

**DOMINICAN REPUBLIC**

**Country/Regional Operational Plan**

**(COP/ROP) 2016**

**Strategic Direction Summary**

June, 2016

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## Goal Statement

PEPFAR/Dominican Republic's (DR) goal is to contribute to the country's efforts to achieve epidemic control (90-90-90) through the development and demonstration of community- and facility-based service delivery models that provide quality interventions for key and priority populations (KP/PP). Key populations consist of men who sex with men (MSM), transgender (TG) individuals, and female sex workers (SW). Priority populations consist of migrants, with a specific concentration on construction and agriculture workers as well as street vendors. The main objectives of COP 2016 are to: (1) identify models of quality KP/PP programming in pilot demonstration sites; (2) strengthen public sector capacity to reduce and address stigma, discrimination, and gender-based violence (GBV); (3) improve capacity to document KP/PP along the clinical cascade; (4) assist the Government of DR (GODR) to rapidly roll-out new policies at PEPFAR-supported sites; and (5) work with GODR to expand and scale-up pilots for long-term impact.

Through a focus on improved case finding, quality clinical and laboratory services, and community-based retention and adherence activities, PEPFAR/DR expects to establish KP/PP models in the public sector that can be transferred to the GODR for national scale-up. The revised strategy includes significant improvements in monitoring KP/PP along the clinical cascade to document the program's ability to treat and retain KP/PP.

PEPFAR/DR proposes two unique models. The first is a twinning model, whereby four local non-governmental organizations (NGO) with experience serving KP/PP are paired with five public sector clinics to transfer expertise and capacity. The second model is the provision of community- and facility-based services through two mobile clinics to hard-to-reach migrants. Both models will include a suite of site-level interventions, focused on addressing six systems-level challenges: stigma/discrimination and gender-based violence (GBV), policy implementation, laboratory, supply chain, strategic information, and human resources for health. These will be accompanied by a limited set of strategic above-site interventions, focused on strengthening the health system.

In FY 2017, PEPFAR/DR will assist the GODR to initiate a phased rollout of several new policies, including Test and START, new service delivery models, and the use of lower cadres for HIV testing services (HTS) at the eleven PEPFAR-supported clinics. To maximize resources, PEPFAR/DR has intensified its efforts to facilitate dialogue among key stakeholders. PEPFAR/DR and the Global Fund (GF) are finalizing a memorandum of understanding to articulate each donor's roles, which includes a HTS technical assistance (TA) role from a PEPFAR/DR partner to GF prime recipients. UNAIDS, civil society, and various arms of the GODR have all been involved in the development of this strategy to ensure alignment to the national response.

The expectation is that by the end of FY 2017, all four provinces will have improved provincial level ART coverage and will be able to estimate ART coverage levels by KP/PP, an exercise not currently possible. The eleven clinics are targeted to increase their ART numbers by 138%, with a 209% increase in migrants, 137% in MSM/TG, and a 44% in SW. This translates to 61% of all new

ART clients at PEPFAR-supported sites coming from KP/PP groups. This scaling of ART coverage will allow the country to move from 54% to 65% ART coverage nationwide.

## 1.0 Epidemic, Response, and Program Context

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### 1.1 Summary statistics, disease burden and country or regional profile

The projected 2017 census data estimated the population at 10,726,367. According to the World Bank (2014), GNI per capita is US\$ 6,040. DHS/2013 estimated an HIV prevalence of 0.8% (15-49 years of age), similar to the 2007 DHS. The 2016 DR Spectrum model estimated 67,544 persons living with HIV (PLHIV), 2,616 HIV-related deaths, and 2,213 new HIV infections per year.

The number of MSM is estimated to be 124,472\*, representing 4.2% of all males 15-49 years old (National AIDS Commission [CONAVIHSIDA, in Spanish] and UNAIDS/2010, updated 2015). MSM HIV prevalence was estimated between 3.9-6.9% across five provinces (Integrated Biological and Behavioral Sentinel Survey [IBBSS]/2012)δ. The study also indicated that only 11-31% of MSM had access to an HIV test in the last 12 months. Moreover, 4-48% of MSM reported discrimination in health services, and 28.9% of a sample of health services providers preferred not to care for MSM or other KPs (Health Policy Project/2014). Between 70-94%δ of MSM reported having sex for some material benefit, and condom use was low: between 42-71%δ in most recent anal receptive sexual intercourse, and between 21-39%δ in most recent insertive anal sexual intercourse. The total number of TG individuals has been estimated at 8,891\*\*\* (Experts Focus Group for CONAVIHSIDA, 2014), and their HIV prevalence was estimated at 17.3% (PLACE/2014). Although the sample size was small (n=33), this is the only study on TG seroprevalence that exists.

The number of SW was estimated at 91,171\*\*, representing 3.4% of all women 15-49 years old (CONAVIHSIDA Experts Focus Group/2000, updated in 2014). SW HIV prevalence was estimated between 1.7-6.3%δ across five provinces. Only 21-52%δ of SW had access to an HIV test within the last 12 months, and between 86-95%δ of SW reported discrimination in health services. Between 61-92%δ of SW reported using a condom at most recent commercial sexual intercourse, and 6-23%δ in most recent non-commercial sexual intercourse.

Migrants living in DR, most of who are of Haitian descent, were estimated at 458,233 (National Immigrants Survey, 2012). A secondary analysis of the DHS indicated that HIV prevalence of those who self-reported as “born in Haiti” was 3.5% (secondary analysis of DHS/2013). Per the IBBSS/2013, HIV prevalence among migrant SW and migrant construction workers was 5.4% and 4.6%, respectively. Only 35.3% of migrant SW and 13.1% of migrant construction workers had access to an HIV test within the last 12 months, and only 48.8% of migrant SW and 18.5% of migrant construction workers reported accessing regular medical care (IBBSS/2013).

The DR military population is approximately 56,000 (91% male). HIV prevalence is estimated at 0.6%, based on a convenience study (DOD KAP study/2010). Military hospitals in Santo Domingo reported 800 patients in HIV care and treatment services, of which approximately 35% were active duty military.

A summary of key National and Demographic data is included in *Table 1.1* below.

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	10,726,367	100%	1,536,838	14%	1,595,215	15%	3,846,696	36%	3,747,618	35%	Projection 2016, National Census
HIV Prevalence (%)		0.8		N/A		N/A		0.7		0.9	DHS 2013 *15-49yrs
AIDS Deaths (per year)	2,616		N/A		N/A		N/A		N/A		2016 Projection, Spectrum 2014
# PLHIV	67,544		30,447		1,450		34,280		35,102		2016 Projection, Spectrum 2014
Incidence Rate (Yr)		0.04		N/A		N/A		N/A		N/A	2016 Projection, Spectrum 2014
New Infections (Yr)	2,213										2016 Projection, Spectrum 2014
Annual births	200,404	N/A									DR Health Statistics MOH 2014
% of Pregnant Women with at least one ANC visit	N/A	N/A	N/A	N/A			N/A	N/A			
Pregnant women needing ARVs	N/A	N/A									
Orphans (maternal, paternal, double)	N/A		N/A		N/A		N/A		N/A		
Notified TB cases (Yr)	4,128		N/A		N/A		N/A		N/A		National TB Program 2015
% of TB cases that are HIV infected	23	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	National TB Program 2015
% of Males Circumcised	N/A	N/A			N/A	N/A			N/A	N/A	
Estimated Population Size of MSM*	124,472	N/A									CONAVIHSIDA-UNAIDS 2010, updated 2015
MSM HIV Prevalence	3.9-6.9 & 3.9	N/A									IBBSS 2012 & Place 2014
Estimated Population Size of FSW	91,171	N/A									Focus Group 2000 CONAVIHSIDA (update 2014) – Concept Note GF
FSW HIV Prevalence	1.7-6.3 & 2.5	N/A									IBBSS 2012 & Place 2014
Estimated Population Size of PWID	N/A	N/A									
PWID HIV Prevalence	N/A	N/A									
Estimated Size of Priority Populations (migrants)	458,233	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Priority Population Prevalence (migrants reported “born in Haiti”)	3.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Secondary analysis of DHS 2013

### HIV Clinical Cascade

As of end of 2015, the PEPFAR-supported electronic HIV patient monitoring system (HPMS), which is utilized in all 76 HIV treatment facilities, registered 32,291 persons on ART (47% of all PLHIV) and another 8,861 individuals in HIV care. Among those on ART, 24,380 (76%) were retained on treatment during the last 12 months. Viral load testing is readily available through the National Lab (18,475 in 2015); however the logistics required for the sending of samples and timely delivery of results to HIV service delivery sites have resulted in limited coverage of VL at sites and a need for more precise data to determine viral load suppression nationwide.

Among migrants, 3,126 are registered on ART (23% of all migrants LHIV), and another 1,974 individuals in HIV care. Among those on ART, 1,846 (59%) were retained on treatment during the last 12 months.

Clinical cascades specific to key populations are not known at this time. With the exception of a limited number of NGO clinics, facilities do not have the ability to classify clients by population. It is estimated that 21% of all clients at the nine existing facilities within the proposed strategy are KP/PP. To better understand this distribution and monitor KP/PP throughout the cascade, PEPFAR/DR is supporting the GODR to capture population categorization in the national electronic database. This will be available at all PEPFAR-supported sites by October 2017.

Current GODR guidance for ART initiation is CD4<500, although many sites have yet to transition from the previous norms of CD4<350. However, the Minister of Health (*see signed letter*) has approved to initiate Test and START in all PEPFAR-supported clinics by October 2016. Key data to reflect the clinical cascade is summarized in *Table 1.1.2* below

### HIV Testing Services

National HTS numbers reported represent the number of tests performed (and not individuals). In 2015, 463,320 HIV tests were performed, of which 10,783 (2.3%) were HIV-positive (National Health Services, 2015). Of the tests performed in 2015, 147,511 were among pregnant women, of which 2,227 (1.5%) were HIV-positive. CDC programmatic data, collected in 13 maternity hospitals during 2013, found an HIV prevalence of 5.4% (182/3,397) among pregnant Migrant women.

### TB/HIV Co-infection

DR has one of the highest TB and MDR-TB rates in the Americas. In 2015, through the PEPFAR-supported electronic national information system, the National TB Program reported 4,128 TB cases, of which 3,084 (75%) received an HIV test and 717 (23%) were found to be co-infected. Collecting information and reporting on TB testing within HIV clinics continues to be a challenge.

### Epidemic Control

Maximizing the resources dedicated to HIV is critical if the GODR intends to meet its ambitious targets for HIV epidemic control. This requires the coordination of key stakeholders, including Ministry of Health, Ministry of Finance, international donors, cooperating agencies, and civil

society partners, to ensure continued analysis of investments based on financial projections and careful forward planning.

As illustrated in Graph 1, the GODR has also demonstrated increasing financial will to support the HIV epidemic. In 2015, the GODR budgeted nearly \$8.8 million to procure ARVs and reagents, the first time that government independently procured all HIV commodities without external resources. In 2016, the GODR budgeted the same amount, although recently reported that an emergency funding request had been approved to meet the projected need of \$12.2 million. The annual financial projections continue to increase and PEPFAR/DR will be supporting the GODR to rollout differentiated models of care as well as the development of a domestic resource mobilization strategy in COP 2016 to better prepare for these rising costs.

**Graph 1: GODR allocated resources to ARV and supplies (2010-2016)**

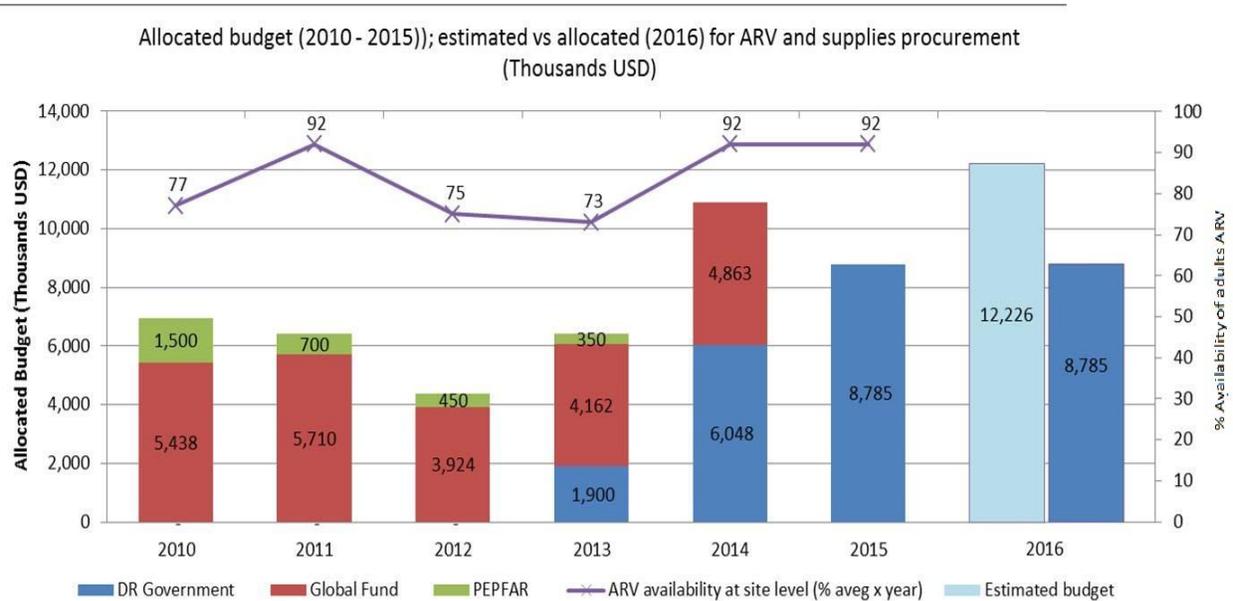


Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	10,726,367	0.8% (15-49yrs)	67,544	32,291	24,380	18,475	463,320	10,783	N/A
Population less than 15 years	3,132,053	N/A	2,564	921	655	N/A	N/A	N/A	N/A
Pregnant Women	N/A	N/A	N/A	N/A	N/A	N/A	147,511	2,227	N/A
<b>MSM</b>	124,472	3.9-6.9	7,174	N/A	N/A	N/A	N/A	N/A	N/A
<b>FSW</b>	91,171	1.7-6.3	2,887	N/A	N/A	N/A	N/A	N/A	N/A
<b>PWID</b>	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
<b>Priority Pop (Migrants)</b>	458,233	3.5% (15-49yrs)	13,547	3,126	1,846	863	N/A	N/A	N/A

## 1.2 Investment Profile

As reported in COP 2015, there are limited data describing countrywide HIV investments in the Dominican Republic. The 2012 UNAIDS-NASA supported report, (MEGAS in Spanish), is the most comprehensive HIV financial report to date. UNAIDS has recently commissioned another HIV expenditure study, known as PORTIA, which has yet to be finalized. The final source is the 2015 GF Concept Note, which reported some national HIV financial information.

The total amount expended for HIV in 2014 is estimated at \$86.2 million (PORTIA, 2016). Of this total, approximately 26% (\$22.4 million) comes from the GODR, including the social security program. Approximately 27% (\$23.3 million) is estimated to be out-of-pocket household expenditures. GF is estimated to have contributed about 26% (\$23.0 million) and PEPFAR/DR about 16% (\$14.0 million).

Given that the PORTIA report shows only broad categories of expenditures, the table below has been inserted in lieu of Table 1.2.1. (NOTE: Tables 1.2.2 – 1.2.4 are not applicable for the country program).

*Percentages of Expenditures by Category: 2008 and 2012*

<b>Program Area</b>	<b>2008</b>	<b>2012</b>
Prevention	25%	39%
HIV care, treatment, and support	41%	36%
Systems strengthening	33%	22%

The HIV financial landscape has changed dramatically with the GF Concept Note considerably less than years past. The Concept Note was funded at \$17.6 million over three years (2016-2018). Fortunately, the GODR has been assuming increasing financial responsibility for the HIV response, as noted earlier with their financial independence in covering the costs of all HIV commodities.

GF’s primary focus is similar to PEPFAR/DR—the provision of high quality services to key and priority populations in geographic areas disproportionately burdened by the HIV epidemic. However, the majority of GF’s resources are focused on community prevention and HTS, which provides an opportunity for PEPFAR/DR to leverage these resources to more rapidly enroll HIV-positive individuals into the ART program.

While PEPFAR/DR has not purchased HIV commodities, significant support has been directed to the National Pharmaceutical Supply System to ensure a continuous supply of ARV and diagnostic commodities. Over the past six years, the country has reduced the number of adult ARV regimens, improved its forecasting for commodity needs, and more than halved the cost per patient treated from \$371/year/patient in 2011 to \$164/year/ patient in 2014.

### 1.3 National Sustainability Profile

On February 25, 2016, PEPFAR/DR convened a consultative meeting on PEPFAR’s Sustainability Index and Dashboard (SID). Attended by 32 key stakeholders representing numerous ministries, civil society, and other cooperating agencies, PEPFAR/DR staff provided an overview of the SID process and then divided participants into four groups (each assigned to one of the four sustainability domains). Each group was expected to reach a consensus on an appropriate score for each sustainability element, of which the results were then translated to the dashboard.

Key findings in the SID included:

- The majority (9/15) of the elements were scored yellow;
- One element was scored red (private sector engagement);

- Both elements under the domain “strategic investments, efficiency, and sustainable financing” were scored green; and
- There was consensus that the GODR has strong planning, coordination, policies, and governance associated with the HIV response.

The discussion groups agreed that sustainability strengths were the following:

- Strong legal and policy framework for HIV/AIDS and for service provision to KPs;
- GODR financial independence in funding HIV commodities, including ARVs; and
- GODR transparency in information sharing and engaging civil society to play an integral part of the national HIV response.

The SID also highlighted some sustainability vulnerabilities, including, but not limited to, the following:

- Poor private sector engagement, highlighting the need for further discussions focused on incorporating HIV treatment as part of private insurance schemes;
- Inadequate quality management for service delivery, including poor GODR Regional and provincial-level coordination and oversight and stigmatizing health provider attitudes towards key and priority populations (despite actual laws and policies in place);
- Poor distribution and inefficient use of human resources leads to challenges with intervention scale-up;
- Insufficient laboratory personnel and poor specimen and results transport infrastructure jeopardizes quality of care offered to PLHIV; and
- Inadequate forecasting of commodity needs translates to inventory challenges at the site-level.

The PEPFAR/DR program has invested heavily in many of these areas and there is acknowledgement (as indicated by the yellow scores on the dashboard) that the situation has been improving. Systems-level needs including human resources for health, laboratory strengthening, and supply chain management have been identified as priorities for PEPFAR/DR programmatic support, and individual mechanisms that focus on these thematic areas have been included in COP 16.

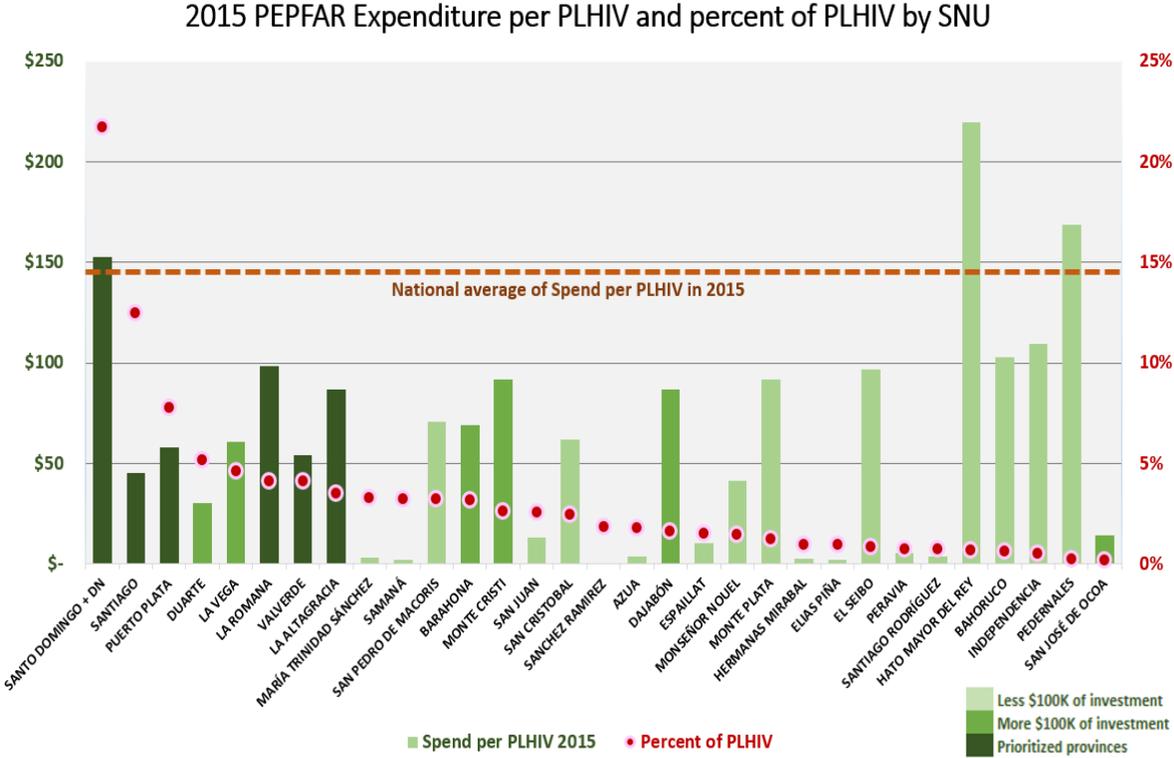
Private sector engagement, however, represents the only red score on the dashboard. This issue will be addressed by PEPFAR/DR support to develop and implement a domestic resource mobilization strategy, which will articulate how the private sector can and will contribute in the national response.

Following the SID review, PEPFAR/DR is proposing for its national systems level partners to have a site-level presence as a means of documenting its impact. These partners will be expected to develop site-level work plans and report on customized indicators to illustrate their contribution to epidemic control. At the same time, the portfolio will reduce its national health systems strengthening activities in an effort to focus its limited resources on site-level issues.

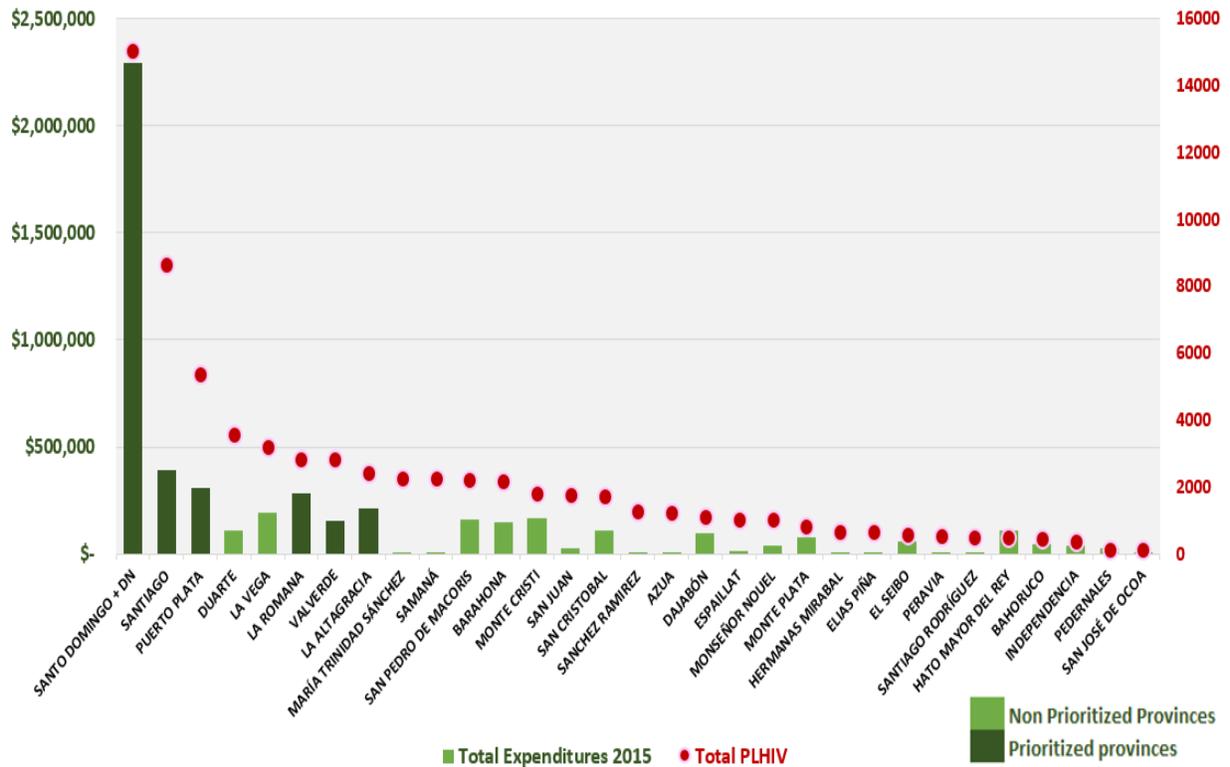
1.4 Alignment of PEPFAR investments geographically to disease burden

In COP 2015, the PEPFAR/DR portfolio was realigned to focus in six high burden, high HIV prevalence provinces. The decision took into account: burden of disease; key and priority population size estimations; number of PLHIV enrolled at HIV clinics; number reached and tested in 2014; unmet need; and cost of outreach, testing and care per person. Slightly different provinces were selected for key vs. priority populations. Despite this decision being made in April 2015 (more than halfway through the FY15 reporting cycle), the portfolio was able to quickly shift its geographic focus. During FY 2015, the PEPFAR/DR portfolio was phasing out of many provinces, which often led to high provincial expenditures per PLHIV; however, this also translated to limited actual funding being spent in these transition province as a whole (as indicated by Figure 1.4.1). Santo Domingo’s expenditures appear quite high per PLHIV, yet this is largely driven by the fact that the capital city provides services to many PLHIV that are not from the province itself. Santo Domingo appears to have exceptionally high rates of coverage, a figure that is undoubtedly skewed by high mobility. Per the national HIV electronic registry, it is estimated that upwards of 30% of all clients receive services outside of their home province.

Figure 1.4.1



## 2015 PEPFAR Total Expenditure and PLHIV by SNU

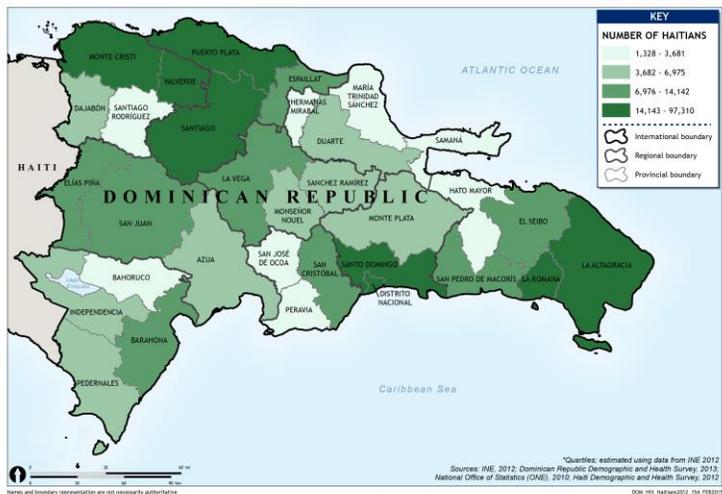


Based on burden of disease and likelihood for success of demonstration sites, PEPFAR/DR identified Santo Domingo, Santiago, Puerto Plata, and La Romana as the four provinces to maintain interventions in COP 2016. Per the FY15 Expenditure Analysis, additional focus in Santiago and Puerto Plata will be critical should the targets be met in these two currently under-resourced settings.



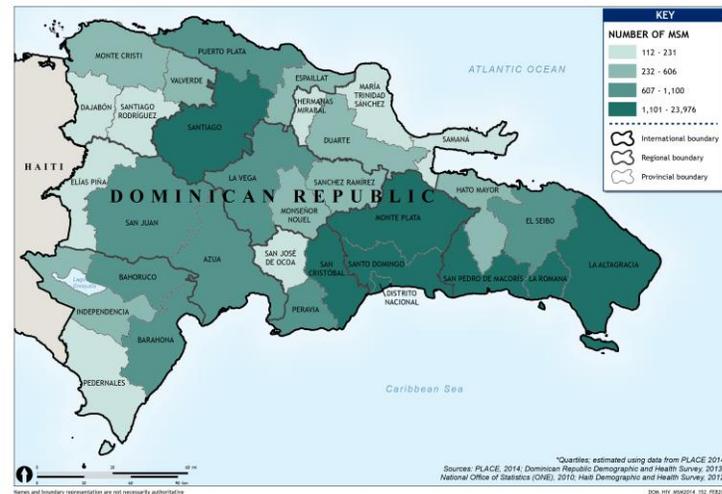
### DOMINICAN REPUBLIC

HAITIAN POPULATION  
BY PROVINCE, 2012



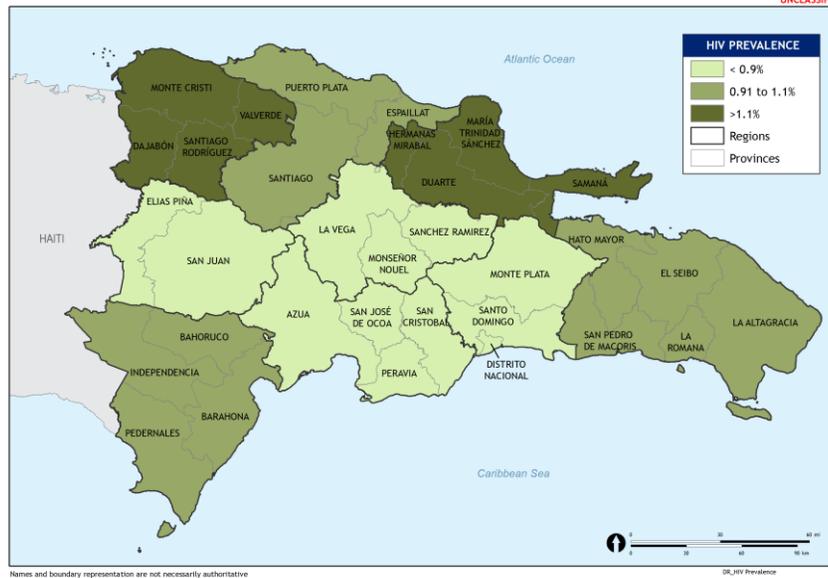
### DOMINICAN REPUBLIC

ESTIMATED NUMBER OF MEN WHO HAVE  
SEX WITH MEN (MSM), BY PROVINCE, 2014



### DOMINICAN REPUBLIC HIV PREVALENCE BY REGION, 2016

UNCLASSIFIED



## 1.5 Stakeholder Engagement

PEPFAR/DR recognizes that effective collaboration with key stakeholders is vital to the success of the strategy. Key stakeholders include: a) host country government, b) civil society, c) the Global Fund, with Portfolio manager and Principal recipients and d) other cooperating agencies. Initial memos of understanding are being established with each of these stakeholders, followed by work plans that will guide continued engagement efforts.

### *Host Country Government*

PEPFAR/DR is committed to strengthening and maintaining its partnership with the GODR to ensure alignment between PEPFAR investments and national priorities. The team regularly consults with counterparts from the CONAVIHSIDA, Ministry of Health (MOH), and National Health Service Authorities at various levels, including engagement with the Minister and Vice Ministers of Health on the need for key policy changes, such as Test & START. PEPFAR/DR is in the process of developing a routine high-level meeting with the GODR to share technical updates and address information sharing challenges. Technical counterparts from PEPFAR/DR and MOH will continue to coordinate through implementation of a series of government-to-government projects and through participation in technical forums led by CONAVIHSIDA.

### *Global Fund and External Donors*

The Global Fund and PEPFAR have complementary strategies and have dramatically increased the level of coordination in the past several months. Following several calls with GF/Geneva and numerous meetings with GF prime recipients, the country's two largest donors are finalizing a memorandum of understanding. This will include work plan, targets, and results sharing. With GF activities largely focused on community-based prevention and HTS, PEPFAR/DR has increased its investments in the latter portions of the cascade. PEPFAR/DR will, however, provide TA to GF prime recipients to conduct HTS yield analyses and maximize HTS efforts.

### *Civil Society*

PEPFAR/DR regularly engages with civil society through its implementing partners. The portfolio's largest partner holds quarterly consultation meetings around four thematic areas: key populations, clinical services, community care and support, and technical quality. These groups are self-managed, include members of numerous civil society organizations, affected populations, and government officials, and provide a forum for PEPFAR/DR to better understand the barriers to and opportunities for improved programming.

For COP 2016 development, PEPFAR/DR held a large stakeholders meeting to share the current PEPFAR direction and seek input on potential FY 2017 focus areas. The meeting was attended by 29 NGOs as well as government and multi-lateral partners. A second meeting, specific to the SID, was held on February 25 that was also widely attended by civil society to help align PEPFAR's health systems investments with programmatic gaps and priorities. PEPFAR/DR has developed a civil society engagement plan to directly address the needs of the communities it intends to serve.

## Private Sector

PEPFAR/DR has not historically directly engaged with private sector entities, although through its implementing partners, the portfolio has leveraged funds. Healing a Nation Foundation, comprised of several large private sector companies, donated opportunistic infection medications and high-protein nutritional supplements to people with HIV after signing an agreement with a PEPFAR/DR partner. PEPFAR/DR's supply chain management partner has also been actively engaged with private health insurance companies to identify opportunities for such schemes to include the costs of HIV treatment. PEPFAR/DR hopes to more directly interact with these insurance companies as a part of a larger domestic resource mobilization strategy for FY 2017.

The table below summarizes the steps that have been taken to ensure coordination with all stakeholders and outlines some of the components of how PEPFAR/DR plans to engage with these stakeholders throughout the course of implementation.

Stakeholder	Pre/Post-COP Engagement	Engagement Strategy
Government of the Dominican Republic	May 9: strategy discussion/feedback	<ul style="list-style-type: none"> <li>Quarterly meetings with senior leadership</li> <li>Regular meetings with SNS, NAC</li> <li>POART participation</li> </ul>
Cooperating Agencies	May 5: strategy discussion	<ul style="list-style-type: none"> <li>Regular meetings with UNAIDS</li> <li>MOU-work with agencies (UN and PAHO) on policy agenda</li> <li>POART participation</li> </ul>
Global Fund (HQ)	April 7: strategy discussion May 13: strategy discussion/SDS feedback May 23: briefing on PRs Meeting	<ul style="list-style-type: none"> <li>Joint participation-TA mechanism</li> <li>M&amp;E framework-additional examination of yield and cascade</li> <li>Quarterly calls with Geneva</li> </ul>
Global Fund (Prime Recipients)	April 12: strategy briefing May 17: MOU in progress	<ul style="list-style-type: none"> <li>Quarterly meetings with PRs</li> <li>Routine discussions between PRs, PEPFAR-supported GF TA partner, and UNAIDS</li> <li>POART participation</li> </ul>
Civil Society	April 28: shared how Feb. 9 meeting was included into COP16 May 1: shared the SDS incorporation May 9: strategy briefing	<ul style="list-style-type: none"> <li>Development of CS Engagement Plan, which includes POART participation and periodic meetings with the NGO Coalition on AIDS</li> </ul>



## 2.0 Core, Near-Core and Non-Core Activities

Apart from geographic focus, there were few major changes in the interagency core, near-core, non-core approach to PEPFAR/DR programming in COP 2016. The document (Appendix A) has been reformatted and enhanced with greater detail to better adhere to the revised strategic approach. Core activities represent those interventions that are deemed essential for PEPFAR support to be able to successfully identify and sustain quality models for key and priority populations. In response to the SBOR and SID results, there is also a shift in mandating national systems partners to having a site-level presence. Some notable changes include:

- TA to the Global Fund Country Coordinating Mechanism is a non-core activity (while TA for Global Fund HTS activities is core); and

- Support for a socially-marketed condom program is a non-core activity, while TA to monitoring and strengthening the total condom market becomes a core activity.

### 3.0 Geographic and Population Prioritization

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As of the end of FY 2015, a total of 32,291 individuals (47%) were receiving ART out of a total estimated 68,459 HIV-positive individuals. In order to reach the second 90, the country would need to put 23,160 PLHIV on treatment. Since 2015, the GODR independently funds all HIV commodities and receives no external financial support. At an estimated annual per person treatment cost of \$646, the HIV treatment commodities for the achievement of the second 90 would cost \$35.82 million. In FY 2016, the GODR initially committed \$8.79 million, although eventually identified a total of \$12.22 million to meet the increased demand.

The proposed portfolio will focus in four provinces (Santo Domingo/Distrito Nacional, Santiago, Puerto Plata, and La Romana). These provinces, all part of the COP 2015 strategy, represent four of the six highest in HIV burden and are home to some of the largest size estimates for key and priority populations. The total number of PLHIV in the country comes from a 2015 Spectrum model. Population size estimates come primarily from the 2013 Demographic and Health Survey (DHS), 2013 Bio-Behavioral Surveillance Study (BBSS), and the 2013 Priorities for Local AIDS Control Efforts (PLACE) study that established national and provincial-level estimates of key populations. The two provinces eliminated in the revised strategy had the lowest number of PLHIV among the six prioritized provinces. The PEPFAR/DR portfolio will focus on three populations, including two key populations—MSM/TG, and SW—and one priority population, migrants.

The following rationale was used for the selection of each of the provinces:

- Santo Domingo/Distrito Nacional (SD/DN): The capital city and its surrounding is home to 19.4% of all PLHIV. In addition to the greatest burden of disease, the geographic area also has largest population size estimates for all four PEPFAR focus populations. ART coverage (82.9%) appears impressively high; however, due to significant migratory patterns with approximately 30% of clients receiving services outside their home province, there remains a substantial coverage gap. Finally, the presence of two strong local NGO clinics provides an ideal opportunity for the aforementioned mentorship relationship.
- Santiago: Home to the second largest city in the country, Santiago has the second largest burden of HIV disease (12.3%) and second largest number of key populations. The ART coverage (39.1%) is substantially lower than the national average and the country must address the challenges in Santiago rapidly if the country is to reach epidemic control. The province also struggles with one of the highest HIV prevalence among MSM (5.3%) and sex workers (3.5%). There are many rural agricultural areas, mainly inhabited by migrants, with higher needs of care services through mobile clinics.

- Puerto Plata: Puerto Plata has the third highest burden of PLHIV (7.3%) and is saddled with below average ART coverage (35.9%). A strong local NGO clinic in the province is well-placed for a twinning relationship with the neighboring public facility. Also, the province contains multiple rural and agricultural areas, inhabited by migrants, with higher needs of care services through mobile clinics.
- La Romana: La Romana has the fifth highest burden of disease (4.5%) and arguably the strongest local NGO partner/clinic in the country. The clinic already serves as a model site for many health interventions and can strengthen its HIV activities to highlight how high quality services for key and priority populations can translate into desired results. The province also struggles with one of the highest HIV prevalence among MSM (5.3%) and SW (4.4%).

Between the current data on ART coverage (FY 2015) and the ART coverage projected by the end of FY 2017, PEPFAR/DR will significantly contribute to the country's efforts to reach 90-90-90. Santo Domingo/Distrito Nacional will progress from 83% to 98% coverage. This exceptionally high coverage is misleading, however, as nearly one quarter of Santo Domingo ART clients reside in other provinces. In fact, the province already has more clients on ART than the estimated number of PLHIV. La Romana will move from 56% to 86% ART coverage, Puerto Plata from 36% to 65%, and Santiago from 39% to 54%. Overall, this will allow the country to move from 54% 65% ART coverage.

Equally importantly, PEPFAR/DR will dramatically increase the gross number and proportion of KP/PP on HIV treatment. At the nine existing clinics, clients on ART are expected to rise by 138%, a figure largely based on increases in the number of migrants (209% increase), MSM (137%), and SW (44%). Of all new treatment clients in FY 2017, 61% will come from KP/PP. PEPFAR/DR's support for improved information systems will allow for ART coverage estimates by population.

## 4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

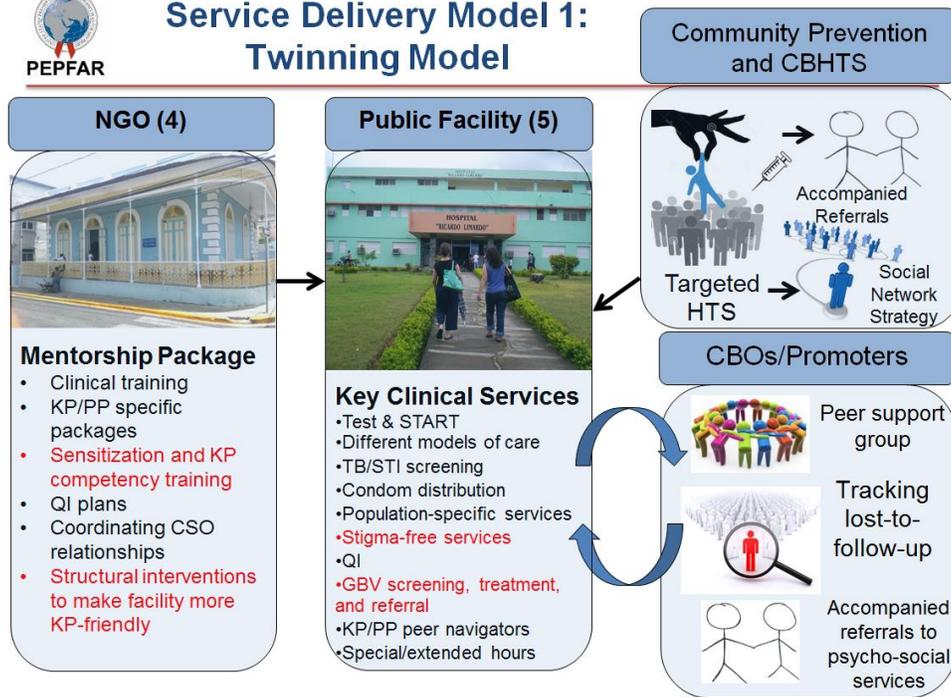
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### 4.1 Service delivery models

In COP 2016, PEPFAR/DR is proposing to use two service delivery models to support the GODR in its efforts to achieve epidemic control by 2020. The first model is to create public facility capacity to effectively provide comprehensive, tailored, stigma-free KP/PP services that can be replicated for national expansion. This will be achieved through the development of a mentoring relationship between KP/PP-experienced NGO clinics and public facilities to transfer the necessary skills. The second model is the use of mobile clinics to provide services to hard-to-reach migrants that are not being adequately served by existing structures. The following two diagrams provide pictorial representations of the models.



## Service Delivery Model 1: Twinning Model



## Service Delivery 2: Mobile HIV Clinic



### *Service Delivery Model 1: Twinning Model*

The aim of this model is to ensure that public facilities have the capacity to provide quality KP/PP HIV services. This will be achieved through a twinning relationship between four experienced NGO clinics and five public health facilities. A detailed mentorship package will be designed, based on the specific needs of each individual public sector clinic. Formal agreements on the terms of the relationship will be described in a memorandum of understanding signed between the NGOs and the provincial/regional authorities and the site itself. Examples of mentorship areas are listed in the diagram, with a concentrated effort on addressing stigma and discrimination issues that often plague public facilities. The public sites will be expected to provide an array of clinical services, including population-specific interventions that meet the needs of KP/PP clients.

In order to ensure an increase in KP/PP entering the clinic, PEPFAR will support community prevention and community-based HTS efforts, which includes targeting HIV testing, unique strategies, such as the social network strategy, to further penetrate social and sexual networks of KP/PP, and accompanied referrals to ensure high linkage rates. There will also be an emphasis on providing a continuum of care from facility to community and back to the facility, which includes engaging clients in peer support groups, monitoring lost-to-follow-up cases, and accompanying referrals to other psycho-social services.

### *Service Delivery Model 2: HIV Mobile Clinic*

The aim of this model is to provide timely and quality HIV services to geographically hard-to-reach migrant populations. There are many migrant communities that exist far from any HIV clinic and the opportunity and real costs associated with visiting these clinics make HIV treatment enrollment and retention a major challenge. A mobile HIV clinic, that provides a range of HIV prevention, treatment, and care services, has the potential to dramatically improve the migrant clinical cascade and document the cost-effectiveness of such a model.

There will be two mobile clinics, one assigned to Santiago and the other to Puerto Plata. These locations were selected to due to large number of migrants and the inaccessibility of HIV clinics to many migrant working locations. The clinics will be operated by the GODR, while the actual units will be procured, staffed, and administered by a NGO. Each unit has a route that includes 20-25 communities that are visited on a bi-monthly basis. Each unit is also affiliated with an existing primary health care center from which it collects many of its commodities, information systems, and additional staff, as needed.

The mobile units will provide community HIV prevention interventions that are linked to its HIV testing activities. The clinics will also provide a comprehensive set of clinical services, including the provision of ART through a Test & START approach. Given the working schedule of migrants, the clinic will operate at hours conducive to its target population. There will also be a strong community care component, which will include accompanied referrals to other psycho-social services and consistent adherence counseling, implemented by existing community-based organizations that have an established presence in these areas. The units will initially be

exclusively HIV mobile clinics; however, the GODR will leverage the HIV component by financing complementary services and/or utilizing the unit for vaccine or other outreach components.

In an effort to make these facilities sustainable, the NGO administering the clinics will engage and train site staff on the administrative, financial, and technical components of running a mobile clinic. Over time, more site-level staff is expected to work inside the mobile unit, with eventual full transition to GODR support. A transition plan will be developed during the first year of implementation.

#### 4.2. Targets for scale-up locations and populations

Given the portfolio's focus on the development of demonstration sites and not the more traditional provincial saturation, targets by program area were set outside of the data pack tool. Some key shifts that affected targets include: (1) a reduction in geographic focus from six to four provinces; (2) an increase in site-level systems support; and (3) a heightened level of coordination and leveraging of GF's HTS activities.

PEPFAR/DR set its HTS targets using provincial population size estimates and geographic- and population-specific HIV prevalence, while assuming 80% and 90% linkage to care for community- and facility-based testing, respectively. PEPFAR/DR also utilized Global Fund's HTS targets to determine in which locations and among which populations there remained gaps in the achievement of the first 90. Targets for partner notification testing at six PEPFAR-supported clinics assumed that all new ART patients would on average bring one sexual partner for an HIV test, of which 10% of them would test HIV-positive. The mobile clinic assumed a higher seroprevalence (5%) than other priority population testing activities given its focus on under-served migrant populations. HIV treatment targets at PEPFAR-supported sites were set with the following assumptions: 10% natural facility-level ART growth; 20% growth among key and priority populations; 80% of current pre-ART clients will be successfully transitioned to the treatment program; and 90% of clients will be retained on ART.

The greatest challenge in setting targets is the lack of information on the number of key and priority populations currently accessing services. The national in-take form does not document risk characteristics or categorize by population. While a limited number of sites have developed parallel reporting structures to better capture this information, the vast majority of HIV clinics cannot disaggregate by population and thus cannot confidently project the number of key and priority populations within their treatment program. PEPFAR/DR is supporting the GODR to revise monitoring tools, strengthen screening protocols, and sensitize providers to allow for monitoring of KP/PPs in the HIV treatment program. This process has been initiated and is expected to be completed in the first quarter of FY 2017.

Within the new strategy, national systems partners will be mandated to document their impact through a site-level presence. However, holding each of these partners accountable for the same indicators as the primary clinical partner did not seem appropriate or useful. Instead, each systems partner will have a set of site-level customized indicators that will be developed prior to

FY 2017. These will form the basis for determining how supply chain, strategic information, human resources, and laboratory support are contributing to each site's clinical cascade.

Given the change in strategy and a reduction in the number of provinces and facilities supported, the COP 2016 targets differ dramatically from COP 2015. While there are significant reductions in HIV prevention activities (KP\_PREV decreasing by 74% and PP\_PREV decreasing by 27%), there is a significant increase in TX\_NEW (201% increase). Meanwhile, HTC\_TST slightly increased by 16%. This was made possible, in spite of a flat-lined budget, through a decrease in above-site activities and an emphasis on completeness of partner reporting. The achievement of these targets, particularly those associated with new on treatment, is predicated on service delivery models that reflect the new WHO guidelines of Test and START, longer duration of follow-up, and reduced laboratory monitoring of stable patients. These costs savings to GODR and immediate decreases in visits will allow enrollment of new patients without increasing the costs or strain on human resources. PEPFAR/DR will work with the GODR to quantify these gains as part of their overall national response costing and domestic resource mobilization strategy.

The targets assume that as of the beginning of FY 2017, Test and START will be implemented in all 11 PEPFAR-supported facilities, with 80% of individuals currently on Pre-ART successfully transitioned to HIV treatment. There is also the expectation that at these 11 sites, CD4 testing will only be utilized at time of enrollment, viral load testing will be reduced from twice to once annually, and multi-month scripting will be enacted for stable clients. Finally, site-level clinical and systems partners are expected to jointly assist in providing patient-centered HIV service delivery models to optimize the care continuum, including: reduced frequency of clinical visits through a strengthened ART supply chain; development of interdisciplinary care teams and better utilization of existing staff to extend clinic hours; improved laboratory results turnaround time through an improved specimen transport system; and, enhanced data systems to support high quality care through clinical cascade monitoring.

The resources required to support COP FY 2016 implementation were largely based on unit expenditures (UE) from Expenditure Analysis 2015. Despite public and NGO clinics currently supporting different packages for KP/PP, the facility-based treatment UE does not differ by site. Without any data source to make assumptions, the expectation is that implementing partners will best placed to determine how to best allocate the resources to the sites. Also, PEPFAR/DR's UE for treatment-related programming was almost entirely derived from personnel and program management costs. Given the standard guidance to assume that these categories are relatively fixed under an optimal service delivery scenario, there was no variable portion of the UE and thus no additional costs associated with these new models. The commodity related costs for Test & START were projected by a PEPFAR-supported implementing partner and this information was presented to high-ranking GODR officials for financial and programmatic planning purposes.

In order for PEPFAR/DR to achieve its targets, several key issues must be rapidly and successfully addressed. As noted earlier, the achievement of PEPFAR/DR targets is dependent on a system that can capture population-disaggregated information among treatment clients. New initiatives, including Test & START and differentiated models of care, must rollout at the beginning of FY

2017, which will require significant preparatory work and revised work plans for existing implementing partners in the latter half of FY 2016. Finally, the GODR must fulfill its financial commitment to fully support the ARV needs of the country, an issue that was remedied in FY 2016 only after an emergency funding request.

In COP FY 2017, PEPFAR/DR will be supporting an IBBSS, co-financed with the Global Fund, to gather more accurate information on the size, distribution, and prevalence of key populations in the four PEPFAR-supported provinces. This information will be crucial to improving the HTS strategy, more effectively allocating provincial targets, and better capturing coverage estimates.

**Table 4.1.1** ART Targets in scale-up SNUs for epidemic control

SNU	Total PLHIV	TX_CURR (FY16)	Additional patients for 80% ART coverage	TX_CURR (FY17)	TX_NEW (FY17)	ART Coverage (FY17)
Santo Domingo	13,272	13,374	-	7,471	2,602	98%*
Santiago	8,362	3,736	2,954	666	477	54%*
La Romana	3,070	2,224	232	3,259	1,258	106%
Puerto Plata	4,999	1,906	2,093	3,466	1,750	69%
<b>Total</b>	<b>29,703</b>	<b>21,240</b>	<b>5,279</b>	<b>14,862</b>	<b>6,087</b>	

\*In Santo Domingo and Santiago, PEPFAR/DR supports only a portion of ART sites (as opposed to supporting 100% of ART sites in La Romana and Puerto Plata). To calculate expected coverage in these two provinces, historical ART growth rates were used at non PEPFAR-supported sites.

**Table 4.1.2** Entry Streams for Adults and Pediatrics Newly Initiating ART

Entry streams for ART enrollment	HTC_TST (FY17)	HTC_TST_POS (FY17)	TX_NEW (FY17)
Clinical patients not on ART			1,878
HIV/TB co-infected patients not on ART			
HIV+ Pregnant Women			
Other KP/PP (including FBHTS)	87,778	3,411	2,361
<b>Total</b>	<b>87,778</b>	<b>3,411</b>	<b>4,239</b>

#### 4.2 Key and priority populations service package

As PEPFAR/DR identifies models with the intention of future GODR expansion, the use of comprehensive, well-articulated, and standardized packages of services is critical. It is equally important to recognize the different needs that each KP/PP face, and to develop interventions that specifically address these needs. The following provides an illustrative example of population-specific issues and interventions.



### Specific KP/PP Issues and Interventions

Population	Challenges	Interventions
<b>FSW</b>	<ul style="list-style-type: none"> <li>• Viral suppression low, associated with younger age and drug use</li> <li>• Stigma and discrimination</li> <li>• Experience of GBV</li> </ul>	<ul style="list-style-type: none"> <li>• Test and START increases uptake</li> <li>• Sensitization and KP competency training to NGO and facility staff</li> <li>• Social network strategy to identify KPs</li> <li>• Community-based HTS and partner notification</li> <li>• Population-specific counseling modules</li> <li>• Peer navigation and support</li> <li>• GBV screening, treatment and referral</li> </ul>
<b>MSM</b>	<ul style="list-style-type: none"> <li>• Stigma and discrimination socially and from providers</li> <li>• Disjointed care and treatment</li> <li>• Substance use and mental health issues</li> </ul>	
<b>TG Women</b>	<ul style="list-style-type: none"> <li>• Overlapping risk of SW/transactional sex prevalent</li> <li>• High stigma and discrimination</li> <li>• Providers unfamiliar with unique risks and needs</li> </ul>	
<b>Migrants</b>	<ul style="list-style-type: none"> <li>• High mobility, not available during facility hours of operation</li> <li>• Stigma and discrimination</li> <li>• Language and cultural barriers</li> </ul>	

In addition to the above summary table, the following grid provides a more specific outline of the package of services. The following table is expected to be implemented at all 11 PEPFAR-supported sites. There is recognition, however, that public facilities have unique challenges that will need to be overcome to ensure that the below listed package is fully implemented. The mentorship package to address this concern is described later in this section (see Section 4.5).

Technical Area	Quality Package	Key Population and Priority Population Tailored Interventions
<b>Community Outreach</b>	<ol style="list-style-type: none"> <li>1. Sexual risk reduction/condoms promotion</li> <li>2. Provision of condoms</li> <li>3. Demand creation for HIV Testing and STI Screening</li> <li>4. Referrals to HTS and STI centers</li> </ol>	<ol style="list-style-type: none"> <li>1. Tailored social and behavioral change communications (all population)</li> <li>2. Condom negotiation strategy (SW)</li> <li>3. Condom and lubricants promotion and distribution (SWs and MSM)</li> <li>4. Use of mapping hotspots PLACE results (SW and MSM)</li> <li>5. Referrals to focused KP/PP network NGOs facilities (All)</li> <li>6. Use of Mobile Units (Migrants)</li> <li>7. Use Creole Materials (Migrants)</li> </ol>
<b>HIV Testing Services</b>	<ol style="list-style-type: none"> <li>1. Pre and post-test counseling</li> <li>2. Clinical and community HIV Testing</li> <li>3. Linkage to care and treatment services</li> </ol>	<ol style="list-style-type: none"> <li>1. KP classification through a standardized in-take form (all PEPFAR supported-sites)</li> <li>2. Partner notification testing (all PEPFAR supported-sites)</li> <li>3. Use of peer navigators (all population)</li> <li>4. Referrals and linkage to other services (all populations)</li> </ol>
<b>Treatment</b>	<ol style="list-style-type: none"> <li>1. Immediate provision of ART (regardless of CD4)</li> <li>2. STI and TB treatment services</li> <li>3. Multiple months of medication for stable clients</li> <li>4. CD4 (upon enrollment) and viral load testing (annually)</li> <li>5. Adherence counseling</li> </ol>	<ol style="list-style-type: none"> <li>1. Facility hours to accommodate KP/PP needs (men's clinic for MSM, evening hours for SW)</li> <li>2. KP-specific counseling modules to ensure integration of key issues such as drug use and adherence, depression, GBV and others.</li> </ol>
<b>Clinical and Community Care</b>	<ol style="list-style-type: none"> <li>1. Community support groups</li> <li>2. TB screening</li> <li>3. GBV screening and referrals</li> <li>4. Retention and adherence support</li> <li>5. Address stigma and GBV</li> </ol>	<ol style="list-style-type: none"> <li>1. Community follow-up by peer navigators (All)</li> <li>2. Sexual and reproductive health services, including family planning (SW)</li> <li>3. Peer community support groups (All)</li> <li>4. Psycho-social and mental health support (All)</li> <li>6. Substance abuse screening and referrals (MSM and SW)</li> </ol>

### 4.3 Key and priority population prevention

The PEPFAR/DR portfolio has always tied its community prevention activities with its community-based testing efforts. However, in past years, the assumption was that between 33%-50% of those receiving an evidence- and curriculum-based HIV prevention intervention would be successfully referred for an HIV test. In COP FY 2017, the expectation is that community prevention activities will be more intimately linked with mobile/outreach HIV testing and thus 90% of those reached will receive an HIV test. This will be made possible by drastically reducing, or eliminating in many cases, community outreach efforts that refer (rather than directly provide) HIV testing services.

The overall targets for key population prevention (KP\_PREV) have reduced significantly in FY 2017. This is due to a decision to better align with Global Fund's efforts and reduce duplication of efforts (see section 4.4 below). The targets for priority population prevention (PP\_PREV) have remained relatively stable, although the outreach modality and population sub-type has changed significantly. Migrants in hard-to-reach areas in two provinces will be serviced with mobile HIV clinics, which are expected to reach more isolated and more at-risk migratory persons. Through the use of Creole-based materials and Creole-speaking peer educators, the program is well-positioned to provide comprehensive risk-reduction and promote HIV testing. Following an analysis of existing epidemiologic data, migrant outreach efforts will focus on construction and agriculture workers as well as street vendors.

Unlike previous years where PEPFAR/DR-supported a social marketing program, the portfolio will move away from promotion and distribution of a single condom to broader support of the total condom market. This decision was made following SIMS visits that confirmed partner reports that indicated a paucity of condoms at both community and facility sites. PEPFAR/DR will continue to strategically distribute centrally-supported condoms and lubricants to NGO partners in the field.

### 4.4 HIV testing and counseling

In FY 2016, new HTS guidelines were developed by the GODR that allow for individuals that complete a government-approved HTS training curriculum to be eligible to perform HTS. This is a radical change from the previous guidelines, which allowed only trained laboratory technicians to perform an HIV test. These new guidelines have yet to materialize into noticeable change; however, PEPFAR/DR plans to initiate new health personnel into its HTS activities. This should allow for more cost-effective HTS strategies.

The HTS portfolio has undergone several significant changes in COP FY 2016. First, PEPFAR/DR conducted an analysis of GF activities and using provincial population-specific size estimates, the team determined the appropriate level of complementary HTS targets. In addition, PEPFAR/DR has negotiated a TA role with GF prime recipients to improve yield analysis and support strengthened linkages between HIV diagnosis and HIV care enrollment. Second, PEPFAR/DR is introducing partner notification testing as a new high-yield strategy that will allow further penetration into the sexual networks of KP/PP. In FY 2017, the intervention will be initially rolled

out at six of the 11 PEPFAR-supported sites, with a vision of expanding to all sites in FY 2018. Third, community-based HTS partners are expected to validate successful referrals for individuals identified as HIV-positive during testing activities, even among those that decide not to attend a PEPFAR-supported HIV clinic. This will include improved documentation as well as a fortified peer navigator system. Fourth, recognizing that many hard-to-reach migrants are unable to access HTS and treatment services, PEPFAR/DR will initiate a mobile clinic, the first of its kind in the country. The clinic will support two provinces with a broad range of services, from community prevention and HTS to clinical and community care services.

#### 4.5 Facility- and community-based care and treatment

In FY 2015, the country modified its HIV treatment guidelines to shift the CD4 threshold from <350 to <500. Despite the new norms, many clinics across the country have yet to operationalize these guidelines. In FY 2017, the expectation is that all facilities will be utilizing a CD4 <500, and the eleven PEPFAR-supported sites will represent the phased initiation of both Test & START as well as differentiated models of care. In order for these new guidelines to be successfully implemented, PEPFAR/DR has programmed for significant systems support at the site-level. Rather than address human resources, supply chain, laboratory, stigma, and supply chain as national and/or above-site issues, PEPFAR/DR's focus on the development of demonstration sites mandates that partners address these specific systems issues at the site itself. These particular systems issues, in addition to policy implementation, were identified through a SIMS analysis, stakeholder engagement, Systems Budget and Optimization Review (SBOR), and partner reports.

In FY 2017, there will be a marked improvement in the documentation and understanding of how PEPFAR support is directly impacting KP/PP along the clinical cascade. To date, there is limited data surrounding the number of KP/PP in HIV care and treatment services due to no national intake form to document population categories. In FY 2017, all 11 PEPFAR-supported sites will be capable of categorizing by population.

#### 4.6 TB/HIV

The DR has the fifth highest prevalence of tuberculosis (98 per 100,000 persons) in the Americas. In 2015, all 4,128 TB cases were registered by the National TB Control Program in the TB electronic database. PEPFAR/DR's above-site support focuses on TA to the MOH to implement the electronic registry at the TB treatment sites and ensure data quality supervision. Additionally, PEPFAR/DR will support the MOH to intensify TB testing and detection among PLHIV (in HIV clinical settings) in targeted, high burden TB/HIV sites. Activities will include the monitoring of national TB screening guidelines, training HIV care providers to recognize TB symptoms and refer patients for TB screening, HIV testing in TB treatment clinics, and infection control programs in TB and HIV clinics.

#### 4.7 Health system strengthening

As a TA country, PEPFAR/DR maintains its support for above-site health systems strengthening interventions to ensure that the GODR is steadily moving towards its goal of 90-90-90 by 2020. Issues surrounding the distribution and efficiency of human resources, improvements in

laboratory protocols and trained personnel, strengthened lab specimen transportation systems, commodity supply chain, and strengthened national electronic medical records will all continue to receive support. With that noted, PEPFAR/DR is significantly reducing its above-site support by transitioning major portions of this TA from the national- to site-level. This was done in large part to respond to SIMS analyses, stakeholder engagement, SBOR, and partner reports, which highlighted that despite progress at the national level, issues such as commodity security and data use for decision-making purposes were relatively low at the site-level.

In FY 2017, a few new activities will be initiated. The third round of an IBBSS on key populations will be conducted, providing the country with critical data for decision-making purposes. Additional emphasis will be placed on integrating population categorization into the national care and treatment in-take form to allow for more tailored clinical cascades. Significant efforts will be placed on providing TA to the GODR on updating their clinical guidelines to adhere to Test & START and differentiated models of care.

To determine whether military personnel should be considered a priority population, an HIV Sero-prevalence and Behavioral Epidemiology Risk Survey (SABERS) will be conducted. While this studying is being performed, PEPFAR/DR staff time will be assigned to supporting two military hospitals to integrate their data into the national program as well as conduct clinical cascade analyses.

## 5.0 Program Activities in Sustained Support Locations and Populations

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### 5.1 Package of services in sustained support locations and populations

In FY 2017, PEPFAR/DR will have four scale-up aggressive provinces and all other provinces will be categorized as non-PEPFAR supported. Therefore, no provinces have been categorized as sustained support.

### 5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

Despite being a TA country, PEPFAR/DR has been supporting direct service delivery (DSD) and TA activities in HIV testing and HIV treatment. In FY 2016, PEPFAR/DR has direct service delivery targets for HIV testing targets (HTC\_TST\_DSD) in 12 provinces yet only one province for TX\_CURR\_DSD. The program was already in the process of transitioning to six provinces by the end of FY 2016, making the proposed shift to four provinces in FY 2017 less dramatic. PEPFAR/DR has already initiated conversations with local and national government authorities regarding the FY 2017 reduced geographic scope. There will be no PEPFAR/DR presence (neither DSD nor TA) outside of the four prioritized provinces. PEPFAR/DR partners will be creating transition plans, with sub-partners as well as health facilities, to ensure that appropriate preparatory steps are taken. PEPFAR/DR is also working closely with Global Fund counterparts to discuss where, if

appropriate and feasible, their activities may be able to supplement previous PEPFAR investments.

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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### 6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

There are an array of critical health systems areas that require ongoing support to address the barriers that directly affect access of KP/PP to quality HIV care and treatment. To address the key programmatic gaps identified within the clinical cascade, the PEPFAR/DR Team will focus on establishing demonstration sites charged to provide quality health service provision for PLHIV.

The PEPFAR/DR program has traditionally invested in systems strengthening, which was reflected in the Sustainability Index and Dashboard (SID), which revealed areas of strength in planning, coordination and governance associated with the HIV response. Certain weaknesses were also affirmed, which include inadequate quality of service delivery, poor GoDR Regional and Provincial-level coordination and oversight and persistent stigma and discrimination towards key and priority populations. Other systemic barriers were also highlighted, such as inadequate distribution and inefficient use of human resources, insufficient laboratory personnel and poor management of the transportation of specimens and prompt delivery of results, all which jeopardize the quality of care offered to PLHIV.

Given the focus of the PEPFAR/DR strategy developing and documenting demonstration sites for key and priority populations as replicable models for the GODR to utilize for national expansion, there are a number of key programmatic gaps that must be addressed. These key programmatic gaps directly influence the KP/PP clinical cascade, which include:

1. Limited access to quality HIV clinical services for KP/PP.
2. Low ART coverage in two target provinces (Puerto Plata and Santiago)
3. Financial gap and policy changes needed for ART scale up

These programmatic gaps are central to the ability to scale ART for key and priority populations in PEPFAR/DR target provinces. Each of these is the result of a series of systemic barriers which will be addressed by COP 16 programming. Specific barriers that contribute to the limited access of quality HIV clinical services for KP/PP (gap #1) include: stigma and discrimination by health care providers, limited working hours for service provision, limited capacity by facilities to tailor interventions to the needs of KP/PP and facilitate referrals, and the inability to track the HIV service cascade by KP/PPs. The low ART coverage in two target provinces (gap #2) is largely due to a limited number of HIV service delivery sites along with service modalities to meet the needs of often isolated migrant populations, along with few KP-friendly public sites at these locations. A centralized laboratory infrastructure also creates challenges to ensure timely viral load testing and return of results for clinical monitoring.

Despite the fact that the GoDR has assumed 100% funding of ARV costs as of 2015, in 2016, a little over US\$8 million was allocated to meet a US\$12 million dollar projected need (gap #3). When accounting for a potential scale up in ART coverage with Test and START, the resources fall short of the need, which ultimately will inhibit its implementation. Absence of a domestic resource mobilization strategy to ensure that these resources are identified, along with policies that reflect CD4 count at 500 are among systems barriers that require immediate response.

Table 6.1.1 Key Programmatic Gap #1: **Limited access to quality HIV clinical services for KP/PP**

Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount*	Associated IM ID	Relevant SID Element and Score
Limited working hours for service provision and stigma and discrimination make access challenging for KP/PP	National HR Plan defined and Regional authorities have defined staffing plans for all 72 HIV sites.  60% of HIV sites implementing performance measures with indicators to reflect stigma and discrimination; improved performance  80% of sites have received training on stigma and discrimination related to KPs and has implemented mechanisms to address violations.	HR analysis conducted to inform National-level staffing needs.  All 11 PEPFAR target sites have revised staffing pattern and defined roles and responsibilities to account for volume and differentiated models of care  SOPs developed to implement differentiated models of care.	HR needs assessment for all 73 service sites and proposal for staffing pattern (roles/responsibilities)  Analysis of differentiated models of care; develop plan to include staffing and SOPs for community-facility coordination.  Reorganization of HR teams to ensure coverage given increased volume and extended hours	HTXS	\$150,000	Capacity Plus	7. Human Resources for Health - 3.86
		Health service providers with 30% increase on scores on items related to client satisfaction (reduced stigma/discrimination) on mid-year performance review	Establishment of performance review process, methods and tools, to measure client satisfaction stigma/ discrimination by providers				

Table 6.1.1 Key Programmatic Gap #1: <b>Limited access to quality HIV clinical services for KP/PP</b>							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount*	Associated IM ID	Relevant SID Element and Score
		100% of health service providers at 11 sites trained on stigma/discrimination related to KP service delivery.  11 PEPFAR-supported sites have policies to address stigma and discrimination and file monthly reports to Human Rights Observatory.	-Training of health providers in KP-friendly service delivery, by NGO partner groups. -Establishment of community-facility forums for continued quality improvement	HBHC	\$119,426	APC	6. Service Delivery – 4.68
Inability to track HIV service cascade by KP/PPs	National Information System (FAPPS) modules that allow for the registry of KPs and tracking of KP cascades nationwide implemented at all 72 sites.	National Information System module for KP tracking developed for National tracking.  Module and tracking tools implemented at 11 PEPFAR sites.	Incorporation of modules to track KPs as part of the National System (FAPPS) and methods and tools for KP identification at the sites	HVSI	\$200,000	TBD (SNS)	13. Epi/Health Data – 5.24
	Modules designed and implemented at all 72 sites between the TB and HIV Programs for	2.1 Module adopted by the HIV and TB Program and implemented at 11 PEPFAR sites.	Develop modules in the National information system (FAPPS) that will collect information on	HVTB	\$125,000	TBD (SNS)	13. Epi/Health Data – 5.24

Table 6.1.1 Key Programmatic Gap #1: Limited access to quality HIV clinical services for KP/PP							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount*	Associated IM ID	Relevant SID Element and Score
	monitoring co-infection among KPs.		co-infection among KPs & PPs				
	All supported facilities using dashboards to record key HIV data and conducting quarterly analysis.	25 Health providers trained on HIV clinical management, 25 on epidemiology and 25 on M&E at 11 PEPFAR sites. 3.2 11 sites using dashboards for quarterly analysis of clinical cascades and using data for improvement plans.	Training for health care providers in HIV clinical Management (25), Epi (25) and M&E (25).  Development of dashboards and tools for data analysis.  Establish baselines (Q1) and conduct quarterly forums with GoDR counterparts.	OHSS	\$375,000	VMGC	13. Epi/Health Data – 5.24
Facilities with limited capacity to tailor interventions to the needs of KP/PP and facilitate referrals	Registry of service offerings established and tools implemented to conduct and track referrals.	Agreement established among public & NGO site within each of the 4 Provinces.	Establishment of agreements and referral process with community partners for complementary services for KP/PP	HTXS	\$120,000	COIN	6. Service Delivery – 4.68
	Models for KP/PP service models established with GoDR counterparts and method	KP models and service packages implemented at 11 sites and methodology documented.	Clinical on-site training and transferring of KP/PP models by NGO sites (to public sector sites)	HTXS	\$150,000	APC	6. Service Delivery – 4.68

Table 6.1.1 Key Programmatic Gap #1: Limited access to quality HIV clinical services for KP/PP							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount*	Associated IM ID	Relevant SID Element and Score
	transferred to an additional 15 target sites.						
<b>TOTAL</b>						\$1,239,426	

Table 6.1.2 Key Programmatic Gap #2: Low ART coverage in two target provinces							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated IM ID	Relevant SID Element and Score
Limited presence by NGOs & few KP-friendly health	40% increase in ART coverage from in Santiago.	15% increase in coverage of ARTs in the Santiago province by	Support KP-friendly HIV service delivery at one public facility in Santiago.	HTXS	\$120,000	COIN	6. Service Delivery - 4.68

Table 6.1.2 Key Programmatic Gap #2: Low ART coverage in two target provinces							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated IM ID	Relevant SID Element and Score
Puerto Plata has the 3 <sup>rd</sup> most PLHIV of any province, but only two HIV clinics	40% increase in ART coverage for migrants through mobile clinics  Increase in ART coverage from in Puerto Plata by 40%.	Increased ART coverage, 15% in Santiago, 25% in Puerto Plata.  2 HIV Mobile Clinics Established for PPs- to provide services in Puerto Plata & Santiago.  Establish differentiated models of care to extend services to at least 3 Municipal Hospitals in PPlata.	Establish and operate full suite of clinical services for PPs through two(2) HIV mobile clinics	HTXS HBHC	\$303,907 \$146,897	PSI	6. Service Delivery - 4.68

Table 6.1.2 Key Programmatic Gap #2: Low ART coverage in two target provinces							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated IM ID	Relevant SID Element and Score
Centralized lab infrastructure	1. Decentralized laboratory network fully functioning in two provinces. Reduction in return time for VL results.  2. Lab staff trained at each facility	Two Regional Sites fully functioning to provide VL testing.	Certify 8 laboratories on quality (RTQII) HIV testing and monitoring guidelines based on WHO recommendations	HLAB	\$182,329	CLSI	10. Laboratory -3.89
<b>TOTAL</b>					\$753,133		

Table 6.1.3 Key Programmatic Gap #3: Financial gap and policy changes for ART scale up							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated IM ID	Relevant SID Element and Score
Lack of a domestic resource mobilization strategy to ensure scaling	1. 25% increase in GoDR financial commitment for ARVs to roll out Test and START by 2018	10% increase in GODR financial commitment  National	Technical assistance for domestic resource mobilization strategy and implementation	OHSS	\$350,000	HFG	11. Domestic Resource Mobilization - 7.50

of ART coverage		domestic resource mobilization strategy established	Support to projecting ARV need and costs related to Test and START at initial sites and nationwide	OHSS	\$150,000	SIAPS	8. Commodity Security and Supply Chain – 5.10
HIV Guidelines are not conducive to ART scale up	1. National norms and/or clinical guidelines have incorporated WHO/Test and START 2. System established for quarterly supportive supervision and implemented in all Regions.	Clinical guidelines adopting national level Test & START.	Support the National HIV Program to develop new national guidelines according to updated	OHSS	\$125,000	DIGECITSS	2. Policies and Governance – Score 7.08
		11 PEPFAR sites receive supportive supervision together with Regional GODR counterparts	Training for health care providers on clinical norms and clinical supervision	HTXS	\$75,000	COIN	6. Service Delivery – 4.68
				HTXS	\$150,000	APC	6. Service Delivery – 4.68
<b>TOTAL</b>					<b>\$850,000</b>		

## 6.2 Critical Systems Investments for Achieving Priority Policies

The adoption of key policies, including Test and START and differentiated models of care are vital to the country’s ability to accelerate its response to the HIV epidemic and achieve increased ART coverage. Key barriers to the adoption of these policies include financing the ART need for National-level roll out of Test and START, along with building site-level capacity to ensure the successful

implementation of changes in the HIV service delivery process. Technical assistance to ensure that sites are able to effectively forecast ARV needs, conduct logistics for VL testing and compliance with revised guidelines are among changes that must be implemented to make these policies a reality at the service delivery sites. The barriers associated with the implementation of these two key policies, Test and START and differentiated models of care, and respective COP 16 programmatic activities are detailed in tables 6.2.1 and 6.2.2.

<b>Table 6.2.1 Test and START</b>							
<b>Key Systems Barrier</b>	<b>Outcomes expected after 3 years of investment</b>	<b>Milestones by APR 2017</b>	<b>Proposed COP/ROP16</b>	<b>Budget Code(s)</b>	<b>Activity Budget Amount</b>	<b>Associated IM ID</b>	<b>Relevant SID Element and Score</b>
Lack of a domestic resource mobilization strategy to ensure scaling of ART coverage	1. 25% increase in GoDR financial commitment for ARVs to roll out Test and START by 2018	National domestic resource mobilization strategy established.	Technical assistance for domestic resource mobilization strategy and implementation	OHSS	\$350,000	HFG	11. Domestic Resource Mobilization
			Support to projecting ARV need and costs related to Test and START at initial sites and nationwide.	OHSS	\$150,000	SIAPS	8. Commodity Security and Supply Chain – 5.10
National clinical guidelines at 500 CD4, do not account for Test and START	1. Implementation of clinical guidelines have incorporated WHO/Test and START	Clinical guidelines adopting national level Test & START.	Support the National HIV Program to develop new national guidelines according to updated WHO recommendations.	OHSS	\$125,000	DIGECITSS	6. Service delivery – Score 4.68
<b>TOTAL</b>					<b>\$625,000</b>		

Table 6.2.2 New and efficient service delivery models							
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
ARV stock outs and need for logistics planning to allow for 3-6 month stock	100% of HIV sites trained to conduct forecasting for stocks and logistics management.  Tools implemented to improve National level stock outs by 20%.	1. Reduction in reported stock-outs (nationally and at sites) of essential HIV treatment commodities at 11 sites 2. 100% of HIV sites conducting site-level forecasting (Y1-PEPFAR sites, Y2-nationwide)	Technical assistance package to sites in forecasting and supply chain management	HTXS	\$75,000	SIAPS II	8. Commodity Security and Supply Chain – 5.10
HIV Guidelines do not account for differentiated service delivery models	1. Revised norms to account for differentiated service delivery models	Clinical guidelines adopting national level Test & Start.	Support the National HIV Program to develop new national guidelines	OHSS	\$125,000	DIGECITSS	6. Service delivery – Score 4.68
Lack of consistent provision of condoms at service delivery sites	1. Provision of condoms and lubricants fully integrated into country's procurement and supply chain systems.	Ensure condom availability at 11 PEPFAR sites.  Condom policy and condom country strategy finalized.	Support for total condom market strategy and integration to the current supply chain system.	HVOP	\$350,000	SHOPS Plus	8. Commodity Security and Supply Chain – 5.10
<b>TOTAL</b>					<b>\$550,000</b>		

Table 6.3 Other Proposed Systems Investments								
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP <sup>16</sup> Activities	Activity Budget Amount	Budget code	Associated Implementing Mechanism ID	Relevant SID Element and Score	
Inst & Org Development								
Other institutional development activity	Local NGO clinics have built capacity of at least 6 public facilities to offer high quality KP/PP service packages	5 public facilities have capacity to implement KP/PP packages	Start up for key partner for clinical quality improvement for KPs	\$451,115	HTXS	Linkages	6. Service delivery – Score 4.68	
Governance								
Policy/protocol development	Protocols adopted by the MOH for partner notification testing and rolled out at 50% or more HIV sites nationwide.	Partner notification testing established at PEPFAR-supported facilities, identifying new HIV-positive individuals.	Develop protocols, tools and capacity for implementation of partner notification testing	\$150,000	HVCT	APC	2. Policies and Governance – Score 7.08	
Strategic Information								
M&E	Robust M&E system and tools for DQA established and implemented at	11 sites implementing DQA and using dashboards	DQA processes established and validated as part of routine	\$350,000	OHSS	Measure Evaluation	13. Epi/Health Data – 5.24	

Table 6.3 Other Proposed Systems Investments								
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP <sub>16</sub> Activities	Activity Budget Amount	Budget code	Associated Implementing Mechanism ID	Relevant SID Element and Score	
	50% of sites by Regional GoDR health services.	for analysis of cascades. Quarterly analysis and improvement plans.	MOH supervision.					
Surveys	IBBS study among key populations has informed KP strategies.	Study completed.	Data available for robust behavioral indicators and refined size estimates	\$500,000	HVSI	TBD	13. Epi/Health Data – 5.24	
Operations research	End of project documentation of successes, lessons learned	Model documented	Lessons learned from KP service delivery documented and inform programming.	\$150,000	HVSI	APC		
Systems Development								
Other Systems development activity	TA to the Global Fund Recipients and partners	Improved performance on the cascade by GF partners (increase yield from 1.1 to 2.5% or greater,	Framework for GF/PEPFAR coordination formalized with tools, processes and delegated in GoDR counterparts	\$400,000	HVCT	TA to Global Fund		

Table 6.3 Other Proposed Systems Investments								
Key Systems Barrier	Outcomes expected after 3 years of investment	Milestones by APR 2017	Proposed COP/ROP <sub>16</sub> Activities	Activity Budget Amount	Budget code	Associated Implementing Mechanism ID	Relevant SID Element and Score	
		increase by 10% retention and linking).						
	TOTAL				\$2,001,115			

## 7.0 Staffing Plan

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### 1) Analysis of staffing footprint and interagency organizational structure

The PEPFAR/DR team conducted a review of its staffing needs and determined that limited shifts would be required to support and oversee this new strategy. The balance between administrative/financial and technical management staff was reviewed, along with an analysis of staffing requirements associated with SIMS requirements. The hiring of one CDC administrative assistant and a PEPFAR Strategic Information (SI) Liaison were identified as human resource needs. However, following discussions with S/GAC, it was agreed that the CDC position would not be included in COP 2016, yet could be considered in the future following a country-led staffing for results exercise.

Consistent with their respective agency operating mechanisms, CDC utilizes technical subject-matter experts in a “hands-on” approach to directly deliver TA, while USAID combines direct TA with the utilization of contractors, working under staff supervision. CDC delivers TA in laboratory management, quality assurance/quality control, and SI, while USAID supports supply chain management, human resources, condom program support, and domestic resource mobilization. Both agencies utilize a mix of local and international staff to manage their respective portfolios.

### 2) Vacant long-term positions

USAID has two vacant positions. The first is a Senior HIV Project Management Specialist to replace a team member that retired in May 2016. The recruitment process has closed and a candidate will be selected in June 2016. The second is an HIV Project Management Specialist, after the incumbent was promoted to a vacant position in May 2016. This position will be posted and a candidate will be selected in July 2016. The start date for both positions will be determined by required clearances.

CDC also has two vacant positions. The first is a driver position that has already been published and is progressing through the recruitment process. The second is a medical epidemiologist, which has been requested through the Embassy HR Office and is currently being processed through their system.

### 3) Proposed new positions

As noted above, following negotiations with OGAC, one new position is being proposed (PEPFAR Coordination Office SI Liaison). The SI Liaison position has full support from the inter-agency team and S/GAC and has been budgeted for as a locally employed staff member. The recruitment process will begin in August 2016 upon the arrival of the new PEPFAR Coordinator.

### 4) Changes to Cost of Doing Business (CODB)

Following long-term staffing vacancies and inaccurate projections, USAID had accumulated a management and operations pipeline and thus applied pipeline for a portion of its CODB. Overall, the inter-agency team does not anticipate significant changes to CODB, even with the new positions.

# APPENDIX A

## APPENDIX A – CORE, NEAR CORE AND NON-CORE MATRIX – COP 16

Table A.1 Program Core, Near-core and Non-core Activities for COP 16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site Level	TA to Global Fund partners to ensure high yield HTS, including data analysis support and funding for navigators to improve linkages		
	Facility-based HIV care and treatment services for PLHIV, with population-tailored interventions to ensure: (a) quality HIV treatment; (b) retention; and (c) adherence d) VL suppression		
	Community-based HIV care services for KP/PP and at-risk ART defaulters at select KP/PP-focused clinics		
	Site-level support in human resources for health, supply chain management, laboratory strengthening, strategic information, stigma reduction, and GBV		
	Site Level Supply Chain Management strengthening		
	Enhanced linkages between TB and HIV clinical services for TB screening and TB/HIV co-infection		
	Stigma/Policy Quality Management/Gender Based Violence/PITC		
	Partner Notification Testing and Partner Notification Testing Protocol development		
	GBV Intervention Expansion		
	Provide services for mobile populations via 2 mobile clinics		
Above Site Level	Enhanced laboratory capacity at national and regional levels for HIV/TB/STI services	Support to Field Epidemiology Training Program (COP18 is final year)	
	Improved strategic information for evidence-based decisions		

TA to strengthened commodity security and supply chain management systems
TA to improve the deployment, retention, and performance of HIV service providers in scale-up saturation provinces
Policy dialogue on domestic resource mobilization and HTS and treatment norms to comply with WHO guidelines
IBSSIII for Key Populations
TA for Regional and National HRH needs
TB/HIV Integration to include KP and PP in health services
Training (FETP, M&E, and clinical)
Domestic Resource Mobilization. Design a strategy to identify resources to support sustainability
Clinical policy advocacy and support to change norms and policies for access to KP and PP and improve quality services.
Support for scaling service delivery
Regulations/Norms development for new guidelines

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16**

<b>Program Area</b>	<b>Core Activities</b>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
<b>HTS</b>	TA to Global Fund partners to ensure high yield HTS, including data analysis support and funding for navigators to improve linkages		
<b>HVCT</b>	Facility-based HIV care and treatment services for PLHIV, with population-tailored interventions to ensure: (a) quality HIV treatment; (b) retention; and (c) adherence		
<b>HVCT</b>	Community-based HIV care services for KP/PP and at-risk ART defaulters at select KP/PP-focused clinics		
<b>HRH</b>	Site-level support in human resources for health, supply chain management, laboratory		

	strengthening, strategic information, stigma reduction, and GBV	
	Site Level Supply Chain Management strengthening	
<b>HVCT</b>	Enhanced linkages between TB and HIV clinical services for TB screening and TB/HIV co-infection	
<b>GENDER</b>	Stigma/Policy Quality Management/Gender Based Violence/PITC	
<b>HVCT</b>	Partner Notification Testing and Partner Notification Testing Protocol development	
<b>GENDER</b>	GBV Intervention Expansion	
<b>HCT</b>	Provide Services for Mobile Populations via 2 mobile clinics	
<b>HLAB</b>	Enhanced laboratory capacity at national and regional levels for HIV/TB/STI services	Support to Field Epidemiology Training Program (COP18 is final year)
<b>HSS</b>	TA to strengthened commodity security and supply chain management systems	
<b>HSS</b>	TA to improve the deployment, retention, and performance of HIV service providers in scale-up saturation provinces	
<b>HSS</b>	Policy dialogue on domestic resource mobilization and HTS and treatment norms to comply with WHO guidelines	
<b>Other</b>	IBSS III for Key Populations	
<b>HRH</b>	TA for Regional and National HRH needs	
<b>HVTB</b>	TB/HIV Integration to include KP and PP in health services	
<b>HSS</b>	Training (FETP, M&E, and clinical)	
<b>HSS</b>	Clinical policy advocacy and support to change norms and policies for access to KP and PP and improve quality services.	
<b>HSS</b>	Support for scaling service delivery	
<b>HSS</b>	Regulations/Norms development for new guidelines	
<b>GENDER</b>	Stigma/Policy Quality Management/Gender Based Violence/PITC Partner Notification Testing and Partner Notification Testing Protocol development	

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<b>HBHC</b>	Provide Services for Mobile populations via 2 mobile Clinics in two provinces
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### **Transition Plans for Non-core Activities**

PEPFAR/DR will not support any non-core activities beyond September 30, 2016.

## APPENDIX B

### B.1 Planned Spending in 2016

<b>Table B.1.1 Total Funding Level</b>		
<b>Applied Pipeline</b>	<b>New Funding</b>	<b>Total Spend</b>
<b>\$US620,569</b>	<b>\$US14,879,431</b>	<b>\$US15,500,000</b>

<b>Table B.1.2 Resource Allocation by PEPFAR Budget Code</b>		
<b>PEPFAR Budget Code</b>	<b>Budget Code Description</b>	<b>Amount Allocated</b>
MTCT	Mother to Child Transmission	
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	\$1,450,263
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	\$2,001,561
HBHC	Adult Care and Support	\$553,296
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	\$4,604,160
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	\$151,722
HLAB	Lab	\$217,050
HVSI	Strategic Information	\$1,423,427
OHSS	Health Systems Strengthening	\$2,709,362
HVMS	Management and Operations	\$2,389,159
<b>TOTAL</b>		<b>\$ 15,500,000</b>

### B.2 Resource Projections

The primary data source to develop the budget was the Expenditure Analysis (EA) 2015. Given that PEPFAR/DR does not have a significant number of mechanisms that report results, the use of the data often relies heavily on a single partner. The primary partner used for target-based budgeting was JSI/Advancing Partners and Communities, as its activities most resemble the type of programming being proposed in COP 2016. Given that each province has unique characteristics that may alter a unit expenditure, a weighted average for JSI's activities was used among three of the four scale-up provinces. The fourth province, Santiago, had limited activity and thus its expenditures were not included. In addition, the lump sum for strategic information was removed as that amount of money was allocated to a strategic information partner.

The major challenge with this budgeting method is that it assumes that: (a) all partners are implementing the same package as this partner did in 2015; and (b) all future partners will have the same unit expenditure as an international NGO. Nevertheless, the use of this unit expenditure to project future costs was deemed the most appropriate method for target-based budgeting. For new interventions, such as the mobile clinic, studies from around the world of similar interventions as well as activity-based budgeting were used to derive a unit expenditure.

Lump sum budgeting was completed using two different methods. For the site-level systems interventions, which play a key role in the COP 2016 strategy, a unit expenditure, with the unit being the site itself, was developed from a TA systems partner. Once it was determined what this site-level systems partner (IntraHealth/Capacity Plus) had spent per site, this amount was used for all other site-level systems partners across the portfolio. Similar to the aforementioned challenge, this method assumes that all site-level systems partners, despite working on different systems issues, have an identical per site cost and will mirror that of an international NGO.

Two activities have a transition of partners during the fiscal year. These partners were allocated the amount of money that corresponds to the intended portion of the year that the project is expected to be implementing. Also, partner notification testing is a new activity in the country and there were no costing studies identified from other countries. Given that additional oversight and training will be needed, in addition to low volume testing that requires community follow-up and testing, a unit expenditure with a nearly 50% increase over more traditional community-based testing methods was used. Finally, several activities were budgeted based on an estimated cost by the agency to complete the scope of work desired. This method was only used when there was no other discernable option.

## APPENDIX C

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### C.1 GBV/HIV Integration Model in Puerto Plata

The PEPFAR-supported LINKAGES Project is developing a model for KP-friendly integrated HIV and GBV services for transgender women, female sex workers, men who have sex with men, and people living with HIV in Puerto Plata. It builds on and strengthens the services currently offered to the general population (primarily women who experience intimate partner violence) while making additional connections to HIV services. Notably, since GBV is commonly understood as sexual and physical violence against women in the Dominican Republic, this activity also serves to educate providers and others on the full range of people who are at risk of GBV and its various forms (including emotional violence, such as humiliation, and economic violence, such as withholding needed support or non-payment for services). The model is designed to provide additional entry points for both GBV response (first-line response and longer-term services) and HIV services for KPs in particular, but also benefits all GBV survivors.

Organizations in Puerto Plata that offer services to survivors of GBV (legal, clinical, and mental health) were identified and asked to be part of a network of service providers that is able to serve KPs. Additionally, organizations working with KPs on the issue of HIV were asked to be involved by tailoring currently offered services for survivors of violence, helping encourage violence response service uptake by KPs (including through messages that change norms around the acceptability of violence), and supporting peer navigators who can help identify survivors and accompany them to services. Organizations that have committed to being involved in this model/network and who are helping determine how the model should operate include:

- the Ministry of Women;
- the local public hospital (including the Emergency Department, Assistance to the User - where complaints can be made when discrimination occurs in the hospital, and the public HIV clinic within the hospital);
- an HIV clinic operated by a local NGO;
- civil society organizations that offer psychosocial support to KPs and organize peer educators from each KP (and connected to the Human Rights Observatory that COIN operates);
- the police; and
- the local branch of the Attorney General's Office.

The final products will be: (1) Standard Operating Procedures that describe how these organizations should work together to serve survivors and encourage their uptake of testing/treatment (as well as screen those who are receiving HIV services for GBV and refer as needed); and (2) piloted training materials that can be used with all providers involved in the model. The training materials will cover first-line response (which is relevant to any survivor but describes the needs of KP survivors particularly), how the model works (SOPs to guide screening, referral, and follow-up), and stigma-free and competent care for KPs. Key sections on the importance of confidentiality – regarding both

experiences of violence and HIV status – are included. All materials will build on existing materials successfully used in the Dominican Republic plus LINKAGES materials from the larger global project.

While this model is being developed at the local level, work is occurring at the national level to identify the relevant protocols/guidance for attention to survivors as well as policies/laws regarding violence. This serves two purposes: (1) it allows whatever SOPs are established in Puerto Plata to be in line with national level guidance and therefore scaled up more easily to other provinces; and (2) it identifies gaps (with the relevant stakeholders at the national level) in policies/protocols that affect both survivors generally and KPs specifically. For example, a recent gap identified is limited guidance on how to ensure timely delivery of PEP to someone who reports sexual violence at the local Attorney General’s Office. Other gaps specific to key populations – such as language about “violence against women” instead of more inclusive language on gender-based violence (which includes violence against MSM and transgender people) – have also been identified and conversations are already underway on how to advocate for the needed policy revisions.

This approach aligns with the findings from the PEPFAR gender analysis in many ways. The gender analysis highlighted the following issues that are addressed through this approach:

- Discrimination against transgender people, FSWs, and MSM by HCWs
- High levels of violence against MSM, FSWs, women living with HIV, and transgender people
- Post-GBV norms exist but are not well known but providers and do not address GBV care for transgender people
- Poor provision of PEP after an incident of rape for MSM and transgender women
- Low self-esteem and self-stigmatization among women living with HIV that causes them to accept/tolerate violence against themselves
- GBV is commonly interpreted as violence against women and not understood to encompass MSM and trans women in particular
- Lack of confidentiality among service providers, including regarding HIV status
- Reaching people who may be hard to reach with HIV services but who would be interested in post-GBV care (such as people engaging in transactional sex but who may not view themselves as sex workers)

These specific recommendations from the gender analysis are addressed through this approach:

- Ensure access to psychological help for LGBT people who deal with trauma from stigma and discrimination
- Working with police to reduce GBV against KPs
- Collaborate with the Ministry of Women to improve implementation/enforcement of the GBV law for all people (including FSWs, LGBT people, PLWH)
- Collaborate with other USG efforts to advocate for a true definition of gender in the GBV law so that it covers all LGBTQ people

- Revision of “normas de atencion” for GBV and sensitization/training for health care providers, including Emergency Room personnel; including increasing provider knowledge about and use of referral system for GBV
- To reduce internal stigma and increase social capital/support networks for women who face increased GBV risk (including FSWs and transwomen)
- Scale-up on-going training programs for KP representatives as peer navigators in health services

## C.2 GBV clinical programming across PEPFAR/DR portfolio

While awaiting for a robust model for scale-up from the aforementioned project, PEPFAR/DR will report in FY 2017 on the number of GBV survivors who receive at least the minimum package of clinical services at the four PEPFAR-supported NGO clinics. Despite a national protocol on the management of GBV survivors, there is significant work required on provider sensitization, GBV screening, in-take form development, and reporting. The proposed targets for GEND\_GB V are exceptionally low and based on anecdotal counting of clients. Lead clinical partners will be expected to increase these numbers in future years once there is a more developed clinical GBV program.