergo comprehensive analysis to determine the total number of individuals from key populations receiving any form of PrEP product. These final figures serve as the numerator for the epidemiological indicator, enabling robust evaluation of both the coverage and effectiveness of the national prevention program. For the PUDR, the total values of the indicator will be reported, as well as its breakdown by key population										
TB diagnosis, treatment and care											
5	TBDT-1 Number of patients with of all forms of TB notified (i.e., bacteriologically confirmed + clinically diagnosed); *includes only those with new and relapse TB	Country: Peru; Coverage: Geographic National, 100% of national program target	N: 30384 D: P: %	2024 Source: DPCTB - MINSA Year: 2024	HIV status,Gender,TB case definition,Age	Yes		No	N: 37170 D: P: %	N: 39530 D: P: %	N: 41300 D: P: %
	Comments										

Coverage indicators and targets

CI Number	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Cumulation Type	Reverse Indicator	01-Jan-2026 31-Dec-2026	01-Jan-2027 31-Dec-2027	01-Jan-2028 31-Dec-2028
5	Baseline: The baseline for this indicator corresponds to the total number of patients with tuberculosis of all forms (new and relapse) from the year 2024. Verification Source: Data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU). Objective Assumptions: An increase in the total number of TB cases of all forms is projected for this indicator over the three years of the grant; increasing by 6% from 2026 to 2027 and by 4% from 2027 to 2028. The targets for this indicator are calculated for each year by applying percentages—63%, 67%, and 70%—to the 59,000 cases estimated by the WHO (Global Report 2024) for the years 2026, 2027, and 2028, respectively. As part of the strategies the country will employ to achieve the indicator's targets, it will strengther its intervention with a combined approach incorporating technological innovation. This includes Community-Based Active Case Finding (CACF) for extramural screening, where artificial intelligence systems will be implemented for the automated analysis of chest X-rays, enabling rapid screening of large population groups in hard-to-reach areas. This will be complemented by Intensified Active Case Finding (IACF) in health facilities. Concurrently, passive TB case finding will be optimized through local TB control programs in Health Facilities (HF), using predictive models to identify high-risk areas and hotspots of active transmission, allowing for more efficient resource allocation. These strategies, supported by AI tools for image and data processing, aim to overcome access and notification gaps, accelerating progress towards TB elimination through earlier and more accurate diagnosis. The country, through the TB Program (PR/DPCTB), will conduct continuous monitoring of coverage. Any variations in population estimates will be reported in a timely manner. Global Fund Contribution: The Global Fund will contribute through financing for the implementation of radiological equipment, hiring of healthcare staff, and operational expenses for the development of Active TB Case Finding in high TB burden areas. Geographical Scope: Interventions targeting this indicator will be developed at the national level. Measurement Methods: This indicator considers the number of patients with all forms of tuberculosis (bacteriologically confirmed and clinically diagnosed) notified to the national health authority during the reporting period. Verification Source: Data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU). Means of Verification: A structured three-stage verification process has been established for information associated with DLI5: 1) Data Collection: Healthcare staff are responsible for the continuous recording of diagnostic activities. This information is recorded promptly in the Treatment Module of the SIGTB. 2) Quality Control: The Directorate of Tuberculosis Prevention and Control (DPCTB), through its three levels (local, regional, and central), assumes responsibility for ensuring data integrity and quality, in accordance with the Tuberculosis Technical Health Standard. This review is conducted monthly by supervising the records contained in the system. 3) Verification: The Principal Recipient (PR) is ultimately responsible for verifying the information. This activity is carried out on a quarterly basis by analyzing the SIGTB database provided by the program. The objective is to identify and resolve discrepancies, such as duplicates, omissions, or inconsistencies in the data.										
6	Number of people screened for TB using radiology with artificial intelligence (AI)	Country: Peru; Coverage: Geographic National, 100% of national program target	N: 71747 D: P: %	2024 Source: DPCTB - MINSA Year: 2024		Yes		No	N: 178960 D: P: %	N: 199085 D: P: %	N: 216901 D: P: %
	Comments										
	Disbursement-Linked Indicator (DLI4): Number of people screened for TB using artificial intelligence-supported radiology Budget: 4,779,469 USD (28% of the budget allocated to payment for results) The estimated per capita cost for IVD4 is 10 USD for 2026, 10 USD for 2027, and 4 USD for 2028. Baseline: The baseline for this indicator corresponds to the total number of people screened with AI-powered X-ray during the year 2024. Verification Source: Data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU). Objective Assumptions: For this indicator, an increase in the total number of people screened for TB is projected during the first two years of the grant, with an 11% increase from 2026 to 2027, followed by an 8% increase from 2027 to 2028. The total screened is 594,946, broken down as follows: • Prisons: 92,226 screened. • Hotspots: 34,560 screened. • Intramural: 468,160 screened. For target calculation, the following was determined: Prisons: 80% of the prison population in 13 penitentiary facilities will be screened in the first year (2026) and 50% in the subsequent years (2027 and 2028). Hotspots: 12 annual interventions will be carried out (one per month), screening 960 people per intervention, resulting in 11,520 screened per year. Intramural: 56 health facilities (HF) will be covered, working 11 months per year (deducting one month for rest due to radiation exposure and holidays). In each facility, 12 X-rays will be performed daily over the 11 months. It should be noted that the productivity of the equipment installed in armed forces institutions will be 6 X-rays daily. There are productivity differences year-over-year in some facilities because not all equipment will be available at the start of the grant. Year 2026 will have 45 units for 8 months and 56 units for 3 months; and all 56 units will be available for years 2027 and 2028. The grant model is structured as follows: Years 1 and 2 (2026-2027): The focus is on massive and intensive screening using additional staff hired with grant funds. This allows for high initial coverage and maximizes case detection while the new AI-powered X-ray technology is installed and its use is consolidated. Year 3 (2028): The strategy shifts towards sustainability. The responsibility for screening is transferred to the permanent staff of the health facilities (HF). By relying on the health system's own human resources, who have multiple responsibilities, the per-equipment productivity normalizes to a level sustainable in the long term. As part of the strategies the country will employ to achieve the indicator's targets, it will strengthen its intervention with a combined approach incorporating technological innovation. This includes Community-Based Active Screening for extramural screening, where artificial intelligence systems will be implemented for the automated analysis of chest X-rays, enabling rapid screening of large population groups in hard-to-reach areas. This will be complemented by Intensified Active Screening in health facilities. Concurrently, passive TB case finding will be optimized through local TB control programs in Health Facilities (HF), using predictive models to identify high-risk areas and hotspots of active transmission, allowing for more efficient resource allocation. These strategies, supported by AI tools for image and data processing, aim to overcome access and notification gaps, accelerating progress towards TB elimination through earlier and more accurate diagnosis. The country, through the TB Program (PR/DPCTB), will conduct continuous monitoring of coverage. Any variations in population estimates will be reported in a timely manner. Global Fund Contribution: The Global Fund will contribute through financing for the acquisition of AI-powered X-ray equipment, as well as the implementation of the respective equipment. Geographical Scope: Interventions targeting this indicator will be developed at the national level. Measurement Methods: Source: Data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU). This indicator considers the number of people screened using artificial intelligence (AI) for TB case detection during the reporting period. The SIGTB generates the database containing the variables: people screened, people with abnormal X-ray, people with positive molecular rapid test (mWRD+), people starting TB treatment; based on this information, records are quantified, and the absolute numbers feeding the numerator are obtained. Means of Verification: A structured three-stage verification process has been established for information associated with DLI4: 1) Data Collection: For interventions in Prisons, Hotspots, and Intramural settings, the continuous recording of Tuberculosis (TB) screening services is the responsibility of the healthcare staff. On the other hand, for interventions involving community participation, such as intramural and extramural Active TB Case Finding (ATCF) activities, this responsibility falls on the designated community organization. This information is recorded promptly in the digital form of SIGTB V.2. 2) Quality Control: The Directorate of Tuberculosis Prevention and Control (DPCTB) assumes responsibility for ensuring data integrity and quality, in accordance with the Tuberculosis Technical Health Standard. This review is conducted every fifteen days by supervising the records contained in the system. 3) Verification: The Principal Recipient (PR) is ultimately responsible for verifying the information. This activity is carried out on a monthly/quarterly basis by analyzing the ATCF database from the SIGTB.										
Drug-resistant (DR)-TB diagnosis, treatment and care											
7	DRTB-2 Number of people with confirmed RR-TB and/or MDR-TB notified	Country: Peru; Coverage: Geographic National, 100% of national program target	N: 2186 D: P: %	2024 Source: DPCTB - MINSA Year: 2024	HIV status,Gender,Age	Yes		No	N: 2646 D: P: %	N: 3283 D: P: %	N: 3430 D: P: %
	Comments										
	Baseline: The baseline for this indicator corresponds to the total number of patients with RR/MDR tuberculosis (new and relapsed) in 2024. Source of verification: The data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU) Assumptions for the objectives: For this indicator, the total number of RR/MDR TB cases is projected to increase over the three years of the grant, increasing by 24% from 2026 to 2027 and by 4% from 2027 to 2028. To calculate the targets for this indicator, the total incidence of multidrug-resistant or rifampicin-resistant tuberculosis for the year 2023 of the WHO has been considered, which corresponds to 4,900 cases of RR/MDR TB, being for the year 2026 54% (2,646), for the year 2027 67% (3,283) and for the year 2028 70% (3,430) the total incidence of multidrug-resistant or rifampicin-resistant tuberculosis for the year 2023 of the WHO. It should be noted that the established targets are subject to changes in WHO estimates. As part of the strategies the country will employ to achieve the indicator targets, the notification of RR-TB and MDR-TB cases will be strengthened through the implementation of GeneXpert technology and AI-assisted chest X-rays in prioritized regions. The country, through the TB Program (RP/DPCTB), will conduct continuous monitoring of coverage. Any variation in population estimates will be reported in a timely manner. FM Contribution: The TB Health Technical Standard approved in December 2024 establishes the treatment of resistant TB with short regimens; this allows the Peruvian state to purchase the drugs with public funds, guaranteeing their availability for TB cases. In addition, active pharmacovigilance is implemented for treatment regimens for TB – DR. Geographic scope: Interventions targeting this indicator will be developed at the national level Measurement Methods: For this indicator, the number of people with bacteriologically confirmed TB-RR and/or MDR-TB reported is considered. Source of verification: The data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU)										

THE GLOBAL FUND

Coverage indicators and targets

CI Number	Coverage Indicator	Country and Scope of Targets	Baseline Value	Baseline Year and Source	Required Dissagregation	Include in GF Results	Cumulation Type	Reverse Indicator	01-Jan-2026 31-Dec-2026	01-Jan-2027 31-Dec-2027	01-Jan-2028 31-Dec-2028
8	DRTB-3 Percentage of people with confirmed RR-TB and/or MDR-TB that began second-line treatment	Country: Peru; Coverage: Geographic National, 100% of national program target	N: 2152 D: 2186 P: 98.44%	2024 Source: DPCTB - MINSA Year: 2024	Treatment regimen,Gender,Age	Yes		No	N: 2620 D: 2646 P: 99.02%	N: 3250 D: 3283 P: 98.99%	N: 3396 D: 3430 P: 99.01%
	Comments										
	Baseline: The baseline for this indicator corresponds to the total number of RR/MDR TB cases that started the second-line regimen in 2024. Source of verification: The data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU) Assumptions for the objectives: For this indicator, it is projected to maintain a constant of 99% of the total cases of RR/MDR TB that start second-line treatment in the three years of implementation of the grant. To calculate the denominator of the goals, the total incidence of multidrug-resistant or rifampicin-resistant tuberculosis for the year 2023 of the WHO has been considered, which corresponds to 4,900 cases of RR/MDR TB, being 54% for the year 2026, 67% for the year 2027 and 70% for the year 2028, the total incidence of multidrug-resistant or rifampicin-resistant tuberculosis for the year 2023 of the WHO. It should be noted that the established targets are subject to changes in WHO estimates. If significant changes occur, the indicator must be reviewed. As part of the strategies the country will employ to achieve the indicator targets, it will strengthen its intervention with a combined approach that incorporates technological innovation. This includes Community-Based Active Case Finding (CACF) for extramural screening, where artificial intelligence systems will be implemented for the automated analysis of chest X-rays, enabling rapid screening of large population groups in hard-to-reach areas. This will be complemented by Intensified Active Case Finding (IACF) in health facilities. In parallel, passive TB case detection will be optimized through local TB control programs in Health Establishments (EE.SS.), using predictive models to identify high-risk areas and active transmission hotspots, allowing for more efficient resource allocation. These strategies, supported by AI tools for image and data processing, aim to overcome access and notification gaps, accelerating progress toward TB elimination through earlier and more precise diagnosis. The country, through the TB Program (RP/DPCTB), will conduct continuous monitoring of coverage. Any variation in population estimates will be reported in a timely manner. FM Contribution: The TB Health Technical Standard approved in December 2024 establishes the treatment of resistant TB with short regimens; this allows the Peruvian state to purchase the drugs with public funds, guaranteeing their availability for TB cases. In addition, active pharmacovigilance is implemented for treatment regimens for TB – DR. Geographic scope: Interventions targeting this indicator will be developed at the national level. Measurement Methods: The numerator of the indicator corresponds to the number of people with bacteriologically confirmed RR-TB and/or MDR-TB reported who started the second-line therapeutic regimen during the specified reporting period; and the denominator is the total number of people with bacteriologically confirmed RR-TB and/or MDR-TB reported during the same reporting period. Source of verification: The data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU)										
9	DRTB-9 Treatment success rate of RR-TB and/or MDR-TB: Percentage of patients with RR and/or MDR-TB successfully treated	Country: Peru; Coverage: Geographic National, 100% of national program target	N: D: P: 56.11%	2021 DPCTB - MINSA Year: 2021	HIV status,Treatment regimen,Gender,Provider type,Age	Yes		No	N: D: P: 70.00%	N: D: P: 75.00%	N: D: P: 85.00%
	Comments										
	Disbursement-Linked Indicator (DLI5): Treatment success rate of RR-TB and/or MDR-TB: Percentage of patients with RR and/or MDR-TB successfully treated. Budget: 2,518,602 USD (15% of the budget allocated to payment for results) The estimated per capita cost for IVD6 is 11,416 USD for 2026, 11,448 USD for 2027, and 10,128 USD for 2028. Baseline: The treatment success rate for RR/MDR-TB from the year 2021 was established as the baseline. Verification Source: Data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU). Objective Assumptions: For this indicator, a success rate (cured + treatment completed) of 70% is projected to be maintained for RR and/or MDR TB cases in Year 1, 75% in Year 2, and 85% in Year 3 of the intervention. In 2024, a total of 51% are on regimens with injectables, 30% on BPALm, and a total of 19% are on BLC (BDQ, LZD, CLf, Lvx, PRZ). In 2025, a total of 15% are on regimens with injectables, 51% on BPALm, and a total of 34% are on BLC. In 2026, a total of 0% are on regimens with injectables, 80% on BPALm, and a total of 20% are on BLC (review estimates in the performance framework, target assumptions sheet). In the country, long and short regimens are coexisting; it is estimated that the use of short regimens will increase and the success rate will rise. As part of the national strategies to achieve the targets regarding treatment success rates, the implementation of shortened oral treatment schemes in all MINSA health facilities is included, along with pharmacovigilance to evaluate, prevent, and identify risks that may arise from the use of medications, ensuring timely and adequate care. The country, through the TB program (PR/DPCTB), will conduct continuous coverage monitoring. Any variations in population estimates will be reported in a timely manner. Global Fund Contribution: The Technical Health Standard for TB, approved in December 2024, establishes the treatment of drug-resistant TB with short regimens; this enables the Peruvian state to purchase medications with public funds, guaranteeing their availability for TB cases. Furthermore, active pharmacovigilance for DR-TB treatment regimens is being implemented. Geographical Scope: Interventions targeting this indicator will be developed at the national level. Measurement Methods: The numerator of the indicator corresponds to the number of patients with bacteriologically confirmed RR-TB and/or MDR-TB enrolled in a second-line therapeutic regimen during the specified reporting period who were successfully treated (cured plus treatment completed). The denominator corresponds to the total number of people with bacteriologically confirmed RR-TB and/or MDR-TB notified during the same reporting period. For reporting this indicator, it is considered that the 2024 RR/MDR-TB treatment cohort will have its programmatic outcome evaluated in 2026; the 2025 cohort will be evaluated in 2027, and the 2026 cohort will be evaluated in 2028. Current treatment regimens last from 9 to 18 months, according to the TB Technical Standard. The PR will also report the results of the 6-month regimen (BPAL) cohort in the corresponding PUDRs, aiming for a treatment success target of ≥80% (a transition to short treatment regimens is currently underway). Reporting is semi-annual and annual. Verification Source: Data is obtained from the DPCTB – MINSA (SIGTB/DPCTB/DGIESP/MINSA/PERU). Means of Verification: A structured three-stage verification process has been established for information associated with DLI6: 1) Data Collection: Healthcare staff are responsible for the continuous recording of treatment-related activities that will contribute to the success rate. This information is recorded promptly in the Treatment Module of the SIGTB. 2) Quality Control: The Directorate of Tuberculosis Prevention and Control (DPCTB), through its three levels (local, regional, and central), assumes responsibility for ensuring data integrity and quality, in accordance with the Tuberculosis Technical Health Standard. This review is conducted monthly by supervising the records contained in the system. 3) Verification: The Principal Recipient (PR) is ultimately responsible for verifying the information. This activity is carried out on a quarterly basis by analyzing the SIGTB database provided by the program. The objective is to identify and resolve discrepancies, such as duplicates, omissions, or inconsistencies in the data.										

Workplan Tracking Measures

Intervention	Key Activity	Milestones	Criteria for Completion	Country	

Comments

THE GLOBAL FUND

Summary Budget

Country	Peru
Grant Name	PER-C-SES
Implementation Period	01-Jan-2026 - 31-Dec-2028
Principal Recipient	Socios en Salud sucursal Peru

By Module	Total Y1 - 2026	Total Y2 - 2027	Total Y3 - 2028	Grand Total	% of Grand Total
Key and vulnerable populations (KVP) – TB/DR-TB	**$42,693**			**$42,693**	**0.2 %**
Payment for results	**$6,416,427**	**$6,476,995**	**$4,027,112**	**$16,920,534**	**81.2 %**
Prevention package for men who have sex with men (MSM) and their sexual partners	**$138,499**			**$138,499**	**0.7 %**
Prevention package for sex workers, their clients and other sexual partners	**$19,786**			**$19,786**	**0.1 %**
Prevention package for transgender people and their sexual partners	**$39,571**			**$39,571**	**0.2 %**
Program management	**$532,311**	**$580,307**	**$614,459**	**$1,727,077**	**8.3 %**
TB diagnosis, treatment and care	**$1,187,976**	**$118,285**	**$16,315**	**$1,322,576**	**6.3 %**
TB/HIV	**$77,905**			**$77,905**	**0.4 %**
Treatment, care and support	**$549,260**			**$549,260**	**2.6 %**
Grand Total	**$9,004,427**	**$7,175,587**	**$4,657,886**	**$20,837,900**	**100.0 %**

By Cost Grouping	Total Y1 - 2026	Total Y2 - 2027	Total Y3 - 2028	Grand Total	% of Grand Total
1.Human Resources (HR)	**$475,730**	**$523,726**	**$524,620**	**$1,524,076**	**7.3 %**
3.External Professional services (EPS)			**$36,000**	**$36,000**	**0.2 %**
4.Health Products - Pharmaceutical Products (HPPP)	**$232,747**			**$232,747**	**1.1 %**
5.Health Products - Non-Pharmaceuticals (HPNP)	**$275,786**			**$275,786**	**1.3 %**
6.Health Products - Equipment (HPE)	**$1,255,933**	**$114,840**	**$15,840**	**$1,386,613**	**6.7 %**
7.Procurement and Supply-Chain Management costs (PSM)	**$291,223**	**$3,445**	**$475**	**$295,143**	**1.4 %**
11.Indirect and Overhead Costs	**$56,581**	**$56,581**	**$53,839**	**$167,001**	**0.8 %**
13.Payment for Results	**$6,416,427**	**$6,476,995**	**$4,027,112**	**$16,920,534**	**81.2 %**
GrandTotal	**$9,004,427**	**$7,175,587**	**$4,657,886**	**$20,837,900**	**100.0 %**

By Recipients	Total Y1 - 2026	Total Y2 - 2027	Total Y3 - 2028	Grand Total	% of Grand Total
PR	**$9,004,427**	**$7,175,587**	**$4,657,886**	**$20,837,900**	**100.0 %**
Socios en Salud sucursal Peru	$9,004,427	$7,175,587	$4,657,886	$20,837,900	100.0 %
Grand Total	**$9,004,427**	**$7,175,587**	**$4,657,886**	**$20,837,900**	**100.0 %**

Source Of Funding	Total Y1 - 2026	Total Y2 - 2027	Total Y3 - 2028	Grand Total	% of Grand Total
Approved Funding	$9,004,427	$7,175,587	$4,657,886	$20,837,900	100.0 %
GrandTotal	**$9,004,427**	**$7,175,587**	**$4,657,886**	**$20,837,900**	**100.0 %**

Schedule II
National Strategic Plan

For the purpose of the Grant Confirmation, the National Strategic Plan consist of (i) the HIV national strategic plan titled "**Specific Plan for Strengthening the Prevention and Control of HIV, Syphilis, and Viral Hepatitis 2027–2031**" (the "HIV NSP"); and (ii) the TB national strategic plan titled "**Tuberculosis Specific Plan (PETB) 2027–2029**" (the "TB NSP").

The **HIV NSP** will be approved in 2026, as the strategic framework that aims to expand universal access to prevention, diagnosis, and care services through integrated, equitable, and sustainable interventions. The plan focuses on expanding access to prevention tools such as pre-exposure prophylaxis ("PrEP"), improving early diagnosis, ensuring timely treatment, and strengthening the health system. Significant populations such as men who have sex with men ("MSM"), transgender women, sex workers, and vulnerable groups including pregnant women, indigenous communities, and migrants are represented.

The plan outlines specific objectives, annual targets, and a detailed budget of over S/ 237 million. The plan also emphasizes reducing stigma, enhancing intersectoral coordination, and implementing robust monitoring and evaluation mechanisms to ensure accountability and impact.

The **five strategic objectives** include:

- **Expand access to HIV prevention (PrEP):** among key populations from 6% of eligible individuals in 2025 to 43% by 2031, focusing on groups such as MSM, transgender women, and sex workers.
- **Ensure timely and sustained access to antiretroviral therapy ("ART") for all people living with HIV ("PLHIV)**, with a special focus on pregnant women to prevent vertical transmission.
- **Improve maternal and child health outcomes:** By 2030, to ensure that 95% of pregnant women living with HIV receive ART and 95% of those diagnosed with syphilis receive appropriate treatment, helping eliminate vertical transmission.
- **Strengthening TB prevention in people with HIV:** aiming to increase coverage of TB preventive therapy among PLHIV from 70% in 2025 to 90% by 2030, reducing co-infection risks and complications.
- **Address human rights, reduction of stigma and discrimination** that ensures equitable access to health services for all, especially key and vulnerable populations, combat stigma in healthcare settings, strengthen legal protections, and foster inclusive communication campaigns.

The **TB NSP** will be approved in 2026 and outlines Peru's national strategy to reduce TB incidence and mortality through four key pillars: early detection, preventive treatment, optimized therapeutic outcomes, and strengthened program management. It aims to reach 75% coverage in TB case detection using rapid molecular diagnostics and AI-assisted radiology, while expanding preventive therapy to cover at least 90% of household contacts and vulnerable groups such as PLHIV. The plan also promotes the use of shortened oral treatment regimens for drug-resistant TB and integrates digital tools like DOT virtual supervision to improve adherence. With an allocation of over S/ 440 million across three years, this plan emphasizes a multisectoral approach involving the Ministry of Health of Peru ("MINSA"), regional health authorities, and different institutions.

The **four main strategic objectives** include:

- **Expand early detection of TB:** Achieve 75% coverage in TB case detection using WHO-recommended rapid diagnostic tests, AI-assisted chest X-rays, and active case finding in high-risk populations.
- **Strengthen preventive treatment (TPTB):** Ensure that at least 90% of household contacts, PLHIV, and other vulnerable groups receive preventive therapy to stop the progression of latent TB.
- **Optimize treatment outcomes:** Maintain a treatment success rate above 90% for all TB cases, including drug-resistant TB, by implementing shorter, fully oral regimens and improving adherence through digital tools like DOT virtual.
- **Enhance program management and coordination:** Improve intersectoral collaboration, monitoring, and data systems (e.g., SIGTB), ensuring effective implementation, accountability, and alignment with national and global TB control goals.

The strategy aligns with WHO targets and the Sustainable Development Goals, aiming for a resilient, inclusive, and evidence-based TB response.

Schedule III
Disbursement Methodology

1. The Grant Funds will be disbursed annually or at such other time as the Global Fund shall deem appropriate at its sole discretion.

2. The application of the Disbursement Methodology might result in a reduction of the total amount of Grant Funds set forth in Section 3.6 of the Grant Confirmation, and in consequence in a reduction of the Grant Funds to be disbursed for any subsequent period until the end of the Implementation Period, after the reporting and verification of the programmatic results.

3. The Disbursement of Grant Funds shall be carried out as follows:

(a) The first AFD is determined in 2026, based on the cash flow needs reflected in the budget, covering (i) a pre-payment for expected results under the relevant DLIs (as defined in Schedule IV of this Grant Confirmation) of the Year 1 of the Implementation Period; (ii) a semi-annual buffer for the pre-payment for expected results under the relevant DLIs of the first half of the Year 2 of the Implementation Period; and (iii) the program management, and the budgeted amount for procurement of Health Products and equipment through the Global Fund's Pooled Procurement Mechanism and/or Global Drug Facility for the relevant periods.

(b) The second AFD will be made in June 2027, covering (i) a pre-payment for expected results under the relevant DLIs of the second half of the Year 2 of the Implementation Period; (ii) a semi-annual buffer for the pre-payment for expected results under the relevant DLIs of the first half of the Year 3 of the Implementation Period; and (iii) the program management costs, and the budgeted amount for procurement of Health Products and equipment through the Global Fund's Pooled Procurement Mechanism and/or Global Drug Facility for the relevant periods.

(c) The third AFD will be made in June 2028, covering (i) a pre-payment for expected results under the relevant DLIs of the second half of Year 3 of the Implementation Period; and (ii) the program management costs, and the budgeted amount for the procurement of Health Products and equipment through the Global Fund's Pooled Procurement Mechanism and/or Global Drug Facility for the relevant periods.

(d) An adjustment to each AFD may be made by the Global Fund based on the verification and validation of the results of the previous year and/or half year of the Implementation Period.

4. Based on verified results, the disbursement amount will be calculated for each indicator based on the Results Framework set forth in Schedule IV of this Grant Confirmation.

5. Unless otherwise determined by the Global Fund in its sole discretion, the following formulas may be used for calculating the amount to be disbursed related to payment for results, according to the performance of each indicator:

(a) If:

- The indicator rating (% indicator achievement to the target) is equal to or greater than 100%, then the performance for that indicator will be considered as 100% for the reporting period, unless paragraph 7 of this Schedule shall apply,

(b) If:

- The indicator rating is less than 100%, then performance of the indicator will be equal to the indicator rating for the reporting period, as set out in the Results Framework,

Disbursement for the reporting period, in both cases, will be calculated based in the following formula, as further detailed in paragraph 7 below:

$$Disbursement_i = \Sigma \{(Unit\ Payment\ DLI\ [1\text{-}5]) * (per\ capita/percentual\ point\ unit\ DLI\ [1\text{-}5]\ achieved\ per\ year) + (pre\text{-}payment\ for\ Program\ Management\ and\ Health\ Products)\}.$$

** Subject to: DLI2 is subject to conditionality, see paragraph 7. i: Year 1, Year 2 and Year 3 Restricted to: maximum national targets and total payment*

6. For the purpose of calculation of disbursement(s) and application the disbursement formula provided in paragraph 5 above, the unit payment and total payment may vary for each DLI as summarized below and in Table 1:

(a) For **DLI1, DLI3** and **DLI4,** the Unit Payment will be paid for each per capita unit of the National Target achieved by the Principal Recipient, up to the Total Payment for each year and relevant DLI, as defined in Table 1.

(b) For **DLI2:** the Unit Payment will be paid for each per capita unit of the aggregated National Target (as defined in Table 1) achieved by the Principal Recipient. In addition, a conditionality threshold is established as outlined below:
- once 90% of the aggregated National Target is achieved, the Principal Recipient will receive 90% of the Total Payment of DLI2; and
- to receive the remaining 10% of the Total Payment of DLI2, the Principal Recipient shall evidence an achievement of HIV testing target in the female transgender group is equal or above to 70%, as detailed in Table 2.

(c) For **DLI5:** the Unit Payment will be paid for each percentage unit of the National Target achieved by the Principal Recipient, up to the Total Payment for each year, as defined in Table 1.

Table 1: DLI1, DLI2, DLI3, DLI4, DL5 Payment structure

DLIs	Payment type	2026			2027			2028		
		National Target (q)	Unit payment (p)	Total Payment (q x p)	National Target (q)	Unit payment (p)	Total Payment (q x p)	National Target (q)	Unit payment (p)	Total Payment (q x p)
DLI 1: Number of key populations who received any PrEP product at least once during the reporting period (KP6-other)	Per capita	17,427	53	925,536	30,231	38	1,147,209	44,843	19	846,245
DLI 2: Number of people in vulnerable population that have received an HIV test during the reporting period and know their results (reached with defined package of services) (HTS-3)	Per capita	194,491	8	1,594,997	207,132	7	1,361,358	221,865	3	675,927
DLI 3: Number of people on ART among all people living with HIV at the end of the reporting period (TCS1.1)	Per capita	110,149	12	1,307,382	116,983	9	1,044,479	121,838	6	719,328
DLI 4: Number of people screened for TB using artificial intelligence-supported radiology	Per capita	178,960	10	1,789,359	199,085	10	2,065,375	216,901	4	924,736
DLI 5: Treatment success rate of RR-TB and/or MDR-TB: Percentage of patients with RR and/or MDR-TB successfully treated.	By percentage point	70	11,416	799,153	75	11,448	858,574	85	10,128	860,875
Total				**6,416,427**			**6,476,995**			**4,027,112**

Table 2: DLI2 Payment structure – conditional threshold

DLI	Description	2026	2027	2028
DLI 2: Number of people in vulnerable population that have received an HIV test	90% of National Target	175,042	186,419	199,679
	90% Total Payment	1,435,497	1,225,223	608,335

during the reporting period and know their results (reached with defined package of services) (HTS-3)	10% Remaining Total Payment	159,500	136,136	67,593
	Female Transgender Target	11,873	12,754	13,900
	70% of Female Transgender Target (minimum conditional threshold)	**8,311**	**8,928**	**9,730**

7. Unless otherwise determined by the Global Fund in its sole discretion, in cases where the achievement rate of a given indicator is less than 100% in a particular year and greater than 100% in the subsequent year, the Disbursement amount will be determined on a cumulative basis which shall not exceed the cumulative allocated total amount by the end of the reporting year for that DLI as set forth in the Results Framework in Schedule IV of this Grant Agreement.

8. Where the pre-payment transferred to the Procurement Service Agent and/or the Global Drug Facility is greater than the calculated disbursement amount for a specific period, any payments made in excess of the calculated disbursement amount will be settled in the following order:

(a) Reduce subsequent pre-payments to the Global Drug Facility; and/or

(b) Reduce subsequent disbursements to the Principal Recipient; and/or

(c) Refund by the Global Drug Facility to the Global Fund.

9. The Global Fund has sole discretion to determine the achievement rate for an indicator, and therefore the commensurate disbursement amount (if any) where:

(a) Results are reported after three months of the expected date for the routine programmatic report. Any exception has to be submitted in writing by the CCM, and approval of such deviations shall be at the discretion of the Global Fund;

(b) Fraudulent reporting is suspected and/or identified. The Global Fund also reserves the right to conduct a data quality audit/additional data quality review at any stage, including after expiration of the Implementation Period; and/or

(c) The Global Fund has determined non-compliance to open access to data.

Schedule IV
Disbursement Linked Indicators/Workplan Tracking Measures

1. Disbursement Linked Indicators ("DLI")

a. Coverage/output indicators will be used to inform the annual disbursements;
b. Indicators are to be captured under the National Health Management Information System (SIG TB and SIG HIV) and should not be based on pure modelling;
c. Indicators shall be measurable and independently verifiable on an annual basis for annual funding decisions; and
d. The following DLIs shall apply:

DLI	DLI Baseline 2024	DLI Targets			Comment
		Year 1 2026	**Year 2 2027**	**Year 3 2028**	
DLI 1: Number of key populations who received any PrEP product at least once during the reporting period	4,504	17,427	30,231	44,843	**Data Source**: National HIV reporting system (SIHCE VIH) **Measurement**: Number of people (key population) who received any PrEP product (oral, injectable) at least once during the reporting period
DLI 2: Number of people in vulnerable populations that have received an HIV test during the reporting period and know their results (reached with defined package of services)	146,882	194,491	207,132	221,865	**Data Source**: National HIV reporting system (SIHCE VIH) **Measurement**: Number of people (key population) reached with a defined package of prevention/estimated aggregate population size (%) during the reporting period
DLI 3: Number of people on ART among all people living with HIV at the end of the reporting period	100,061	110,149	116,983	121,838	**Data Source**: National HIV reporting system (SIHCE VIH) **Measurement**: Number of people on ART at the end of the period/estimated PLHIV (%)
DLI 4: Number of people screened for TB using artificial intelligence-supported radiology	71,747	178,960	199,085	216,901	**Data source:** National TB reporting system (SIGTB 2) **Measurement**: Number of adults screened for TB using AI-based technology in prisons and health facilities in the reporting period.
DLI 5: Treatment success rate of RR-TB and/or MDR-TB: Percentage of patients with RR and/or MDR-TB successfully treated.	56%	70%	75%	85%	**Data Source**: National TB reporting system (SIGTB 2) **Measurement**: Numerator: number of patients with bacteriologically confirmed RR and/or MDR-TB enrolled on second-line treatment regimen during the specified reporting period who are successfully treated (cured plus completed treatment). Denominator: total number of people with bacteriologically confirmed RR TB and/or MDR-TB notified during the same reporting period

1. **Indicators baseline:**

Represented target baselines for all indicators correspond to the end of year 2024. Along Q3 2025, during grant negotiations, the interim achievements of each indicator were analyzed to ensure the progression to GC7 targets is realistic, achievable, and still ambitious. Information about calculation of targets is found in the GC7 performance framework ("target assumptions" tab).

2. **Programmatic reporting of results**

(a) The Principal Recipient is expected to report within 60 calendar days after the end of the last reporting period end-date by (1 March 2027, 2028, and 2029 respectively), for results of the 12-month prior period (from 1 January to 31 December of the previous year, inclusive), except when the Performance Framework set forth in Schedule I states otherwise.

(b) Together with the results against the aforementioned DLIs, the Principal Recipient will be requested to provide, (by 1 March of each year for results up to 31 December of the previous year), a quantity-qualitative annual progress report with an analysis of program achievements, challenges and improvement strategies focusing on areas and interventions related to the DLIs. For DLI 1, DLI 2, DLI 3, DLI 4 and DLI5, the report should specifically describe the progress disaggregated by each of the populations, according to the agreed targets, included in the PF. Additionally, the Principal Recipient will be requested to provide an annual quantitative results interpretation narrative, with an analysis of the robustness and reliability of data quality mechanisms, program challenges and successes, etc. (by 1 March of each year for results from 1 January up to 31 December of the previous year). With regards to DLI2, the Unit Payment will be paid for each per capita unit of the aggregated National Target achieved by the Principal Recipient. In addition, a conditionality threshold is established as outlined below:
    a. Once 90% of the aggregated National Target is achieved, the Principal Recipient will receive 90% of the Total Payment of DLI2; and
    b. To receive the remaining 10% of the Total Payment of DLI2, the Principal Recipient shall evidence an achievement of HIV testing target in the female transgender group is equal or above to 70%, as detailed in Table 2.

(c) During the annual review of results, based on new epidemiological data, WHO updated estimations, new WHO guidelines and/or other predefined NSP costing scenarios, the Principal Recipient and the Global Fund may, on an exceptional basis, agree to revise targets upwards or downwards.

3. **Verification of results and data quality**

The Principal Recipient, the HIV program and the TB program have standard operating procedures for the data quality control and validation of the indicators included in the PF, defined in the "HIV program data management Consistency Rules" and the "Technical norm TB 221-2024". For the HIV program, the data for DLI 1, DLI 2, DLI 3 is included in the SIHCE HIV database, that comprises data from the health sector and community organizations. For the TB program, the data for DLI 4 and DLI 5 will transition from SIGTB 1 to SIGTB 2 in 2026 and will include the health sector and community organizations. The primary owner of the information system is the Ministry of Health and data analysts in the TB and HIV programs, who oversee standard data validation processes embedded in the system. This procedure includes both automated completeness and consistency of data validation processes, as well as monthly quarterly on-site audits for data

consistency verification in selected sites. A detailed procedure for data quality and verification is available in the grant M&E monitoring plan.

The following mechanisms and actions will be considered to verify results and ensure data quality:

(a) Results will be reported by no later than 60 calendar days after the end of the reporting period by (1 March 2027, 2028, and 2029 respectively), for results of the 12-month prior period, except when the Performance Framework set forth in Schedule I states otherwise.

(b) The LFA and/or another external provider, as may be deemed necessary by the Global Fund, will implement a tailored Data Quality Review (DQR) in a national representative sample using the WHO standard DQR toolkit (WHO, [September 2017]) for both TB and HIV data annually, or as considered by the Global Fund. The selection of the external provider should be documented and subject to Global Fund's written approval, and in both cases the terms of reference have to be agreed with the Global Fund.

(c) Following the verification activities, a verification factor ("VF") will be calculated for each DLI using verified results divided by reported result. If the VF is between 90% and 110%, i.e. 90% ≤ VF ≤ 110%, no adjustment will be made to the agreed disbursement amount as stated above. If the VF is larger than 110% or smaller than 90%, (e.g. > 10% total discrepancy at health facility levels compared to central level reported results), the Global Fund reserves the right to purposively set the percentage of achievement of that particular indicator.

(d) If fraudulent reporting is suspected and/or identified, then the Global Fund reserves the right to conduct a data quality audit/additional data quality review and/or consider the achievement of a particular indicator as zero.

(e) Unless otherwise agreed in writing by the Global Fund, the adjustment to the reported results will be permitted for under-reporting the national surveillance systems.