



## **FY 2015 Dominican Republic Country Operational Plan (COP)**

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on [www.PEPFAR.gov](http://www.PEPFAR.gov), reflect the approved FY 2015 COP for Dominican Republic.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

**Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.**

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

- 3) *Sustainability Index and Dashboard*

**Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on [www.PEPFAR.gov](http://www.PEPFAR.gov) in the “FY 2015 Country Operational Plan Budget and Target Report.”**

**Dominican Republic**  
**Country Operational Plan**  
**(COP/ROP) 2015**  
**Strategic Direction Summary**

Last Updated 9-9-15, 2015

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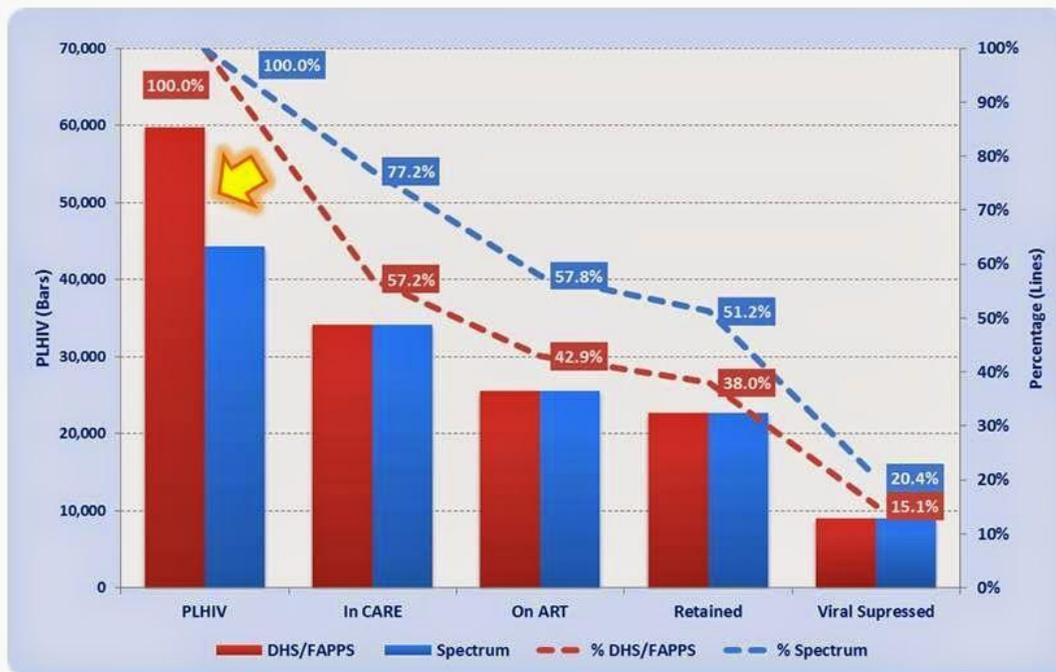
## GOAL STATEMENT

PEPFAR/DR's overarching goal is to collaborate with the National Response (NR) to achieve epidemic control (90-90-90) by helping to increase testing availability, linking and retaining KP/PP LWHA into care and treatment, reaching viral suppression and reducing new infections. The overarching strategies are to: 1) reduce the number of new infections by supporting the identification of new cases (testing), linkage and retention into care and treatment services for men who have sex with men (MSM), transgender persons (TG), female sex workers (FSW), and migrant populations (Haitians or Dominicans of Haitian descent); and 2) support services which provide the underpinnings of prevention, care and treatment to KPs: improving clinical and care services, lab strengthening, TB/HIV co-infection, reducing stigma and discrimination, strategic information, condom social marketing, supply chain management and Technical Assistance (TA) to ensure the proper deployment of service personnel. PEPFAR-DR will also work with GODR, Civil Society, Global Fund and other cooperating agencies on sustainability and implementation issues.

In selecting these strategies, the team used estimated KP and PP population size estimations, prevalence rates, EA expenditure data (cost per person reached), and the Global Fund (GF) Concept Note, to set priority provinces and target groups. APR data were also used to develop realistic targets, and SIMS results provided insights into program implementation. The SID exercise revealed a number of potential sustainability elements to be addressed with the GODR, and the Civil Society consultation showed a clear agreement with the team's analysis and strategies. However, CS also revealed a number of additional elements which need to be addressed with the GODR.

Graph A.1

### Comparison of care cascade using SPECTRUM Estimates vs. DHS/FAPPS Estimates



Per team agreements, the necessary program pivots/changes to achieve these goals involve setting “end-game” conditions and time frames for certain Core and Near-Core activities and moving the program out of Non-Core activities. For example, PEPFAR has prioritized five scale-up to saturation provinces where activities will take place and identified a critical mass of approximately 12 labs (from 21 currently being intervened) for quality improvement and/or accreditation interventions. The Field Epidemiology Training Program will set a total number of epidemiologists to be trained. TA to the CCM will continue only through FY 2015.

PEPFAR is phasing out of Non-Core activities. For example, PMTCT clinical services are now fully under the MOH; drug users and truck drivers are no longer considered priority populations; general prevention programs to youth and blood safety programs have also been phased down.

The team believes that the resulting selected target populations, activities, and locations are justified by our interpretation of the data. The time horizon for this goal is two years (September 2017).

## **1.0 EPIDEMIC, RESPONSE, AND PROGRAM CONTEXT**

### **1.1 Summary Statistics, Disease Burden and HIV Response Profile**

Estimated 2014 census data set the Dominican Republic (DR) population at 10,378,267. According to the World Bank (2013), GNI per capita is US\$ 5,770. DHS/2013 estimated an HIV prevalence of 0.8% (15-49 years of age) similar to the 2007 DHS. The Spectrum model estimated 44,254 PLHIV in DR, but it did not use data from the DHS/2013 and did not include data on Haitians living in DR, one of largest priority populations in the country. Using DHS/2013 data, adjusted by age distribution of PLHIV in care as of 2014, PEPFAR estimates 59,704 PLHIV in the DR, which is considerably more than the Spectrum estimate. NOTE: The most recent (unpublished) Spectrum exercise (March 2015) estimated the number of PLHIV at about 62,000, confirming our assumptions. If this figure is adopted by the MoH it will have a mayor downward impact on the percentages of KP reached and treated in the treatment cascade. For 2014, Spectrum estimated 1,799 HIV-related deaths and 837 new HIV infections per year.

The number of MSM is estimated to be 124,000\* (4.2% of males 15-49 years old, CONAVIHSIDA 2010, updated 2014) and MSM HIV prevalence was estimated between 3.9-6.9% (Integrated Biological and Behavioral Sentinel Survey- IBBSS/2012)δ. Only 11-31%δ of MSM had access to an HIV test in the last 12 months. Moreover, 4-48%δ of MSM reported discrimination in health services, and 28.9% of a sample of health services providers prefer not to care for MSM or other KPs (HPP/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, between 21-39% δ in most recent insertive anal sexual intercourse. Number of Transgender persons (TG) has been estimated at 3,900\*\*\* (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.

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

Migrants living in DR, mostly of Haitian descent, were estimated at 458,000 (National Immigrants Survey, 2012). Their HIV prevalence was 3.5% (secondary analysis of DHS/2013). HIV prevalence among Haitian Construction Workers (IBBSS/2013) was 4.6%, and 5.4% among Haitian FSW (IBBSS/2013). Only 35.3% of Haitian FSW and 13.1% of Haitian construction workers had access to an HIV test within last 12 months, and

only 48.8% of Haitian FSW and 18.5% Haitian construction workers reported accessing regular medical care. (IBBSS/2013)

The Military population in the DR is approximately 49,000 (91% males). HIV prevalence is estimated at 0.6% based on a convenience study done previously (DOD KAP study/2010). In the second quarter of FY15, the two military hospitals in Santo Domingo reported 455 patients in Care and Treatment, approximately 35% are active duty military, and 93 of those cases were newly detected during calendar year 2014. Based on a 0.6% prevalence estimated among active duty military, approximately only 45% uniformed PLWHIV are in Care

### **HIV Care Cascade**

A PEPFAR-supported electronic HIV Patient Information System (HPIS) implemented in 76 (100%) public HIV treatment facilities in 2014, registered 34,165 persons receiving clinical follow-up (57% of estimated PLWHA), of which 25,596 (75%) were on ART. Of these, 22,671 (88%) were retained on ART during the last 12 months, and 9,028 (40%) had evidence of viral suppression. Among Haitian migrants, the cascade showed 3,463 in care (25% of estimated Haitians LWHA), of which 1,915 (55%) were on ART; of those, 1,545 (81%) were retained on ART for 12 months and 379 (25%) had evidence of viral suppression. Currently the HPIS system does not record risk factor information. The DR has recently adopted the new WHO treatment guidelines from a CD4 count of 350 to 500, and it is in the process of training staff on this new requirement. The country is also working on estimating the number of individuals currently in care that will have to be placed in treatment.

### **HIV Testing**

In the DR there is no system which collects individual level data of persons tested and only collects the total number of tests performed. In 2014, 652,069 HIV tests were performed, of which 10,409 (1.6%) were HIV positive (MOH National Laboratory Report, 2014). Of the tests performed in 2014, 15,913 were among Haitians, of which 1,535 (9.6%) were HIV positive. Also, of the total tests performed in 2014, 154,175 were among pregnant women of which 2,007 (1.3%) were HIV positive. Of the tests performed among pregnant women, 20,168 were among pregnant Haitian women of which 1,004 (5.0%) were positive for HIV. CDC programmatic data, collected in 13 maternity hospitals during 2013, found that 19,905 pregnant Dominican women were tested and 243 of these (1.2%) were seropositive. Among pregnant Haitian women 5.4% (182/3,397) were HIV positive.

### **Tuberculosis/HIV Co-infection**

DR has one of the highest TB and TB-Multi Drug resistance rates in the Americas. In 2013, through electronic national information system (SleTB, supported by PEPFAR), the TB Program reported 4,117 TB cases; 3,121 of these were tested for HIV (76%) and 804 (26%) were found to be co-infected. Collecting and reporting on TB testing in HIV clinics continues to be a challenge. To improve diagnostic coverage of MDR-TB from the current level of 25% to almost 100%, PEPFAR has recommended to the GoDR the use of a GeneXpert unit 4 modules of accurate diagnoses.

### **Epidemic Control**

Collaborations with GODR, PEPFAR and GF investments in testing and treatment will have a positive impact by increasing the number of PLHIV in the cascade. In 2015, the GODR has budgeted nearly \$ 8.8 million to procure ARVs and reagents, the third year that the GODR has contributed counterpart to ARV procurement. The GF Concept Note proposes a focus on prevention and treatment among KP and PP. At PEPFAR's behest, a "Vulnerable Populations Working Group" has been established to promote the articulation of PEPFAR and GF programs, to ensure complementarity. A major gap in the process continues to be the lack of full access to services on the part of KPs. PEPFAR plans to address the issues of stigma and discrimination, quality of services and in-service training of service delivery staff.

**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	10,378,267	100	1,540,016	14.8	1,597,320	15.4	3,663,577	35.3	3,577,354	34.5	Projection 2014, National Census
Prevalence (%)		0.4		0.3		0.3		0.7*		0.6*	Projection 2014, Spectrum 2013 *15-49 yrs (#)
								0.7*		0.9*	DHS 2013 *15-49yrs
AIDS Deaths (per year)	1,799		136		245		575*		843*		Projection 2014, Spectrum 2013 *15-49 yrs
PLHIV	44,254		1,110		1,155		21,810		20,179*		Projection 2014, Spectrum 2013
							18,975		24,064		DHS 2013(#) *15-49yrs
	59,704										DHS Adjusted by FAPPS 1,970<15yrs 57,714>15yrs
Incidence Rate (Yr)		0.08		0.01		0.01		0.1*		0.1*	Projection 2014, Spectrum 2013

											per 1,000 hab *15-49 yrs
New Infections (Yr)	837		20		40		399*		378*		Projection 2014, Spectrum 2013 *15-49 yrs
Annual births	220,000	2.1									Health Statistics MoH 2013
% >= 1 ANC visit											Not applied for this portfolio
Pregnant women needing ARVs											Not applied for this portfolio
Orphans (maternal, paternal, double)											Not applied for this portfolio
TB cases (Yr)	4117 (3444 >15yrs)		N.A.		N.A.		N.A.		N.A.		National TB Program 2013
TB/HIV Co-infection	804 (685 >15yrs)		N.A.	N.A.	National TB Program 2013						
Males Circumcised	N.A.	N.A.			N.A.	N.A.			389,908	12.7	DHS 2013 (15-59yrs)
Key Populations											
Total MSM*	124,472										CONAVIHS IDA 2010 (update 2014) - Concept Note GF
	50,172										Place 2014

MSM HIV Prevalence	3.9-6.9										IBBSS 2012
	3.9										Place 2014
Total FSW	91,171										Focus Group 2000 CONAVIHS IDA (update 2014) – Concept Note GF
	80,107										Place 2014
FSW HIV Prevalence	1.7-6.3										IBBSS 2012
	2.5										Place 2014
Total PWID	I.Q.	I.Q.									Not applied for this portfolio
PWID HIV Prevalence	I.Q.	I.Q.									Not applied for this portfolio
Priority Populations Haitians	458,233										ENI 2012
Priority Populations Prevalence Haitians	Haitians	3.5									DHS – 2013 (15-49yrs)
	Bateyes					2.4		2.6			DHS – Bateyes 2013 (15-49yrs)
Haitians Construction Workers Prevalence	4.6										Santo Domingo- IBBSS 2013
Haitians FSW Prevalence	5.4										Santo Domingo- IBBSS 2013
Priority Population	3,900										Focus group CONAVIHS IDA 2014 –

s TRANS											Concept Note GF
	9,793										Place 2014
Priority Populations Prevalence TRANS	17.8 (L.G.)										Place 2014
Military Prevalence	0.6										KAP 2010
*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.											

(#) Projection for 2014 of National Census estimate 2,673,716 male and 2,710,613 female 15-49 yrs persons in DR



Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
			HIV Care and Treatment					HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	10,378,267 (National Census)	0.43 (NOT 15-49yrs)	44,254 (Spectrum 2013)	34,165 (FAPPS 2014)	25,596 (FAPPS 2014)	22,671 (FAPPS 2014)	9,028 (FAPPS 2014)	652,069 tests (MoH-DIGECITSS)	10,409 tests (MoH-DIGECITSS)	N.A
Population less than 15 years	3,137,336 (National Census)	0.27	8,613 (Spectrum 2013)	1,153 (FAPPS 2014)	949 (FAPPS 2014)	845 (FAPPS 2014)	296 (FAPPS 2014)	N.A	N.A	N.A
Pregnant Women	220,000	0.8 (Sentinel Surveillance in Pregnant 2009)	I.Q.	I.Q.	I.Q.	I.Q.	I.Q.	154,175 tests (MoH-DIGECITSS)	2,007 tests (MoH-DIGECITSS)	N.A
<b>MSM</b>	124,472 50,172 (Table 1.1.1)	3.9-6.9 (IBBSS 2012)		N.A	N.A	N.A	N.A	N.A	N.A	N.A
<b>TRANS</b>	3,900 9,793 (Table 1.1.1)	17.8 (Place 2014)								
<b>FSW</b>	91,171 80,107 (Table 1.1.1)	1.7-6.3 (IBBSS 2012)		N.A	N.A	N.A	N.A	N.A	N.A	N.A
<b>PWID</b>	Not applied	Not applied	Not applied	Not applied	Not applied	Not applied	Not applied	Not applied	Not applied	Not applied
<b>Priority Pop Haitians</b>	458,233 (ENI 2012)	2.5 (DHS 2013)		3,463 (FAPPS 2014)	1,915 (FAPPS 2014)	1,545 (FAPPS 2014)	379 (FAPPS 2014)	15,913 tests (MoH-DIGECITSS)	1,513 tests (MoH-DIGECITSS)	N.A

\*These should be national data, if the data do not exist, PEPFAR data **may be** used if relevant.

\*TA/TC operating units should create Standard Tables 1.1.1 and 1.1.2 for each country prioritized for program focus in COP 2015.

\*Estimates for testing, care, treatment, retention and suppression for key and priority population groups (below grey line) should only be included if reliable data exists.

## 1.2 Investment Profile

Currently there are somewhat limited data to fully describe the HIV/AIDS investment in the Dominican Republic (DR), using the same categories required by PEPFAR. The UNAIDS report, “MEDICIÓN DEL GASTO EN SIDA 2012 Y SERIE DE TIEMPO 2009-2011 REPÚBLICA DOMINICANA” (MEASUREMENT OF EXPENDITURES IN AIDS 2012 AND TIME SERIES 2009-2011 FOR THE DOMINICAN REPUBLIC), known as “MEGAS,” is the most comprehensive report to date. It describes the HIV/AIDS investments made as of 2012. The PEPFAR/DR team decided not to use this report for two reasons: 1) MEGAS/2012 under-reports PEPFAR’s investment in the DR by about \$13 million, and 2) it does not reflect the fact that the DR has assumed most of the cost of treatment, as required by the Global Fund (GF). In order to provide the most accurate picture, the PEPFAR team decided to use the financial data provided in the DR’s 2015 GF Concept Note.

The overall HIV/AIDS response (see table 1.2.1.) in the DR is estimated at \$ 33.8 million, of which PEPFAR is the second largest contributor (21.8%), followed by the Global Fund (4.7%). As a World Bank-classified middle income country, the DR has assumed all treatment and care costs within public health facilities. Most of the HIV/AIDS investment (49.9%) is for treatment and care, followed by prevention among Key Populations (35.6%). Of total prevention costs, 28.9% will be covered by PEPFAR, 1.79% by GF, and 64% by the private sector (largely out-of-pocket contributions) and other international donors.

The recently submitted Concept Note primarily focuses on providing HIV prevention services to KP. There is limited investment in laboratory improvement or strategic information activities. The Concept Note does not separate HIV testing and counselling (HTC) from the treatment and care costs. Based on the only available data, HTC costs represent 2.9% of the overall investment, of which 100% incorrectly seems to be covered by PEPFAR.

PEPFAR is supporting the organization of a National Pharmaceutical Supply System to assure a continuous supply of ARV and diagnostic commodities. Since 2010 and within this approach we have contributed to: Reduction of adults ARV therapeutic schemes; Provide evidence to close a financial gap for ARV and the reduction of cost per patient treated from USD 371/ year patient in 2011, to USD 164/ year patient in 2014. The PEPFAR team will also continue to work with the Dominican Government to clarify investments to the NR, such that would allow for better description and stronger financial and programmatic planning.

**Table 1.2.1 Investment Profile by Program Area**

<b>Program Area</b>	<b>Total Expenditure</b>	<b>% PEPFAR</b>	<b>% GF</b>	<b>% GRP</b>	<b>% Other</b>
Clinical care, treatment and support	\$16,888,583	21.76%	4.72%	55.80%	17.72%
Community-based care	\$950,000	100.00%	0.00%	0.00%	0.00%
PMTCT		0.00%	0.00%	0.00%	0.00%
HTC	\$980,000	100.00%	0.00%	0.00%	0.00%
VMMC	\$0	0.00%	0.00%	0.00%	0.00%
Priority population prevention	\$150,000	100.00%	0.00%	0.00%	0.00%
Key population prevention	\$12,035,859	28.91%	1.79%	6.44%	64.11%

OVC	\$9,928	0.00%	0.00%	0.00%	0.00%
Laboratory	\$500,000	100.00%	0.00%	0.00%	0.00%
SI, Surveys and Surveillance	\$281,318	88.87%	0.84%	0.00%	0.00%
HSS	\$2,047,500	100.00%	0.00%	0.00%	0.00%
<b>Total</b>	<b>\$33,843,188</b>				

Table 1.2.2: not applicable

Table 1.2.3: not applicable

### 1.3 National Sustainability Profile

PEPFAR/DR invited a group of approximately 40 stakeholder representatives to a consultative meeting on the Sustainability Index. Representatives of the NR, Ministries of Health, Labor, Defense, Finance, and Planning, Civil Society, and other collaborating agencies were present. The invitees were sent the SID tool in advance and asked to complete it and bring it to the meeting. Participants were divided into four discussion groups (we combined “Accountability and Transparency” and “Enabling Environment” into one group), which reviewed the appropriate items of the tool and reached a group consensus on the response for each one. These are reported in the Dashboard, which is part of this COP.

Per the Dashboard, the items identified by the discussion groups as the least sustainable are:

- Under “Institutionalized Data Availability”: Lack of a financial data tracking system;
- Under “Domestic Program and Service Delivery”: KPs generally do not receive services at MOH sites; inadequate service staffing and in-service training of care providers;
- Under “Health Financial and Strategic Investments”: less than 3% of GDP (2.8%) allotted to the health sector (although Dominican Central Bank reports show this at 6.1%); NR does not use financial or programmatic data to set or shift priorities for activities.
- Under “Accountability and Transparency”: there is low public access to reports; the OBI score of 29 is categorized as “minimal information”; no national audits are done or the results are not made public.

The discussion groups agreed that most of the items in the domains and elements can be strengthened and become more sustainable. There was some consensus that the following items are in the greatest need of attention, in order to maintain progress towards sustained epidemic control:

- The level of domestic investment in the health sector in general, and the NR specifically, should be strengthened. The MOH has invested over \$ 17 million in the past three years (2013-2015) as counterpart for the procurement of ARVs and other treatment-related supplies. However, there was a recognition that the MOH and the GODR need to continue to provide increasing contributions to the NR. This is a requirement of the Global Fund, and the GODR has presented a signed “Willingness to Pay” statement as part of the Concept Note submission package;
- The collection and use of data to drive decisions on program investments or reprogramming, especially in terms of supporting treatment and service sites. Currently, little analysis takes place, and in order to achieve the most efficient use of funds, the NR needs to utilize service data to reach decisions on the appropriate shifts of investments;
- Attention to the allocation of service staff to achieve the most efficient use of the NR’s human resource in service delivery; continual in-service training of staff in service norms and guidance; appropriate supportive supervision; attention to training to sensitize services delivery staff on stigma and discrimination issues, so that KPs can freely access services at MOH sites.

For a number of years PEPFAR has worked with the NR/MOH to develop and utilize an efficient data collection process, in order to promote a “culture of data,” which utilizes data to reach programmatic and management decisions. PEPFAR has invested in the Field Epidemiology Training Program, a monitoring

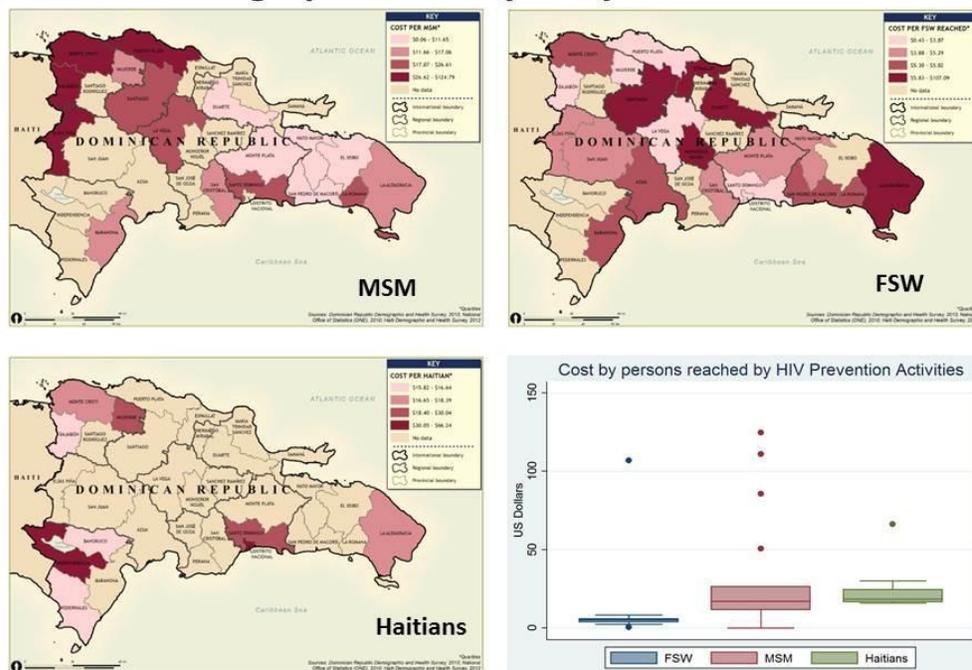
and evaluation diploma program, directed at improving the collection, analysis and use of data. PEPFAR supports TA to the MOH Human Resources system, focusing on the most efficient deployment of staff, with appropriate position descriptions, to enable supportive supervisors to provide the appropriate mentoring to strengthen the quality of service delivery. COP 2015 continues to work in these areas and also contains funding and activities to reduce stigma and discrimination against KPs. The provision of increased national resources to the NR is an ongoing PEPFAR policy dialogue theme with MOH and NR authorities.

#### 1.4 Alignment of PEPFAR investments geographically to disease burden

PEPFAR/DR considered a number of data sources in reaching agreement on the alignment of geographical priorities with disease burden. The discussions took into account population size estimations; number of PLWHA enrolled at public HIV clinics; number reached and tested in 2014; unmet needs; cost of outreach, testing and care per person; assumptions on percentages of those reached who will agree to a test, and of those how many will test positive. The result of these discussions and analyses was a list of first- and second-level priority provinces where PEPFAR has decided to focus our interventions. Among General Population, considering prevalence rates (DHS/2013; HPIS/2014), numbers of PLWHA (DHS/2013; HPIS/2014), number PLWHA in care (HPIS/2014) and crossing prevalence in the general population and PLHIV in care data shows that it would be most effective to prioritize the provinces of Santiago, Puerto Plata, La Romana, Valverde, and La Altagracia.

Graph 1.4.1

### Cost and Geographical Analysis by KP and PP



Among MSM/Trans, considering burden of disease by province, size estimation (PLACE/2014), numbers reached by PEPFAR prevention activities (APR/2014), cost per MSM/Trans reached in prevention actives (Expenditure Analysis/2014), and crossing EA data with provincial prevalence, showed that the most cost-effective, scale-up to saturation provinces for PEPFAR to work are Santo Domingo (including the National District), La Romana, Santiago,, Puerto Plata and La Altagracia.

Among FSW, considering the burden of disease by province, size estimation (PLACE/2014), numbers of FSW reached by PEPFAR prevention activities (APR/2014), cost per FSW reached in PEPFAR prevention activities (Expenditure Analysis/2014) and crossing the data of unmet FSW needs and cost per FSW reached in PEPFAR prevention activities, show that the optimal scale-up to saturation provinces for PEPFAR interventions appear to be Santo Domingo (including the National District), La Romana, Santiago, Puerto Plata and La Altagracia, the same provinces as for MSM/Trans.

Among Haitian migrants, considering the disease burden by province, size population (National Immigrant Census/2012), numbers reached by PEPFAR prevention activities (APR/2014), cost per migrant reached by PEPFAR prevention activities (Expenditure Analysis/2014) and crossing the data of unmet needs and the cost per person reached, suggest that PEPFAR focus on the scale-up to saturation provinces of Santiago, Puerto Plata, La Romana, La Altagracia, and Valverde.

### **1.5 Stakeholder engagement**

PEPFAR/DR engages our stakeholders on an ongoing basis. As a partner in, but not the lead for, the Dominican National Response (NR), it is important for us to constantly seek “reality checks” for the relevance and focus of our program. The PEPFAR Coordinator is a voting member of the CCM, constantly engages with the National AIDS Council, and dialogues frequently with CSOs. Many CSOs are also PEPFAR implementing partners (IP).

The GODR played an active role as part of the Sustainability Index consultative meeting. About 40 persons participated from the Ministries of Health, Education, Defense, Labor, Finance, and Planning. Their comments and feedback to the SID questionnaires provided important material for the PEPFAR team to consider for COP 2015.

Sixty Civil Society representatives attended the CS consultative meeting and gave us their feedback in terms of the needs of KPs and PPs, to reach epidemic control. To reach a broader audience, we shared an electronic version of the power point and an online version of the questions. The dialogue with the CS sector is ongoing.

As part of our process to engage external stakeholders, the PEPFAR Coordinator gave a presentation at a CCM meeting on the COP 2015 process. The presentation emphasized PEPFAR’s process for data-based program decision making and the focus on Key and Priority Populations. Additionally, the Coordinator and the directors of the CDC and USAID programs briefed MOH and NR leadership on the process and proposed content of COP2015 and solicited their feedback, prior to submission. The PEPFAR team also briefed Ambassador Brewster on the COP process and content.

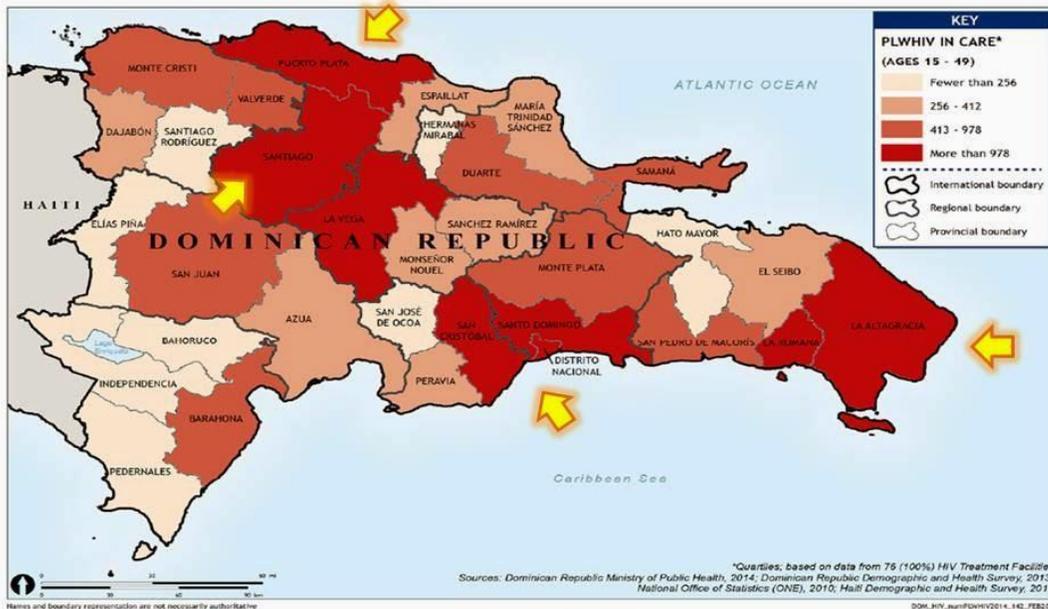
USG team representatives played an active role with the GODR and Civil Society in the development of the recently submitted GF Concept Note. If approved, the Concept Note will provide approximately \$ 5.8 million in GF cycles 2016 and 2017. The MOH currently has budgeted nearly \$8.8 million to procure ARVs in 2015, the third year that it has provided counterpart for this purpose. PEPFAR promotes and applauds this initiative and will continue the dialogue so that each succeeding year this amount is increased.

As GF resources are phased down, there will be a greater need for the USG and GODR to work together even more closely. Because of the similar focus of the two programs, joint decision making will be a necessity. Additionally, PEPFAR has promoted the establishment of a “KP working group” with the NR, to discuss and reach agreement on issues and approaches of common concern. Using results and financial data for making programmatic and realignment decisions and sharing indicators and results will necessarily be part of this dialogue. Because the GF Concept Note and PEPFAR focus on the same target populations, it is important that PEPFAR continually communicate with the NR to ensure the complementarity of both

programs. The Dominican private sector is not involved in the NR and PEPFAR has little contact with this sector.

Graph 1.5.1

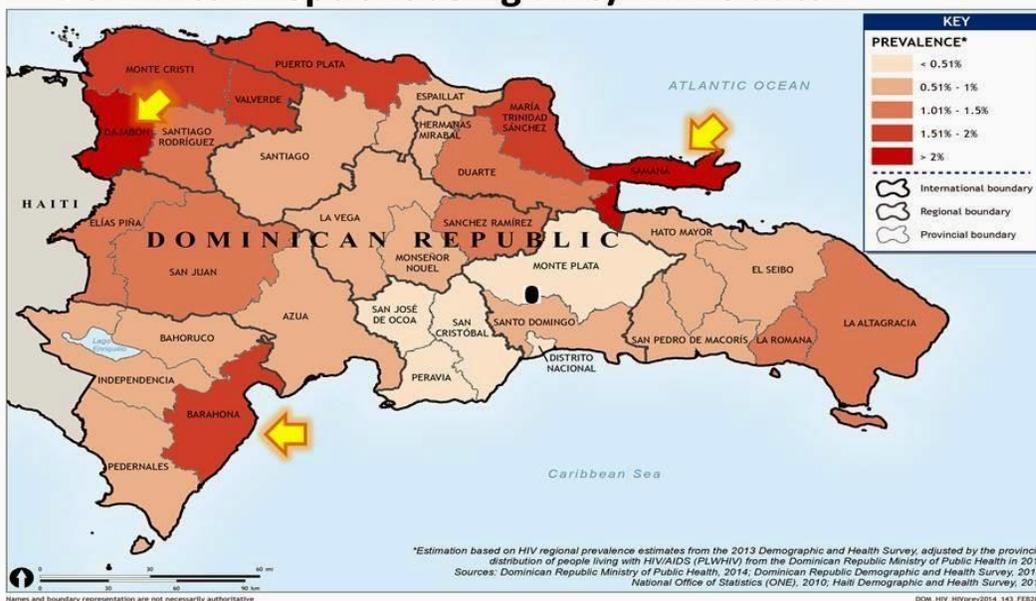
### MAP: PLWHIV receiving care at HIV Clinics



✓ Most HIV patients in CARE live in Santo Domingo, San Cristóbal, La Altagracia, La Romana, La Vega, Santiago and Puerto Plata

Graph 1.5.2

### MAP: Estimated HIV Prevalence by province in Dominican Republic using DHS/FAPPS data



✓ HIV Prevalence is higher in Dajabón, Montecristi, Valverde, Puerto Plata, Samaná, Duarte, María Trinidad and Barahona.



## **2.0 CORE, NEAR-CORE, NON-CORE ACTIVITIES**

PEPFAR/DR was part of the Wave I exercise in July 2014. For COP 2015, the team reviewed the conclusions of that exercise in the context of the rigorous data-based approach to programming which has begun with this COP. The review process was participative and highly active. As a team we reviewed the available epidemiological data, expenditure analysis and progress reports. We identified existing needs/gaps, key populations to be addressed, provinces with the greatest gaps and unmet need, interventions to address the need, and possible issues of USG-GF overlap. The final list represents the consensus of the PEPFAR team.

Core activities, those designed to save lives and reduce the number of new infections, include the following: 1) support to prevention, care and treatment services focused on the most vulnerable populations, namely men who have sex with men and transgender persons, female sex workers, and mobile populations; 2) Laboratory Capacity Building on HIV/TB/STI quality management; 3) TA to support a strengthened strategic information capability in the MOH; 4) TA to strengthen HIV/TB co-infection clinical linkages; 5) TA to improve the quality of MOH- and MOD-provided clinical care services in HIV, TB and STI; 6) TA to the MOH to improve the deployment and job performance of HIV/AIDS service provision staff; 7) working with the MOH to reduce stigma and discrimination encountered by KP and PLHIV, including GBV; 8) continued TA support to strengthen the MOH commodity security and supply chain management systems; 9) condom and lubricant social marketing directed at KP.

Near-core activities are those which support core activities and which have a limited time frame. These include: 1) support to the Field Epidemiology Training Program; 2) TA to the CCM; 3) PITC-HTC in the Dominican military; 4) Policy dialogue to continue and increase the National contribution to the HIV NR; and 5) support to carry out an HIV incidence study.

Non-core activities (those which do not directly serve PEPFAR goals in HIV/AIDS prevention); we agreed to maintain the same activities identified during wave 1 in Washington. They are: 1) TA and support to blood safety programs; 2) removing drug users from the categorization as KP; 3) phasing down general prevention activities targeting youth and military; 4) support to PMTCT services and phasing down PMTCT information system; 5) support to a study to understand the behavioral risk characteristics and quality of health among PLHIV enrolled in ART. We also agreed to phase out from the non-prioritized provinces and scale down STI clinical services.

Appendix A contains more information on these activities.

## **3.0 GEOGRAPHIC AND POPULATION PRIORITIZATION**

To assess general needs PEPFAR/DR reviewed the Global Fund Concept Note which used 44,251 as the estimated number of PLHIV and 32,102 (73%) as the number of individuals who know their status. However, the in-country PEPFAR team has scientific reasons to believe that the estimation used under-represents the actual number of PLHIV in the country. Using DHS/2013 data we estimate the number of PLHIV to be 59,704, of which 34,165 (57%, as of August 2014) know their status and are in care and of those, 25,596 (75%) are on ART.

In order to reach 90-90-90 by September 2017, a total of 53,733 persons (90% of 59,704) would need to know their status and be linked into care, a deficit of 19,568 persons (53,733 less 34,165). Of these, a total of 48,360 (90% of 53,733) would have to be placed on ART, a gap of 22,764 persons (48,360 less 25,596). At an estimated annual per person cost of \$646, an additional 22,764 persons on ART could cost the NR approximately \$14.7 million (by comparison, the GODR counterpart commitment for ARV procurement in

2015 is \$8.79 million). Of those on ART, 43,524 (90% of 48,360) would be expected to show viral suppression.

PEPFAR/DR decisions on priority populations and geographic locations (scale-up to saturation provinces) were based on a variety of epidemiological, program, and expenditure analysis data. Among the data sources, the team consulted EA, SIMS, APR for results, DHS/2013, BSS, PLACE study, ePIS, and other sources. The team analyzed the estimated population size of the different KP (MSM/TG and CSW) and PP (mobile populations, Bateyes, and military) by province and by seroprevalence rate, using patient level data, extrapolated from DHS/2013 data down to the province level. The team also took under consideration the Global Fund Concept Note, which indicates where the National Response plans to focus its resources.

Because the target groups for PEPFAR and for the CN/NR are similar, PEPFAR is sensitive to the need to articulate our program and activities with those of the NR. PEPFAR's plan with KP and PP will focus on identifying persons at risk, getting them tested, linking those who test positive to treatment and care services, and improving/ensuring CD4 and viral load testing to those who are on ARVs, thus monitoring our contribution to epidemic control.

### **SNU key findings**

Overall, the highest HIV prevalence rates were found in the provinces of Samana, Dajabón, María Trinidad Sánchez, and Puerto Plata (DHS/2013; HPMS/2014). Highest numbers of PLHIV were in the provinces of Santo Domingo, Distrito Nacional, Santiago, Puerto Plata and San Cristóbal (DHS/2013; HPMS /2014). The highest number PLHIV in care were in the provinces of Santo Domingo, Distrito Nacional, Santiago, Puerto Plata and San Cristóbal (HPMS /2014). Crossing prevalence and PLHIV in care data shows that it would be most effective to prioritize the provinces of Santiago, Puerto Plata, La Romana, Valverde, and La Altagracia. MSM live mainly in the large provinces of the country, they are: Santo Domingo, San Pedro de Macorís, Santiago, and San Cristóbal (PLACE/2014). PEPFAR prevention activities reached more MSMs in Santo Domingo, La Romana, Santiago, Barahona, Puerto Plata and San Cristóbal (APR/2014). Considering size estimation (PLACE/2014), reached by PEPFAR prevention activities (APR/2014), cost per MSM reached in prevention actives (Expenditure Analysis/2014), and crossing EA data with provincial prevalence showed that the most cost-effective provinces were Santo Domingo, La Romana, Santiago, Barahona, Puerto Plata and San Cristóbal. [PLEASE NOTE THAT THESE PROVINCES, AND THOSE LISTED IN THE NEXT TWO PARAGRAPHS OF THIS SECTION, ARE THE RESULT OF THE SNU KEY FINDINGS; THEY ARE NOT/NOT IDENTIFIED BY THE TEAM AS PRIORITY, SCALE-UP TO SATURATION, PROVINCES. THOSE ARE LISTED ELSEWHERE IN THIS COP.]

The largest number of FSW can be found in Santo Domingo, San Pedro de Macorís, Santiago and La Romana (PLACE/2014). PEPFAR prevention activities reached more FSW in the provinces of Puerto Plata, Santiago, San Cristóbal, Elías Piña and Monte Cristi (APR/2014). Considering size estimation (PLACE/2014), FSW reached by PEPFAR prevention activities (APR/2014), cost per FSW reached in PEPFAR prevention actives (Expenditure Analysis/2014) and crossing the data of unmet FSW needs and cost per FSW reached in PEPFAR prevention activities show that the optimal locations for interventions appear to be the National District and the provinces of Santo Domingo, La Romana, and San Pedro de Macoris.

The largest number of Haitian migrants can be found in Santo Domingo, Santiago, Valverde and La Altagracia (National Immigrant Census/2012). PEPFAR prevention activities reached more Haitians in Santo Domingo, La Altagracia, Pedernales, Independencia and Dajabón (APR/2014). Considering size population (National Immigrant Census/2012), Haitians reached by PEPFAR prevention activities (APR/2014), cost per migrant reached by PEPFAR prevention actives (Expenditure Analysis/2014) and crossing data of unmet needs of Haitian migrants and cost per person reached suggest that PEPFAR focus on the provinces of Santo Domingo, La Altagracia, Montecristi and Valverde.

The team agreed to phase out from the provinces that were not identified during our prioritization exercise. Also, it was decided that over time the population of the Bateyes has changed which mirrors more the Dominican general Population, both in composition and distribution.

*\*Published in 2012 by CONAVIHSIDA and Amigos Siempre Amigos (ASA): "Dimensionamiento de la población de hombres, gay, trans y otros hombres que tienen sexo con hombres en República Dominicana, 2010"*

*\*\* Reported by a group of experts in sex work supported by CONAVIHSIDA in 2000. They estimated that 3.36% of women between 15-49 years of age perform sex work in the DR. This percentage is official recognized and is still used (update according demographics changes)*

*\*\*\* Reported by a group of experts in MSM and Trans supported by CONAVIHSIDA in 2014.*

*δ Range of values represents lowest and highest provincial findings in IBBSS/2012 supported by PEPFAR. This survey was performed in 5 provinces (Santo Domingo, Santiago, La Altagracia, Barahona and Puerto Plata) See Appendix D for more details.*

## **4.0 PROGRAM ACTIVITIES FOR EPIDEMIC CONTROL IN PRIORITY LOCATIONS AND POPULATIONS**

### **4.1 Targets for priority locations and populations**

Based on priority (PP) and key population (KP) data, the national and province level context, and the core, near-core, and non-core analysis, the PEPFAR/DR team proposes to invest in core prevention interventions in the coming cycle to accelerate epidemic control. The team plans to saturate five priority provinces, in order to reach 90-90-90 objectives in those provinces by the end of FY 2017. Estimations are based on the prioritization of these five provinces, which allow greater focus of resources on higher numbers of MSM, FSW and migrant populations. These activities will be completed principally through technical assistance and direct services, in order to improve reach, test, treat and retain key populations.

According to the UNAIDS MSM Size Estimation/2010 study, MSM consisted of 4.2% of the general population (UNAIDS 2010, HIV Modes of Transmission Model). In order to identify the estimated number of MSM by the five prioritized, scale-up to saturation provinces in COP2015 (Santo Domingo, Santiago, La Altagracia, La Romana, and Puerto Plata), the following calculations were conducted: (1) We applied the estimated proportion of MSM (4.2%) to the total number of male between the ages of 15-49 years, as reported in 2010 National Census. This calculation resulted in an estimated number of MSM 15-49 within each prioritized province. (2) We then subtracted the reported number of MSM reached by the USG during FY2014 from the estimated number of MSM 15-49 years, to generate the number of potential people within each province expected to be reached by USG FY2016 (the "UNMET/needs for MSM REACH". (3) Based on the numbers of MSM reached in 2014, we calculated FY2014 yield for MSM reached (PEPFAR 2014 MSM Reached/UNAIDS Size Estimate) across the prioritized provinces. (4) Based on these results, we propose to reach a total of 49.6% of the MSM target population, in accordance with the 90-90-90 strategy.

FSW consisted of 3.4% of the general population (UNAIDS/2010: HIV Modes of Transmission Model). In order to identify the estimated number of FSW by prioritized province in COP2015, the following calculations were conducted: (1) We applied the estimated proportion of FSW (3.4%) to the total number of female between the ages of 15-49 years, per 2010 National Census. This calculation resulted in an estimated number of FSW among the 15-49 age groups within each prioritized province. (2) We then subtracted the number of FSW reached by the USG during FY2014 from the estimated number of FSW 15-49 years, to generate the unmet need; (3) Based on the number of FSW reached in 2014, we calculated the expected FY2014 yield for FSW reached (PEPFAR 2014 FSW Reached/UNAIDS Size Est.) across the prioritized scale-up to saturation provinces. (4) Based on these results, at the end of FY2016 we expect to have reached 49.6% of the estimate FSW population in these provinces.

According to the National Migrant Survey/2012, 60% (458,233/768,783) of the migrant population residing in the DR are Haitian born. In order to identify the estimated number of Haitians within each of the priority, scale-up to saturation provinces, by age and sex, the following calculations were conducted: (1) We applied the estimated proportion of Haitians migrants residing in the DR between the ages of 15-49 years 88% [387,009/437,902] to the number of Haitians migrants within in each province, resulting in an estimated number of Haitian Migrants in each prioritized province. (2) To obtain the disaggregation by sex within the prioritize provinces, we applied the total proportion of male (66%) and female (34%) Haitian Migrants between 15-49 years of age to the estimated number of Haitian Migrants, within each province. (3) In order to disaggregate the 15-49 age group into finer age groups (15-19, 20-24, 25-49) by gender, we applied the proportion of Haitian Migrants within each age and sex group [Male:10%, 24%, 66%; Female: 11%, 24%, 65%], to the total number of Haitian Migrants between the ages of 15-49 within each province. (4) We then subtracted the reported number of Haitians reached by the USG during FY2014 from the estimated number of Haitian Migrants by age and sex, in order to generate the number of persons in each province expected to be reached by the USG by FY2016, the “unmet need.” (5) Utilizing the numbers of Haitians reached in 2014, we expect to reach an estimated total of 53.7% of the Haitian migrants in the five priority provinces..

According to Ministry of Defense, the total military population is 49,000, consisting of 91% male and 9% female. In prevention activities, DOD reached 3,392 (3,087 males and 305 females), a yield of 7% of the total military population. Based on these results, PEPFAR DR proposes a 10% increase military in targets settings.

#### **4.2 HIV Testing and Counseling (HTC)**

Taking into consideration the new "REACH to TEST" approach in order to identify positive individuals and linked them to clinical treatment services, the team estimated the number of people to be tested using as references the "MSM to be Reached Target for FY2016", the "FSW to be Reached Target for 2016", and the "Haitians to be Reached Target for 2016." We utilized IBSS 2012 (conducted in 5 provinces) to estimate the number of MSM/TG and FSW; we also consulted the IBSS/2013 for mobile population to estimate the number of migrants to be tested (i.e., these studies showed that 20.9%, MSM/TG reported receiving an HIV test in the last 12 months; 39.8% of FSW reported receiving an HIV test in the last 12 months; and 28% of Haitians reported receiving an HIV test in the last 12 months). Thus, for 2016, PEPFAR/DR proposes to test MSM, FSW and Haitian Migrants, and the military, in accordance with 90-90-90 objectives. PEPFAR-provided TA and direct services will continue to work with the MOH and certain NGO clinics to improve the quality and efficiency of HTC.

These targets were estimated for prioritized geographical, scale-up to saturation provinces, which allows for an efficient use of resources and reach/test a larger number of MSM, FSW, and Haitians. [Haitian mobile groups include street vendors, construction workers, and agricultural workers.]

#### **4.3 Care and Treatment**

The new treatment target includes the total number of newly identified PLWHA receiving ART at the national level. The indicator was evaluated by calculating the number of adults and children newly receiving ART, in accordance with 90-90-90 objectives and the nationally approved treatment protocols, disaggregated by sex and age.

#### **4.4 TB/HIV Co-Infection**

The DR has the fifth highest prevalence of tuberculosis (98 per 100,000 persons) in the Americas. In 2013 over 3500 TB cases were registered by the National TB Control Program in a TB electronic patient register, developed jointly by CDC and the MOH. As of January 2014, 46 out of 148 secondary- and tertiary-level clinics had implemented the register, with more than 300 people trained in its use and over 900 TB cases (30% of all TB cases in the country) registered.

PEPFAR-supported TB/HIV co-infection interventions will provide continued (above site) assistance to the MoH to implement the registry in all 148 TB treatment sites. Additionally, PEPFAR will support the MoH to

intensify TB testing and detection among PLHIV (in HIV clinical settings) in targeted high burden TB/HIV provinces. Activities will include developing national TB screening algorithms, training HIV counselors to recognize TB symptoms and refer patients for TB screening, and supporting the MOH to ensure linkages to HIV and TB care and treatment across TB and HIV clinics.

The MOH has set a 2016 national target that 20% of MSM who are HIV positive will be screened for TB symptoms in PEPFAR-supported HIV clinics.

#### 4.5 Health System Strengthening

Health systems strengthening activities align with Core/Near-Core priorities and geographical and program focus. For example, although PEPFAR’s TA for SI strengthening will continue to encompass the country as a whole, per the MOH’s mandate, PEPFAR’s specific work in SI will focus on the priority populations and provinces. MOH personnel have been and will be invited to join PEPFAR SIMS teams, to gain a further common understanding of monitoring and supervision and the use of data for decision-making. PEPFAR laboratory interventions are designed to support the testing and clinical care and treatment functions, in order to make these services more efficient and effective. PEPFAR support to the Field Epidemiological Training Program proposes to enhance the quality of the local epidemiology human resource. PEPFAR’s work in HR deployment will assist the MOH to place the right number and kind of service providers at the sites where they are most needed and can respond with quality attention to the demands of the clientele. PEPFAR support to the supply chain management system has resulted in major improvement in the procurement and distribution of ARVs and other key supplies, as well as dramatically increased counterpart contributions from the GODR.

Key to the success of the 90-90-90 strategy will be the involvement of public hospitals and clinics in providing counseling, testing and treatment services to KP and PP. PEPFAR technical assistance will work with the MOH to strengthen its technical and “KP/PP-friendly” capacity to serve the expected increase in demand for these services.

<b>SNU (Province)</b>	<b>MSM in TX TARGET FY2016 (90%)</b>	<b>MSM RETAINED TARGET FY2016 (90%)</b>	<b>MSM in VL suppressed TARGET FY2016 (90%)</b>	<b>Co-infection TB- HIV TARGET FY2016 (100%)</b>
Santo Domingo**	316	285	256	316
Santiago	68	61	55	68
La Romana	19	17	15	19
Puerto Plata	18	16	15	18
La Altagracia	17	15	14	17
<b>Totals</b>	<b>438</b>	<b>394</b>	<b>355</b>	<b>438</b>

Table 4.1.2 Target Populations for Newly Initiating ART MSM Patients in Priority Scale-up to Saturation Provinces								
SNU (Province)	Size Estimation	Prevalence	# of MSM LHIV in DR (Estimated)	MSM LHIV in Care*	MSM LHIV not in care	MSM LVIH TARGET FY2016 (85%)	MSM to be tested TARGET 2016	# of MSM to be reached TARGET 2016
Santo Domingo	41071	6.50	2670	57%	1148	351	5404	16212
Santiago	13094	4.40	576	57%	248	76	1723	5169
La Romana	2984	5.30	158	57%	68	21	393	1178
Puerto Plata	3930	3.90	153	57%	66	20	517	1551
La Altagracia	2972	4.80	143	57%	61	19	391	1173
<b>Total</b>	<b>64051</b>		<b>3700</b>		<b>1591</b>	<b>487</b>	<b>8428</b>	<b>25284</b>

Table 4.1.3 FSW ART Targets in Priority Scale-up to Saturation Provinces for Epidemic Control			
SNU (Province)	FSW in TX TARGET FY2016 (90%)	FSW RETAINED TARGET FY2016 (90%)	FSW in VL suppressed TARGET FY2016 (90%)
Santo Domingo - DN	65	59	53
Santiago	66	60	54
Puerto Plata	16	14	13
La Romana	9	8	7
La Altagracia	17	15	14
<b>Totals</b>	<b>173</b>	<b>155</b>	<b>140</b>

**Table 4.1.4 Target Populations for Newly Initiating ART FSW Patients in Priority Scale-up to Saturation Provinces**

SNU (Province)	Size Estimation	Prevalence	# of FSW LHIV in DR (Estimated)	FSW LHIV in Care*	FSW LHIV not in care	FSW LVIH TARGET FY2016 (85%)	FSW To be tested TARGET 2016	# of FSW to be Reached TARGET 2016
<b>Santo Domingo - DN</b>	32336	1.7	550	57%	236	72	4255	8510
<b>Santiago</b>	9986	5.6	559	57%	240	74	1314	2628
<b>Puerto Plata</b>	2981	4.4	131	57%	56	17	392	784
<b>La Romana</b>	2345	3.3	77	57%	33	10	309	617
<b>La Altagracia</b>	2240	6.3	141	57%	61	19	295	589
<b>Total</b>	<b>49888</b>		<b>1459</b>		<b>627</b>	<b>192</b>	<b>6564</b>	<b>13128</b>

## 5.0 PROGRAM ACTIVITIES TO SUSTAIN SUPPORT FOR OTHER LOCATIONS AND POPULATIONS

### 5.1 Sustained package of services in other locations and populations

As a result of the PEPFAR/DR geographical focus exercise, current PEPFAR/DR investment in non-prioritized provinces will be phased out between FY 2015 and 2016. Over the next implementation year (FY 2016), PEPFAR/DR will support interventions primarily in prioritized provinces.

### 5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

Over the next implementation year (FY 2016), the PEPFAR/DR team will phase out its work with MSM and FSW (currently supported by Budget Codes HVOP, HTC and HBHC) in six non-prioritized provinces. As part of the prioritization discussion, the team also noted that Global Fund Concept Note proposes to work with KP populations in Bateyes. Therefore, PEPFAR made the decision to phase out of its work in Bateyes; our work with Bateyes in eight non-prioritized provinces will terminate by the end of FY16.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Districts				
Sustained Group	Volume by	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HTC_TST-DSD			4320	
HTC_TST_TA			150	
KP_PREV_DSD			4620	
PP_PREV_DSD			13525	

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

### 6.1 Laboratory strengthening

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s)  ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
<ul style="list-style-type: none"> <li>Ongoing support to national, regional and provincial laboratories on quality improvement and accreditation so that they can provide higher standards of quality-assured diagnostics, care, and treatment to HIV/AIDS patients</li> </ul>	<ul style="list-style-type: none"> <li>Implementing SLMTA/SLIPTA Quality Management System (QMS) Program in 21 National, Regional, provincial and Reference Laboratories</li> </ul>	<ul style="list-style-type: none"> <li>Continue implementation of Lab QMS SLMTA/SLIPTA in 13 prioritized Labs</li> <li>National Lab QA Strategic Plan (NLQAS) developed</li> <li>Train staff to conduct Regional level laboratories will have the appropriate infrastructure and trained personnel to conduct CD4 and HIV VL</li> </ul>	HLAB  \$150,000	HLAB  \$150,000	CDC: FIND  11957	Domestic Program and Service Delivery #7	x	x	x		x
						Light green Score-15.2	Increased access of key and priority populations to high standard quality HTC and lab services to correctly identify PLHIV and improved linkage to care and treatment follow up to assure Viral suppression.				

	prioritized TB laboratories in QC/QI TB-GLI/SLIPTA QMS program	testing · Conduct HIV incidence studies at the NRL  · Train and mentor Laboratories Staff and supervisors on equipment maintenance, biosafety, , QA/QI, TB QMS									
Development and strengthening Quality Assurance and Quality improvement for HIV rapid testing at POCT and prioritized Laboratories to ensure services meet	Developing a Plan to strengthen the National Reference Laboratory (NRL) capacity on HIV RT EQA (PT) proficiency testing  Adapting and	National Reference Lab will conduct a HIV RT EQA (PT) , HIV RT kits validation, HIV incidence, DR population viral load, etc.	HL AB	HLA B	CDC: FIND	NA	x	x	x		x
			\$270,00	\$320,000	11957		Availability of reliable and timely HIV diagnosis to ensuring accuracy of number of HIV-positive patients prior to putting patients on treatment and measurement of viral load to confirm suppression.				

<p>existing HTC standards</p>	<p>implementing QA Program for HIV RT in 20 laboratory and 8 Point of Care Testing (POCT)</p>	<p>Train laboratories supervisors and mentors in RT QII</p>					
		<p>Train and certify HIV test providers at Labs and POCT in RT QII</p>					

## 6.2 Strategic information (SI)

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control					
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression	
Technical support to MoH (REDES) to improve HIV Patient Monitoring System (HPMS) in order to collect TX cascade indicators and risk factors for key populations (MSM and FSW, TG) and priority populations (Haitian migrants and military).	<p>Training relevant staff in data collection, quality assurance, data analysis, and reporting among TX cascade indicators for KP</p> <p>Developing KP relevant Indicators with disaggregation, and risk factors within the HPMS/FAPS tool</p> <p>Supervision visits conducted to HIV clinics to assess DQ and data</p>	<p>Implement in 76 public the HIV Clinics HPMS/FAPS tool</p> <p>HPMS full integrated to Laboratory Information System (LIS) and SINAVE</p> <p>76 HIV Clinics will develop accurate and timely reports of treatment cascade and risk factors among</p>	HVSI  \$100,00	HVSI  \$100,000	CDC:  REDES  17915	<p>Domain A:</p> <p>CEE: 1.1. Epidemiological and Health data.</p> <p>Score 10.6</p>	x	x	x	x	x	<p>Availability of accurate and timely data on the treatment cascade and risk factors among key and prioritized populations will provide the necessary data to national stakeholders to develop strategies to improve access of KP and other populations to HIV treatment, retention and viral suppression.</p>

	audit of HPMS	key and priority population indicators										
Technical support to the MoH to integrate HIV Patient Monitoring System (HPMS) and SIE-TB to increase availability of HIV-TB co-infection data	<ul style="list-style-type: none"> <li>· Training relevant staff in data collection, quality assurance, data analysis, and reporting and utilization of co-infection indicators</li> <li>· Implementing SIE-TB among 148 TB sites at primary, secondary and tertiary-level clinics</li> <li>· Developing an interface plan for tuberculosis-electronic information system with Info-Lab, SINAVE and HPMS/FAPPS</li> </ul>	<ul style="list-style-type: none"> <li>· Implement in 50% of primary, secondary - and tertiary-level clinics the TB electronic register SIE-TB and the HIV Patient Monitoring System (HPMS)</li> <li>· 148 prioritized Tuberculosis (TB) sites reported TB/HIV co-infection indicators with completeness, timeliness and accuracy</li> <li>· Conduct supervision visits to TB/HIV clinics to assess DQ audit</li> </ul>	HVSI \$100,000	HVSI \$100,000	CDC: MOH 17561	Domain A: CEE: 1.1. Epidemiological and Health data. Score 10.6	x	x	x	x	x	
							Availability of accurate HIV-TB co-infection data will allow stakeholders to develop strategies to increase access to HIV treatment.					

<p>Support the MoH with the uptake of National Epidemiology Surveillance System data (SINAVE)</p>	<ul style="list-style-type: none"> <li>Updating the SINAVE electronic platform to maintain the development of tools to exporting data, analysis and developing priority HIV/AIDS/TB/ STI indicators</li> <li>Develop an interphase plan for SINAVE with the tuberculosis-electronic information system, LIS and HPMS)</li> <li>Developing and implementing SINAVE DQA procedures</li> <li>Training epidemiology and Laboratory staff in the use of SINAVE and national standards of notification</li> </ul>	<ul style="list-style-type: none"> <li>Health regional and provincial directorate improve HIV cases notification indicators with completeness, timeliness and accuracy</li> <li>SINAVE full integrated with TB electronic register and the HIV Patient Monitoring System (HPMS)</li> <li>Conduct supervision visits to health regional and provincial directorate to assess DQ audit</li> </ul>	<p>HVSI</p> <p>\$100,000</p>	<p>HVSI</p> <p>(\$100,000)</p>	<p>CDC: MOH</p> <p>17561</p>	<p>Domain A:</p> <p>CEE: 1.1. Epidemiological and Health data.</p> <p>Score 10.6</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>x</p>
<p>Strengthens HIV case surveillance to monitor the clinical cascade of services.</p>											
<p>Behavioral Sentinel Survey with PLWHA</p>	<p>BSS PLWHIV protocol developed</p>	<p>Implement study and</p>	<p>HVSI</p>	<p>HVSI</p>	<p>CDC: TBD</p>	<p>Domain A</p> <p>CCE: 1.1</p> <p>Epidemiolo</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>x</p>	<p>x</p>

(including key and priority populations) in HIV clinics	and approved by IRB	complete analysis · Report completed and disseminated among the stakeholders and decision makers	50,000	\$0	17916	Epidemiological and Health data. Score 10.6						
							BSS results will provide a better understanding to national stakeholders about access, uptake of care and treatment services, risk behaviors and ARV adherence among PLWHIV to inform decisions.					
Support the MoH to develop and implement a Laboratory National Information system at public laboratories and HIV testing points (POCT)	· Electronic and paper-based Laboratory Information Systems (LIS) developed to support operations of clinical and public health laboratories · Develop an interphase plan for LIS with the	· LIS full integrated with TB electronic register and the HIV Patient Monitoring System (HPMS) · Implement an electronic and paper-based Laboratory Information Systems (LIS) in the 10 out of 20	HIVI LAB 10,000	HIVI LAB 100,000	CDC: MOH 17561	Domain A CCE: 1.1 Epidemiological and Health data. Score 10.6	x	x		x	x	
							Availability of reliable and timely laboratory data will help to ensure accuracy of HIV-positive patients prior to putting patients on treatment and measure viral load to confirm suppression.					

	tuberculosis-electronic information system, SINAVE and HPMS.	national-regional prioritized laboratories and POCT  · Train Laboratory staff in data collection, storage, analysis, and reporting of HIV, TB, CD4 testing module and Viral Load (VL).									
Support the MoH (REDES) to improve data collection of HIV testing (HTC) into the Mother-to-Child Transmission (PMTCT) program	<ul style="list-style-type: none"> <li>Conduct a data management need assessment in 16 prioritized maternities</li> <li>Counseling registers revised and updated</li> <li>MoH staff trained in the use of data collection, electronic reporting, analysis and data use</li> </ul>	Implement an HIV counseling electronic and paper-based information system in 16 maternities  16 prioritized maternities improve HIV testing data collection and reporting with	HVSI 00,000	HVSI 50,000	DC: REDES 17915	Domain A  CCE: 1.1  Epidemiological and Health data.  Score 10.6	x	x			
							Increase accuracy of pre and posttest counselling data in MTCT in order to have the exact number of HIV-positive patients in that population to improve access to care and inform treatment decisions.				

	· Conduct supervision visits to PMTCT sites to assess DQ audit	complete, timeliness and accuracy									
KP Cascade Assessment	Operationalize and assess recommended prevention and treatment cascade indicators, review the appropriateness of currently used identifiers to track persons across cascade, recommend what additional data could be collected in surveys.		OHSS \$296,214		Linkages		X	X	X	X	X
Conduct BSS to gather risk and HIV prevalence among active military personnel	BSS PLWHIV protocol revised and approved by IRB	· Study performed, databases and analyses completed Report completed and disseminated among	HVSI	HVSI 175,000	DOD	Domain A CCE: 1.1 Epidemiological and Health data. Score 10.6	x	x	x	x	x

		the stakeholders and decision makers									
National and Provincial size estimation for MSM/TG and FSWs	Collect additional data in provinces not covered by PLACE in 2014 in order to generalize PLACE findings to all other geographic areas. Acquire data from other sources, such as the National Office of Statistics, to use the models for generalizability.		HVSI \$200,000		MEASURE EVALUATION		x	x	x	x	x
Assess adaptation and implementation of an Integrated Intervention to Promote Prevention, Treatment and Care among MSM Living with HIV in La Romana.	Conduct formative qualitative research to adapt and develop the model for the Abriendo Puertas intervention for MSM, develop process and outcome evaluation tools and management system		OHSS \$100,000		LINKAGES		x	x	x	x	x

	for adapted intervention, train local intervention team, conduct follow-up assessments, and; analyze quantitative and qualitative data to assess effects of the intervention indicators.										
Provide TA to routinely gather data on HIV tests conducted at military hospitals.	· Conduct training on data generation, quality assurance, data analysis, and reporting of indicators	HIV Clinics generated accurate and timely data reports.	HVSI \$175,000	HVSI	DOD	Domain A: CEE: 1.1. Epidemiological and Health data. Score 10.6	x	x	x	x	x

### 6.3 Health System Strengthening (HSS)

	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression

<p>Technical assistance to complete the integration of 21 major hospitals to the National Pharmaceutical Supply System (SUGEMI) and the transfer of ARVs procurement and storage from the current Global Fund (GF) beneficiary (and a warehouse rented with GF resources) to the public logistic manager (PROMESE/CAL).</p>	<p>All HIV/AIDS medicines and commodities are procured and managed by SUGEMI without the need of further financial assistance by the GF</p>		<p>OHSS \$310,000</p>		<p>SIAPS/MSH</p>	<p>Commodity Security and Supply Chain (score 10.2)</p>	x		x		x
<p>Transferring of needs estimations, financial analysis and communication and presentation competencies to UNGM and HIV/AIDS Control Program staff to effectively mobilize national</p>	<p>UNGM and HIV/AIDS Control Program professionals will have the capacity to analyze pharmaceutical and financial data to assure the necessary resources for the procurement and distribution of ARV and HIV/AIDS diagnostic</p>		<p>OHSS \$145,000</p>		<p>SIAPS/MSH</p>	<p>Commodity Security and Supply Chain (score 10.2)</p>	x		x		x



<p>staffing norms according to workload to meet coverage needs through sufficient number and skills mix at high to moderate volume sites including those run by NGOs</p>	<p>cadre.</p>	<p>of care atf MOH sites NGOs referrals for Rx increased</p>										
<p>Build capacity of health workers at high to moderate burden SAIs in FP education, counseling, method provision, management of side effects, and recordkeeping as well as strengthen adherence to ART through promoting facility-community linkages by incorporating the roles of the promoters and NGO liaisons into the workflow and patient follow up including task-sharing as</p>	<p>Facility-community linkages built facilitating follow up of PLWHAs to support adherence to ART and care</p>		<p>OHSS \$147,285</p>		<p>IntraHealth Associate Award</p>	<p>Human Resources for Health (score 4.5)</p>	<p>x</p>	<p>x</p>	<p>x</p>		<p>x</p>	

appropriate.											
Assist the MOH to develop tailored financial and non-financial recruitment and retention strategies to motivate health workers to accept and stay in job posts for a consistent and sustainable distribution of skilled health workers in PEPFAR-supported sites and high-HIV burden geographic areas.	MOH identification of motivational preferences of critical cadres for HIV/AIDS services by applying the Rapid Retention Survey Toolkit to conduct a discrete choice experiment (DCE)	MOH continued efforts to identify inactive or ghost workers from payroll frees resources to cover costs of hiring additional health workers at PEPFAR supported-sites and improve working conditions including incentives.	\$172,408	\$100,000	IntraHealth Associate Award	Human Resources for Health (score 4.5)	x	x	x		x
Technical assistance to the MOH to develop and implement appropriate accountability mechanisms to monitor and deter health worker absenteeism and increase access to HIV services in PEPFAR-supported	Health worker absenteeism monitored and deterred resulting in increase access to HIV services in PEPFAR-supported sites.		\$74,347		IntraHealth Associate Award	Human Resources for Health (score 4.5)	x		x		x

sites.											
Assist the MOH to link the performance management system to the HRIS to better store, track, and use the data on the results of staff performance assessments, supportive supervision visits, and performance development plans to monitor and improve the performance of health workers and the quality of HIV services.	Results from staff performance plans and assessments, and supportive supervision visits, are used by the MOH to monitor and improve the performance of health workers and the quality of HIV services.		\$85,780	\$75,000	IntraHealth Associate Award	Human Resources for Health (score 4.5)	x		x		x
Support the MOH to strengthen HIV-TB linkages and referrals and HIV-FP integration within PEPFAR-supported sites for long term sustainability of critical services in the clinical and prevention continuum	HIV-TB linkages and referrals and HIV-FP integration in strengthened to ensure critical services in the clinical and prevention continuum of response.		\$120,640		IntraHealth Associate Award	Human Resources for Health (score 4.5)	x	x	x		x

of response.											
Continue to improve Epidemiology capacity among MoH personnel in high-HIV burden areas.	· Train and mentor 40 regional and provincial epidemiologists in basic and intermediate level of field epidemiology (FETP).	· Health regional and provincial directorate improve HIV cases notification indicators with completeness, timeliness and accuracy	OHSS/HS \$125,000	OHSS/HS \$150,000	CDC: MOH (17561)	Domain A CCE: 1.1 Epidemiological and Health data. Score 10.6  Domain C: CEE: 10 Allocative Efficiency. · Score 11.0	x	x	x		x
							Strengthen HIV case surveillance to monitor the clinical cascade of services.				
Support the MoH to improve Monitoring and Evaluation (M&E) Capacity	· A National Strategic MoH Plan with its M & E components, (i e.g., metrics, evaluation agenda, data quality assurance procedures, and data use and communications strategy)	· Process, outcome and impact evaluations to strengthen HIV/AIDS program implementation and effectiveness	OHSS/HS \$200,000	OHSS/HS \$200,000	CDC: MOH (17561)	Domain C: CEE: 10 Allocative Efficiency. · Score 11.0 Domain A CCE: 1.3 Performance	x	x	x	x	x

	<ul style="list-style-type: none"> <li>· A ministry wide M&amp;E Directorate to establish guidelines, coordinate and harmonize M&amp;E systems</li> <li>· Implementation of Diploma/Postgraduate training program and mentoring of senior M&amp;E professionals</li> </ul>	<ul style="list-style-type: none"> <li>· Economic evaluations to assess cost-effectiveness, cost-benefit and cost-utility of HIV/AIDS programs or interventions.</li> </ul>				<p>data.</p> <p>Score 14</p> <p>Domain B:</p> <p>CEE: 7.4. Quality Management</p> <p>· Score 15.2</p>					
						<p>Increase the M&amp;E capacity among MoH personnel.</p>	<p>Increasing MoH staff competencies to conduct program monitoring and to evaluate the effectiveness of programs and interventions that will inform decisions needed to achieve HIV epidemic control.</p>				
Train Health Care providers in HIV Care and Treatment practices at Military International HIV Training Program	trained in basic care and treatment	trained in basic care and treatment	OHSS/HSS \$20,000	OHSS/HSS	DOD	Domain B, HHRR for Health Score 7.5	x.	x	x	x	x

## **7.0 USG MANAGEMENT, OPERATIONS AND STAFFING PLAN TO ACHIEVE STATED GOALS**

The DR PEPFAR team did an assessment of current staff and operations in the context of core, near-core, and non-core activities, including program phase-down in some areas and priority focus in others. Staffing gaps were noted, especially with USAID personnel. In order to close this gap, the team agreed that USAID needed to budget for two PSC positions, with modified scopes of work, which would strengthen its management team considerably and align new staff more completely with the new PEPFAR model. All agencies will use current staff to meet the SIMS requirements. The budget level does not allow the team to employ any additional staff, even less costly LES staff, to undertake SIMS site visits. Budget constraints also precluded requesting a new SI position with Team-wide responsibilities, to work under the Coordinator, even though the team acknowledges the need for such a position.

The cost of doing business has increased already and will continue to increase in the next COP cycle. ICASS charges have increased by 8% in 2015. Occupying a new embassy compound will generate hefty Capital Security Cost Sharing (CSCS) rates. PEPFAR estimates that CSCS will cost the program about \$35,000 per person in 2017, the year that CSCS fees will be fully assessed. That will represent a major outlay of our limited budget going to non-program requirements. CDC had to convert three of its PSC staff to local hires, because of budget constraints. SIMS requirements will consume a larger part of the budget in transportation and per-diem outlays.

## APPENDIX A - CORE, NEAR-CORE, NON-CORE MATRIX

**Table A.1 Program Core, Near-core, and Non-core Activities for COP 15**

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	TA to increase the number of MSM and TG that have an HIV test within the clinics	Establish friendly services for military in training centers for the personnel at the SAI in order to reduce stigma and discrimination.	
	Support HTC (quality and reach) and linkage to care for MSM/TGs, FSWs and priority population in community and facility-based settings at prioritized provinces.	Assess adaptation and implementation of an Integrated Intervention to Promote Prevention, Treatment and Care among MSM Living with HIV in La Romana.	
	To increase the number of Haitian migrants tested for HIV among construction workers, agricultural workers and street vendors focused in key markets.	Provide TA for timely and accurate collection of National Indicators within Military HIV programs.	
	Support community follow up interventions among Haitian migrants who test positive for HIV to link them to services.		
	Provide TA in HTC and linkage to care for military who test positive.		
	Provider-initiated HTC for military personnel over 30 as well as spouses and other dependents of PLWHIV		
	Support community based activities with MOH in highly populated migrant villages that lead to active referrals and/or rapid testing activities		
	Close out and transition training of trainers (TOT) for grass root organizations, focusing on improving capacity and continued use of approved curricula (Escojo, Healthy Homes, DPV, Etc.)		
	Support adherence and retention counseling for key populations MSM/TG within MSM/TG friendly services		
	Implement a positive prevention model for MSM/TG, risk reduction for PLWH in friendly services.		
	Provide a package of care and support interventions for HIV +, MSM/TG/FSW and other PLHIV including PHDP services related to the prevention of onward transmission of		

	HIV as well as the overall quality of life of PLHIV including needed psycho-social and other forms support.		
	Improve adherence and reduce loss to follow up or abandonment of treatment through strong linkages from community care and support to clinical services in prioritized provinces.		
	Develop, validate, transfer and replicate a care and support model for HIV positive FSWs, TGs and MSM based on the PHDP framework.		
	Reduce military loss to follow-up through PHDP and case management, designed to improve partner testing as well as quality and continuity of care throughout military career including frequent change of duty station. Address low instance of VL testing.		
	Improve linkage and retention in care for PLWH at HIV clinics in military hospitals.		
	Strengthen the capacity of civil society Organizations to effectively address stigma and discrimination and gender-based violence, especially in relation to key populations and other priority populations.		
	Ensure the quality of rapid testing of HIV (RTQII) at testing points (POCT)		
<b>Sub-national level</b>	Establish MSM/TG friendly services with training centers for Public HIV Clinics in order to reduce stigma and discrimination		
	Support the implementation of a care model among public HIV services to improve access, retention and viral suppression of Haitian migrant workers living with HIV		
	Improve quality and effectiveness of referral and counter-referrals between HIV prevention and treatment for key populations, building the continuum of response in care and support through public-private partnerships. Effectively mobilize, coordinate, and efficiently utilize resources from PEPFAR, GF and domestic sources.		
	Expand outreach using science base behavior change interventions among Haitian migrants (workers in the construction, agricultural and street vendors)		
	Deliver a comprehensive package of HIV/STI prevention interventions for MSM/TGs, FSWs and priority populations in high priority		

	locations. This includes: Peer education, community-based outreach (using evidenced based interventions), STI prevention/treatment, distribution of condoms and condom-compatible lubricants, referrals to HTC, interventions addressing stigma and discrimination, and community empowerment.		
	Develop materials and tools on GBV and S&D, Training policy makers and service providers on GBV and S&D, implementing comprehensive S&D and GBV reduction package at military health facilities.		
	Work with 15 selected high burden SAI hospitals to promote and implement mechanisms to ensure human rights, reduced S&D and violence for key populations.		
	Continue to support the implementation of a quality management system (accreditation) for testing of HIV, CD4, and VL		
<b>National level</b>	Technical support to MoH (REDES) to improving HIV Patient Monitoring System (HPMS) in order to collect TX cascade indicators and risk factors for key populations (MSM and FSW, TG) and priority populations (Haitian migrants and military).	Support the development/implementation/update of norms and protocols for servicing HIV patients with emphasis on KP (with emphasis on the CD4 laboratory test, Viral Load, stigma and discrimination) through a KP committee in the national HIV/AIDS program.	Support the MoH (REDES) to improve data collection of HIV testing (HTC) into the Mother-to-Child Transmission (PMTCT) program
	Support the MoH to develop and implement a Laboratory National Information system at public laboratories and HIV testing points (POCT)	National and Provincial size estimation for MSM/TG and FSWs	
	Support the MoH with the uptake the National Epidemiology Surveillance System (SINAVE)	Behavioral Sentinel Survey with PLWHA (including key and priority populations) in HIV clinics	
	KP Cascade Assessment		
	Conduct BSS to gather risk and HIV prevalence among active military personnel.		
	Technical support to the MoH to integrate HIV Patient Monitoring System (HPMS) and SIE-TB to increase availability of TB/HIV co-		

	infection data		
	Work with HIV clinics to improve regular TB testing improving adherence to country's guidance for HIV patients who initially test negative for TB and vice versa.	Continue to improve Epidemiology capacity among MoH personnel in high-HIV burden areas.	
	Continue to strengthen QMS of TB testing in prioritized facilities.	Support the MoH to improve Monitoring and Evaluation (M&E) Capacity	
	Staffing distribution and performance management for HIV related clinical services in high burden sites.		
	TA for rights-based work to ensure that structural barriers affecting access to/progression along the different steps along the cascade are effectively addressed.		
	Provide TA to the MOH to ensure continuous availability of HIV/AIDS and TB medicines and supplies through: strengthening governance, supply chain management capacity, data use for decision making, efficient allocation of resources and improving services		

<b>Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15</b>			
	<b>Core Activities</b>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
<b>HVCT/HTC</b>	TA to increase the number of MSM and TG that have an HIV test within the clinics (Pending to discuss with USAID service coordinators/referred to MSM clinics).		
	Support HTC (quality and reach) and linkage to care for MSM/TGs, FSWs and priority population in community and facility-based setting at prioritized provinces.		
	Support community follow up interventions among Haitian migrants who test positive for HIV to link them to services.		
	Provide TA in HTC and linkage to care for military who test positive.		
	Provider-initiated HTC for military personnel over 30 as well as spouses and other dependents of PLWH		

<b>HBHC/Care and Support</b>	Establish MSM/TG friendly services with training centers for Public HIV Clinics in order to reduce stigma and discrimination.	Support the development/implementation/update of norms and protocols for servicing HIV patients with emphasis on KP (with emphasis on the CD4 laboratory test, Viral Load, stigma and discrimination) through a KP committee in the national HIV/AIDS program.	
	Support adherence and retention counseling for key populations MSM/TG within MSM/TG friendly services		
	Implement a positive prevention model for MSM/TG, risk reduction for PLWH in friendly services.		
	Support the implementation of a care model among public HIV services to improve access, retention and viral suppression of Haitian migrant workers living with HIV		
	Improve quality and effectiveness of referral and counter-referrals between HIV prevention and treatment for key populations, building the continuum of response in care and support through public-private partnerships. Effectively mobilize, coordinate, and efficiently utilize resources from PEPFAR, GF and domestic sources.		
	Provide a package of care and support interventions for HIV +, MSM/TG/FSW and other PLHIV including PHDP services related to the prevention of onward transmission of HIV as well as the overall quality of life of PLHIV including needed psycho-social and other forms support		
	Improve adherence and reduce loss to follow up or abandonment of treatment through strong linkages from community care and support to clinical services in prioritized provinces.		
	Develop, validate, transfer and replicate a care and support model for HIV positive FSWs, TGs and MSM based on the PHDP framework.		
	Reduce military loss to follow-up through PHDP and case management, designed to improve partner testing as well as quality and continuity of care throughout military career including frequent change of duty station.		
<b>HVOP/Prevention</b>	Expand outreach using science base behavior change interventions among Haitian migrants (workers in the construction, agricultural and street		

	vendors)		
	Deliver a comprehensive package of HIV/STI prevention interventions for MSM/TGs, FSWs and priority populations in high priority locations. This includes: Peer education, community-based outreach (using evidenced based interventions), STI prevention/treatment, distribution of condoms and condom-compatible lubricants, referrals to HTC, interventions addressing stigma and discrimination, and community empowerment.		
	Improve linkage and retention in care for PLWH at HIV clinics in military hospitals.		
	Targeted GBV, S&D and condom promotion training for non-healthcare personnel including CESFRONT (Border Patrol) and military leadership. Coordination with USAID, MOD and MOH for condom provision at key sites.		
	Developing materials and tools on GBV and S&D, Training personnel including policy makers and service providers on GBV and S&D, implementing comprehensive S&D and GBV reduction package at military health facilities.		
	Provide HIV Prevention interventions among older youth and adult population in migrant Haitian communities. This includes: promoting behavior change through peers, healthy decision making, condom demonstrations, stigma and discrimination reduction, etc.		
HVS/ SI	Technical support to MoH (REDES) to improving HIV Patient Monitoring System (HPMS) in order to collect TX cascade indicators and risk factors for key populations (MSM and FSW, TG) and priority populations (Haitian migrants and military).	National and Provincial size estimation for MSM/TG and FSWs	Support the MoH (REDES) to improve data collection of HIV testing (HTC) into the Mother-to-Child Transmission (PMTCT) program
	Support the MoH to develop and implement a Laboratory National Information system at public laboratories and HIV testing points (POCT)	Behavioral Sentinel Survey with PLWHA (including key and priority populations) in HIV clinics	
	Support the MoH with the uptake the	Assess adaptation and implementation of an	

	National Epidemiology Surveillance System (SINAVE)	Integrated Intervention to Promote Prevention, Treatment and Care among MSM Living with HIV in La Romana.	
	Technical support to the MoH to integrate HIV Patient Monitoring System (HPMS) and SIE-TB to increase availability of TB/HIV co-infection data	Provide TA for timely and accurate collection of National Indicators within Military HIV programs.	
	KP Cascade Assessment		
	Conduct BSS to gather risk and HIV prevalence among active military personnel		
<b>HVTB/Co-infection</b>	Work with HIV clinics to improve regular TB testing improving adherence to country's guidance for HIV patients who initially test negative for TB (Viceversa desde TB a VIH). (this will include DOD Sites).		
	Continue to strengthen QMS of TB testing in prioritized facilities.		
<b>OHSS/HSS</b>	Staffing distribution and performance management for HIV related clinical services in high burden sites.	Continue to improve Epidemiology capacity among MoH personnel in high-HIV burden areas.	
	Strengthen the capacity of civil society Organizations to effectively address stigma and discrimination and gender-based violence, especially in relation to key populations and other priority populations.	Support the MoH to improve Monitoring and Evaluation (M&E) Capacity	
	Work with 15 selected high burden SAI hospitals to promote and implement mechanisms to ensure human rights, reduced S&D and violence for key populations.		
<b>HLAB</b>	Ongoing support to national, regional and provincial laboratories on quality improvement and accreditation so that they can provide higher standards of quality-assured diagnostics, care, and treatment to HIV/AIDS patients		
	Development and strengthening Quality Assurance and Quality improvement for HIV rapid testing at POC and prioritized Laboratories to ensure services meet existing HTC		

	standards		
<b>SUPPLY CHAIN</b>	To ensure continuous availability of HIV/AIDS and TB medicines and supplies through: strengthening governance, supply chain management capacity, data use for decision making, efficient allocation of resources, and improving services		

**Table A.3 Transition Plans for Non-core Activities**

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
<b>PMTCT Information System</b>	Phase out	100,000	100,000	TBD	Sept FY2016	<p>CDC has worked with the MoH since 2013 to improve the use of existing paper-based data collection and reporting tools for PMTCT. Regular monthly reports and data quality assurance activities are being implemented and the PMTCT program is ready to move to the next step of revising the registers and implementing an electronic reporting tool. Specific activities include: Revision of PMTCT registers and monthly consolidation instruments, Develop a tool to report consolidated reports electronically, Create procedures and indicators for monitoring and evaluation and performance management of the PMTCT program using the consolidated data, Implement a data quality assurance process.</p> <p>Currently this activity is considered NON-core, PEPFAR will fund these activities only during FY 2016. This intervention is transitioning to the Ministry of Health, expecting they will assume 100% of the information system.</p>
<b>USAID transitioning from youth</b>						<p>Out of 1887 youth tested for HIV infection by the Alerta Joven project during 2014, none were positive.</p> <p>USAID/DR decided to reorient its focus from supporting general large scale prevention programs for youth to work only on very high risk youth whose behavior makes them at-risk to acquiring HIV; the Alerta Joven project will phase out and</p>

						complete all activities by September 30, 2015.
<b>USAID KP prevention outreach, HTC, Care</b>	Transitioning out of non-priority provinces	\$208,652	-	1	By the end of FY16	Moving out of 7 provinces which the team determined are no longer priorities
<b>USAID - Bateyes</b>	Phasing out of all work in Bateyes	\$261,748	-	1	By the end of FY16	The team decided that Bateyes are no longer a priority. The team moving out of 8 Bateyes which the team determined are no longer priorities by the end of FY2016
<b>PC transitioning from bateyes</b>	Phase out	287,500	-	1		As this is the final year of PEPFAR funding, Peace Corps DR activities will include a special focus on creating sustainable community structures for continuing initiatives and activities in the future without direct support. These activities include training of trainers (TOT), strengthening advisory and leadership committees, and strengthening community and NGO capacity. We will involve existing local leaders and coordinators for the initiatives, many of them role models in their bateys, and continue network with existing organizations working in HIV intervention and testing. Peace Corps DR activities will continue to use approved curricula, and funds have been allocated to print approved manuals and materials. Peace Corps Volunteers previously funded by PEPFAR will be covered by PC appropriated funds.
<b>Totals</b>						

## APPENDIX B - BUDGET PROFILE AND RESOURCE PROJECTIONS

### Appendix B.1 Planned Spending in 2016

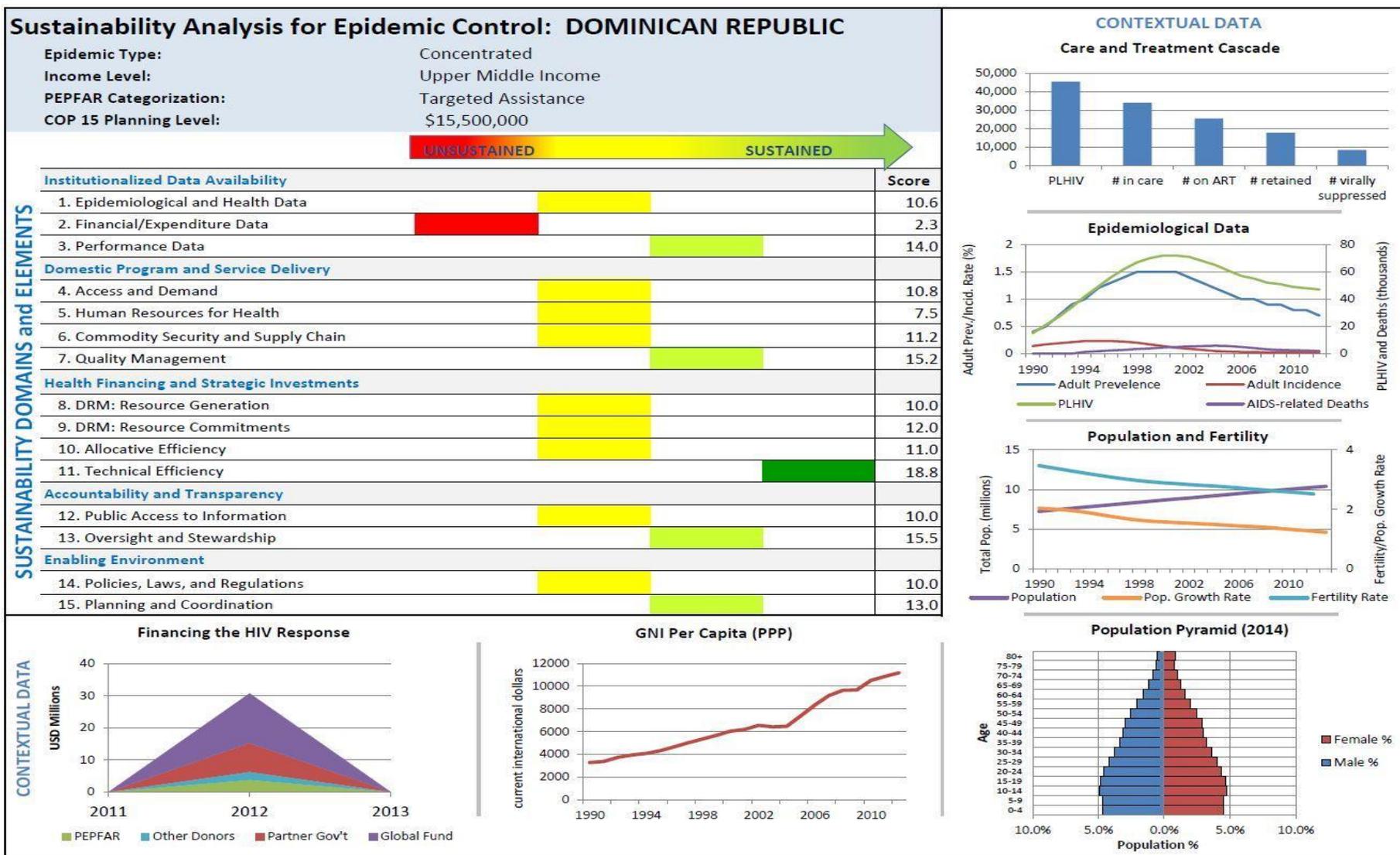
Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$699,500	\$14,800,500	\$ 15,500,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$0
HVAB	Abstinence/Be Faithful Prevention	\$0
HVOP	Other Sexual Prevention	\$2,773,411
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$0
HVCT	Counseling and Testing	\$1,609,520
HBHC	Adult Care and Support	\$1,891,259
PDCS	Pediatric Care and Support	\$0
HKID	Orphans and Vulnerable Children	\$0
HTXS	Adult Treatment	\$0
HTXD	ARV Drugs	\$0
PDTX	Pediatric Treatment	\$0
HVTB	TB/HIV Care	\$600,000
HLAB	Lab	\$700,000
HVSI	Strategic Information	\$770,000
OHSS	Health Systems Strengthening	\$2,567,662
HVMS	Management and Operations	\$4,588,149
<b>TOTAL</b>		<b>\$12,500,000</b>

### B.2 Resource Projections

PEPFAR/DR utilized a combination of the epidemiological profile, results per MER/APR (especially regarding the numbers of KP reached), the sustainability index, DHS/2013 and a number of BSS studies on different KP and PP, estimates of total numbers of KP by province, analysis of costs, Core/Near-core priorities, data from SIM site visits, Global Fund Concept Note priority populations and provinces, unit expenditures from the most recent available EA results (2014), and our own assessment of numbers of KP and their respective locations, to establish the COP 2015 budget by Budget Code and IM. Many of these sources are graphically represented and/or described earlier in this SDS. The process was complex, but team participation was active and involved; the final budget represents the team's best consensus on the myriad inputs to this process.

# APPENDIX C: SUSTAINABILITY ANALYSIS FOR EPIDEMIC CONTROL



## APPENDIX D: COMPARISON OF PROVINCES SERVED BY USG-PEPFAR AGENCIES AND GLOBAL FUND BY KEY/PRIORITY POPULATION

LEGEND			
<b>Red</b>	Currently in and phasing out by the end of FY15	Black	In and will stay
<b>Blue</b>	Moving in	Other	PLHIV, PC, DOD
<b>Green</b>	Currently in and phasing out during FY16.		

Province	MSM/TG	FSW	Mobile Pops	Bateyes	Other
AZUA					
BAHORUCO			GF, CDC	GF, PC	
BARAHONA	GF, AID, CDC	GF, AID	GF, CDC	GF	AID, DOD
DAJABON	GF, AID	GF, AID	CDC	AID	
DUARTE					
EL SEIBO	AID	AID		AID	AID, PC
ELIAS PIÑA	GF	GF			DOD, PC
ESPAILLAT					
HATO MAYOR	AID	AID		AID, PC	AID
HERMANAS MIRABAL					
INDEPENDENCIA	GF	GF	GF	GF	PC
LA ALTAGRACIA	GF, AID, CDC	GF, AID	GF, CDC	GF	AID
LA ROMANA	AID	GF, AID	CDC		AID, PC
LA VEGA	AID	AID	CDC		AID
MARIA TRINIDAD SANCHEZ					
MONSEÑOR NOUEL					
MONTE CRISTI	AID	AID	CDC	AID	PC, AID
MONTE PLATA	AID	AID	GF	GF, AID, PC	GF, AID
PEDERNALES			CDC		DOD, PC

PERAVIA			GF	GF	DOD
PUERTO PLATA	GF, AID	GF, AID	GF, CDC	GF, AID, PC	AID, DOD
SAMANA					
SAN CRISTOBAL	AID	GF, AID	GF	GF	AID
SAN JOSE DE OCOA					
SAN JUAN					PC
SAN PEDRO DE MACORIS	AID	GF, AID	GF	GF, AID, PC	AID, DOD, PC
SANCHEZ RAMIREZ					
SANTIAGO	GF, AID, CDC	GF, AID	CDC	GF	AID, DOD
SANTIAGO RODRIGUEZ					DOD
SANTO DOMINGO	GF, AID, CDC	AID	CDC		GF, AID, DOD
VALVERDE	AID	AID	GF, CDC	GF, AID	AID, DOD, PC

### Dominican Republic COP15 Targets by Province: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
AZUA	-	-	-	-	-
BAHORUCO	-	-	-	-	-
BARAHONA	240	-	-	-	-
DAJABÓN	180	-	-	-	-
DISTRITO NACIONAL	8,206	1,705	12,095	1,053	9,585
DUARTE	-	50	225	-	125
EL SEIBO	297	13	-	-	-
ELIAS PIÑA	-	-	-	-	-
ESPAILLAT	-	-	-	-	-
HATO MAYOR DEL REY	399	17	-	-	-
HERMANAS MIRABAL	-	-	-	-	-
INDEPENDENCIA	-	-	-	-	-
LA ALTAGRACIA	9,142	177	1,050	100	850
LA ROMANA	7,500	349	3,100	104	2,330
LA VEGA	1,121	325	1,950	115	1,130
MARÍA TRINIDAD SÁNCHEZ	-	-	-	-	-
MONSEÑOR NOUEL	-	-	-	-	-
MONTE CRISTI	120	25	150	-	50
MONTE PLATA	120	-	-	-	-
Montecristi (no usar)	-	-	-	-	-
PEDERNALES	-	-	-	-	-
PERAVIA	-	-	-	-	-
PUERTO PLATA	10,129	458	2,750	117	1,950
SAMANÁ	-	-	-	-	-
SAN CRISTOBAL	240	-	-	-	-
SAN JOSÉ DE OCOA	-	-	-	-	-
SAN JUAN	-	-	-	-	-
SAN PEDRO DE MACORIS	6,413	221	1,148	89	701
SANCHEZ RAMIREZ	-	-	-	-	-
SANTIAGO	20,867	553	2,825	381	2,250
Santiago de los Caballeros (no usar)	-	-	-	-	-
SANTIAGO RODRÍGUEZ	-	-	-	-	-
SANTO DOMINGO	6,033	130	1,100	60	715
VALVERDE	4,867	60	350	-	100
<b>Total</b>	<b>75,874</b>	<b>4,083</b>	<b>26,743</b>	<b>2,019</b>	<b>19,786</b>

**Dominican Republic COP15 Targets by Province: Key, Priority,  
Orphan and Vulnerable Children Indicators**

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
AZUA	-	-	-
BAHORUCO	215	-	-
BARAHONA	200	800	-
DAJABÓN	150	600	-
DISTRITO NACIONAL	-	-	-
DUARTE	-	-	-
EL SEIBO	1,168	990	-
ELIAS PIÑA	60	-	-
ESPAILLAT	-	-	-
HATO MAYOR DEL REY	1,162	1,312	-
HERMANAS MIRABAL	-	-	-
INDEPENDENCIA	60	-	-
LA ALTAGRACIA	8,129	1,762	-
LA ROMANA	5,226	1,796	-
LA VEGA	600	3,735	-
MARÍA TRINIDAD SÁNCHEZ	-	-	-
MONSEÑOR NOUEL	-	-	-
MONTE CRISTI	2,220	400	-
MONTE PLATA	100	400	-
Montecristi (no usar)	-	-	-
PEDERNALES	-	-	-
PERAVIA	-	-	-
PUERTO PLATA	8,385	2,335	-
SAMANÁ	-	-	-
SAN CRISTOBAL	200	800	-
SAN JOSÉ DE OCOA	-	-	-
SAN JUAN	60	-	-
SAN PEDRO DE MACORIS	2,465	2,380	-
SANCHEZ RAMIREZ	-	-	-
SANTIAGO	19,455	7,797	-
Santiago de los Caballeros (no usar)	-	-	-
SANTIAGO RODRÍGUEZ	-	-	-
SANTO DOMINGO	2,128	24,722	-
VALVERDE	9,794	-	-
<b>Total</b>	<b>61,777</b>	<b>49,829</b>	-



## HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

<b>Dark Green Score (17-20 pts)</b> (sustainable and requires no additional investment at this time)
<b>Light Green Score (13-16.9 pts)</b> (approaching sustainability and requires little or no investment)
<b>Yellow Score (7-12.9 pts)</b> (emerging sustainability and needs some investment)
<b>Red Score (0-6.9 pts)</b> (unsustainable and requires significant investment)

# Sustainability Analysis for Epidemic Control: DOMINICAN REPUBLIC

**Epidemic Type:** Concentrated  
**Income Level:** Upper Middle Income  
**PEPFAR Categorization:** Targeted Assistance  
**COP 15 Planning Level:** \$15,500,000

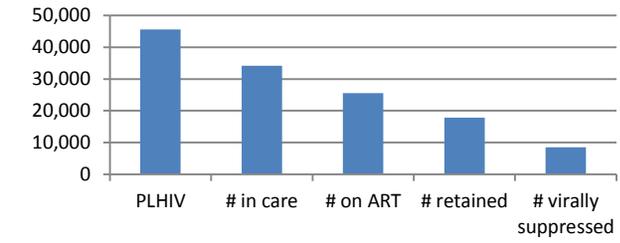


SUSTAINABILITY DOMAINS and ELEMENTS

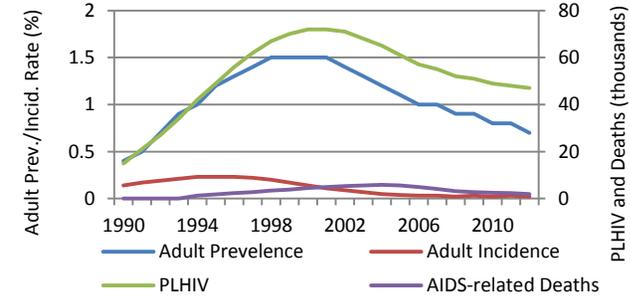
Category	Element	Score
<b>Institutionalized Data Availability</b>	1. Epidemiological and Health Data	10.6
	2. Financial/Expenditure Data	2.3
	3. Performance Data	14.0
<b>Domestic Program and Service Delivery</b>	4. Access and Demand	10.8
	5. Human Resources for Health	7.5
	6. Commodity Security and Supply Chain	11.2
	7. Quality Management	15.2
<b>Health Financing and Strategic Investments</b>	8. DRM: Resource Generation	10.0
	9. DRM: Resource Commitments	12.0
	10. Allocative Efficiency	11.0
	11. Technical Efficiency	18.8
<b>Accountability and Transparency</b>	12. Public Access to Information	10.0
	13. Oversight and Stewardship	15.5
<b>Enabling Environment</b>	14. Policies, Laws, and Regulations	10.0
	15. Planning and Coordination	13.0

## CONTEXTUAL DATA

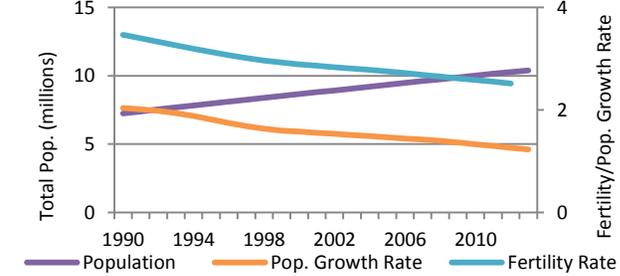
### Care and Treatment Cascade



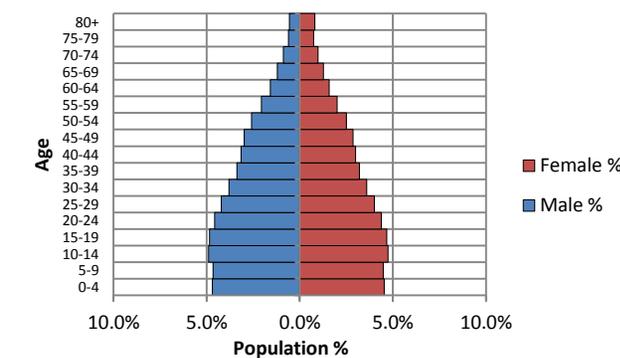
### Epidemiological Data



### Population and Fertility

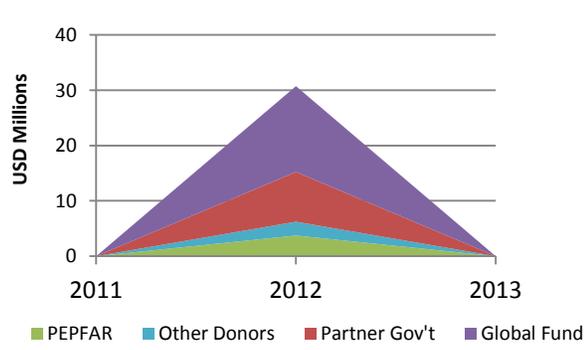


### Population Pyramid (2014)

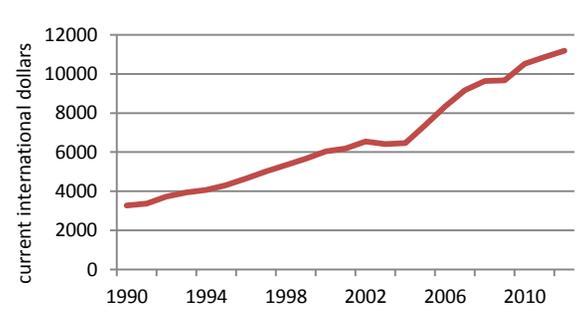


CONTEXTUAL DATA

### Financing the HIV Response



### GNI Per Capita (PPP)



## Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

			Source of data	Notes/Comments
<p><b>1. Epidemiological and Health data:</b> Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.</p>				
<p><b>Q1. Who leads:</b> Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?</p>	<p><input checked="" type="radio"/> A. Host Country Government/other domestic institution</p> <p><input type="radio"/> B. External agency with host country government</p> <p><input type="radio"/> C. External agency, organization or institution</p> <p><input type="radio"/> D. Not conducted</p>	4.5	<p>DHS/2002, 2007, 2013. MOH Sentinel Surveillance Surveys, 1991-2009.; Behavior Surveillance Surveys (BSS) 2008, 2012. Minutes from survey planning meetings (MOH, National AIDS Council)</p>	
<p><b>Q2. Who finances:</b> Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?</p>	<p><input type="radio"/> A. 80-100% of the total cost of latest survey was financed by Host Country Government</p> <p><input type="radio"/> B. 60-79% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> C. 40-59% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> D. 20-39% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> E. 10-19% of the total cost of latest survey financed by Host Country Government</p> <p><input checked="" type="radio"/> F. 0-9% of the total cost of latest survey financed by Host Country Government</p>	0	<p>DHS/2013 budget, MOH. BSS 2012 budget, National AIDS Council</p>	
<p><b>Q3. Comprehensiveness of Prevalence and Incidence Data:</b> Does Host Country Government collect HIV prevalence and or incidence data?</p>	<p><input type="radio"/> No, the government does not collect HIV prevalence or incidence data</p> <p><input checked="" type="radio"/> Yes, the government collects (check all that apply):</p> <p><input checked="" type="checkbox"/> A. HIV prevalence</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data analyzed for trends</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data made publicly available</p> <p><input type="checkbox"/> B. HIV incidence</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input type="checkbox"/> Data analyzed for trends</p>	2.5	<p>DHS/2002, 2007, 2013. MOH Sentinel Surveillance Surveys/1991-2009 BSS/2008,2012 Reports from PMTCT Program; National HIV estimations and projections</p>	<p>the surveys do not report samples by age, even though age data are collected. PMTCT data are not collected on children &gt;18 months.</p>

	<input type="checkbox"/> Data made publicly available			
<b>Q4. Comprehensiveness of Viral Load Data:</b> Does Host Country Government collect viral load data?	<input type="radio"/> No, the government does not collect viral load data <input checked="" type="radio"/> Yes, the government collects viral load data (check all that apply): <input checked="" type="checkbox"/> Collected by age <input checked="" type="checkbox"/> Collected for children <input checked="" type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input type="checkbox"/> Sub-national data <input checked="" type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed to understand trends	2.4	National Laboratory data base; electronic Patient Information System reports	
<b>Q5. Key Populations:</b> Does the Host Country Government conduct size estimation studies for key populations?	<input type="radio"/> No, the host country government does not conduct size estimation studies for key populations <input checked="" type="radio"/> Yes, the government conducts key population size estimates (check all that apply): <input checked="" type="checkbox"/> Men who have sex with men (MSM) <input checked="" type="checkbox"/> Female sex workers <input checked="" type="checkbox"/> Transgender <input type="checkbox"/> People who inject drugs (PWID) <input type="checkbox"/> Government finances at least 50% of the size estimation studies <input type="checkbox"/> Government leads and manages the size estimation studies	1.2	Report on Key Populations/2014, National AIDS Council; PLACE survey/2013, implemented by NGOs and the MOH; Report on MSM Populations/2010, ASA and the National AIDS Council	

**Epidemiological and Health Data Score:** 10.6

<b>2. Financial/Expenditure data:</b> Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.		Source of data	Notes/Comments
<b>Q1. Expenditure Tracking:</b> Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	<input checked="" type="radio"/> No, it does not have a national HIV/AIDS expenditure tracking system <input type="radio"/> Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): <input type="checkbox"/> A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input type="checkbox"/> B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening <input type="checkbox"/> C. Collected sub-nationally <input type="checkbox"/> D. Collected annually <input type="checkbox"/> E. Data is made publicly available	MEGAS expenditure studies (2008, 2012)	the NR does not have an expenditure tracking system. The MEGAS studies are retrospective studies, done and published a couple of years after the target year.

<p><b>Q2. Quality of Expenditure Tracking:</b> Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others:</p>	<p><input checked="" type="radio"/> No, they are not using any international standards for tracking expenditures</p> <p><input type="radio"/> Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.</p>	0	NA - there are no data sources for this item.	Measurement of expenditures are done through MEGAS studies (AIDS Expenditure studies), 2008 y 2012. Also each project (PEPFAR, Global Fund, UNAIDS) maintain their own expenditure tracking systems.
<p><b>Q3. Transparency of Expenditure Data:</b> Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?</p>	<p><input type="radio"/> No, they do not make expenditure data available to the public</p> <p>Yes, check the one that applies:</p> <p><input type="radio"/> A. Annually</p> <p><input type="radio"/> B. Bi-annually</p> <p><input checked="" type="radio"/> C. Every three or more years</p>	1	Various financial reports: Global Fund, PEPFAR, UNAIDS, others.	this will require follow on analysis
<p><b>Q4. Economic Studies:</b> Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?</p>	<p><input type="radio"/> No, they are not conducting special health economic studies for HIV/AIDS</p> <p><input checked="" type="radio"/> Yes, check all that apply:</p> <p><input checked="" type="checkbox"/> A. Costing studies or analyses</p> <p><input type="checkbox"/> B. Cost-effectiveness studies or analyses</p> <p><input type="checkbox"/> C. Efficiency studies or analyses</p> <p><input type="checkbox"/> D. Cost-benefit studies or analyses</p>	1.25	Studies done by National AIDS Council, World Bank, others; Also Costing studies of NAC and UNAIDS	

**Financial/Expenditure Data Score:**

**2.25**

<p><b>3. Performance data:</b> Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.</p>		Source of data	Notes/Comments
<p><b>Q1. Collection of service delivery data:</b> Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?</p>	<p><input type="radio"/> No, the government does not have an HIV/AIDS service delivery data collection system</p> <p><input checked="" type="radio"/> Yes, service delivery data are collected/reported for (check all that apply):</p> <p><input checked="" type="checkbox"/> A. For HIV Testing</p> <p><input checked="" type="checkbox"/> B. For PMTCT</p> <p><input checked="" type="checkbox"/> C. For Adult Care and Support</p> <p><input checked="" type="checkbox"/> D. For Adult Treatment</p> <p><input checked="" type="checkbox"/> E. For Pediatric Care and Support</p> <p><input checked="" type="checkbox"/> F. For Pediatric Treatment</p> <p><input checked="" type="checkbox"/> G. For AIDS-related mortality</p>	7	HIV/AIDS service delivery HMIS policy/SOP and latest report citation: Reports from the NAC and MOH; Reports from the National Service Network (REDES) and the electronic Patient Information System; data base on death certifications, MOH/Statistics
<p><b>Q2. Analysis of service delivery data:</b> Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?</p>	<p><input type="radio"/> No, the government does not routinely analyze service delivery data to measure performance</p> <p><input checked="" type="radio"/> Yes, service delivery data are being analyzed to measure (check all that apply):</p> <p><input checked="" type="checkbox"/> A. Continuum of care cascade, including testing, care, treatment, retention and adherence</p> <p><input type="checkbox"/> B. Results against targets</p> <p><input checked="" type="checkbox"/> C. Coverage</p>	3	Reports from electronic Patient Information System and MOH/REDES; Productivity Reports, REDES

	<input checked="" type="checkbox"/> D. Site specific yield for HIV testing (HTC and or PMTCT) <input type="checkbox"/> E. AIDS-related death rates			
<b>Q3. Comprehensiveness of service delivery data:</b> Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?	<input type="radio"/> No <input checked="" type="radio"/> Yes, service delivery data are being: (check all that apply): <input checked="" type="checkbox"/> A. Collected at least quarterly <input checked="" type="checkbox"/> B. Collected by age <input checked="" type="checkbox"/> C. Collected by sex <input checked="" type="checkbox"/> D. Collected from all clinical sites <input type="checkbox"/> E. Collected from all community sites <input type="checkbox"/> F. Data quality checks are conducted at least once a year	4	Reports from electronic Patient Information System, MOH/REDES	
<b>Q4. Transparency of service delivery data:</b> Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?	<input checked="" type="radio"/> No, they do not make program performance data available to the public Yes, check the one that applies: <input type="radio"/> A. At least annually <input type="radio"/> B. Bi-annually <input type="radio"/> C. Every three or more years	0	HCG does not publish a formal annual report of program performance and service data.	MOH- published "Memorias" include a summary of major accomplishments in HIV/AIDS each year.
<b>Performance Data Score:</b>		<b>14</b>		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

## Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIV/AIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

<b>4. Access and Demand:</b> There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.		Source of data	Notes/Comments
<p><b>Q1. Access to ART:</b> What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing ART.</p>	<p>Q1 Score: 4</p>	<p>DHS/2013; MOH electronic Patient Information System/2014</p>
<p><b>Q2. Access to PMTCT:</b> What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?</p>	<p><input checked="" type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.</p>	<p>Q2 Score: 0</p>	<p>National Strategic Plan for the Elimination of Mother-child HIV Transmission</p>
<p><b>Q3. Who is delivering HIV/AIDS services:</b> What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input checked="" type="radio"/> B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p>	<p>Q3 Score: 2</p>	<p>MOH electronic Patient Information System/2014</p> <p>There are 76 HIV treatment sites in the MOH system</p>
<p><b>Q4. Access to ART:</b> What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input checked="" type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p>	<p>Q4 Score: 0</p>	<p>The electronic Patient Information System does not register patients by KP/non-KP.</p>

<p><b>Q4. Services to key populations:</b> What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p>		<p>or other similar category.</p>	
<p><b>Q5. Uptake of services:</b> What percent of PLHIV are currently receiving ART? _____%</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of PLHIV are currently receiving ART</p> <p><input checked="" type="radio"/> B. 50-79% of PLHIV are currently receiving ART</p> <p><input type="radio"/> C. 20-49% of PLHIV are currently receiving ART</p> <p><input type="radio"/> D. Less than 20% of PLHIV are currently receiving ART</p>	<p>Q5 Score 3</p>	<p>DHS/2013, MOH electronic Patient Information System. The denominator used comes from the Spectrum 2014 modeling of total PLHIV, which is 44,254.</p>	<p>77.4% is the result, using the Spectrum model of total PLHIV. However, PEPFAR believes that DHS/2013 data are more accurate, which gives a total of 59,704. the resulting percentage would then be 43% in ART. The GODR accepts the Spectrum number.</p>
<p><b>Q6. Rights to Access Services:</b> Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations.</p> <p><input checked="" type="radio"/> Yes, there are efforts by the government (check all that apply):</p> <p><input checked="" type="checkbox"/> educates PLHIV about their legal rights in terms of access to HIV services</p> <p><input type="checkbox"/> educates key populations about their legal rights in terms of access to</p> <p><input type="checkbox"/> National policy exists for de-stigmatization in the context of HIV/AIDS</p> <p><input checked="" type="checkbox"/> national law exists regarding health care privacy and confidentiality protections</p> <p><input checked="" type="checkbox"/> government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>Q6 Score 1.8</p>	<p>Revised AIDS Law no. 135-11; Data from Labor Technical Unit (UNIDAD TECNICA LABORAL), Ministry of Labor</p>	

Access and Demand Score

10.8

<p><b>5. Human Resources for Health:</b> HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.</p>	<p>Source of data</p>	<p>Notes/Comments</p>
<p>Check the one answer that best describes the current situation:</p>	<p>Q1 Score: 0</p>	<p>Data Sources include the MOH electronic Patient Information System and directly from The service staff in the</p>

<p><b>Q1. HRH Sufficiency:</b> Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?</p>	<p><input type="radio"/> This information is not available</p> <p><input checked="" type="radio"/> A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand</p> <p><input type="radio"/> B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply)</p> <p><input type="checkbox"/> HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand</p> <p><input type="checkbox"/> HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites</p>		<p>the treatment units themselves. MOH HR information system doesn't yet produce reports on the sufficiency of current staff to meet the service delivery needs.</p>	<p>MOH system are trained, but there are insufficient numbers to effectively attend the high demand for services.</p>
<p><b>Q2. HRH Transition:</b> What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input type="radio"/> B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date</p> <p><input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date.</p> <p><input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input checked="" type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p>	<p>Q2 Score: 3</p>	<p>MOH payroll records; PEPFAR agency records</p>	<p>All HIV health workers already are financed locally, either by the payroll of the MOH or an NGO payroll system.</p>
<p><b>Q3. HRH Financial reform:</b> Has financial reform been undertaken in the last 5 years to address government financing of health workers?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. No financial reform has been undertaken in the last 5 years to address government financing of health workers</p> <p><input type="radio"/> B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply):</p> <p><input type="checkbox"/> Wage reform to increase salaries and or benefits of health workers</p> <p><input type="checkbox"/> Increase in budget allocation for salaries for health workers</p>	<p>Q3 Score: 0</p>	<p>there is no data source for this item.</p>	<p>the discussion group agreed that this is a "no"</p>
	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p>	<p>Q4 Score: 0</p>	<p>Website of the Ministry of Higher Education, Science and Technology</p>	

<p><b>Q4. Pre-Service:</b> Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</p>	<p><input type="checkbox"/> content updated for all HIV/AIDS services</p> <p><input type="checkbox"/> updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input type="checkbox"/> updated curriculum is problem based/competency based</p> <p><input type="checkbox"/> updated curriculum includes practicums at high volume clinical/ social services sites</p> <p><input type="checkbox"/> institutions that track students after graduation</p>			
<p><b>Q5. In-Service:</b> To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training.</p> <p><input type="radio"/> B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented.</p> <p><input type="radio"/> C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date.</p> <p><input checked="" type="radio"/> D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.</p>	<p>Q5 Score: 0</p>	<p>there is no data source for this item. The response reflects the consensus of the discussion group.</p>	
<p><b>Q6. HRIS:</b> Does the government have a functional Human Resource Information System (HRIS) for the health sector?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No, there is no HRIS</p> <p><input checked="" type="radio"/> B. Yes, the government does have a HRIS (check all that apply)</p> <p><input checked="" type="checkbox"/> The HRIS is primarily funded by host country institutions</p> <p><input type="checkbox"/> There is a national interoperability strategy for the HRIS</p> <p><input type="checkbox"/> The government produces HR data from the HRIS at least annually</p> <p><input type="checkbox"/> The government uses data from the HRIS for HR planning and management</p>	<p>Q6 Score: 0.5</p>	<p>MOH HR INFORMATION SYSTEM</p>	<p>An MOH HR information system exists, but it does not offer the kind of information for effective allocation of staff to the need for HIV services. the MOH is in an implementation phase, and the group believes that in the future this system will be more functional.</p>
<p><b>Q7. Domestic funding for HRH:</b> What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. Less than 20%</p> <p><input type="radio"/> B. 20-49%</p> <p><input type="radio"/> C. 50-79%</p> <p><input checked="" type="radio"/> D. 80% or more</p>	<p>Q7 Score: 4</p>	<p>MOH PAYROLL Records</p>	
<p><b>Human Resources for Health Score</b></p>			<p><b>7.5</b></p>	

6. <b>Commodity Security and Supply Chain:</b> The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.		Source of data	Notes/Comments
<b>Q1. ARV domestic financing:</b> What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input checked="" type="radio"/> D. 80% or more obligated from domestic public sources	Q1 Score: 3	MOH BUDGET ; ALLOTMENTS FROM MINISTRY OF TREASURY; reports from pepfar TA in the Supply chain Management system (called SIAPS). Also, the "Analysis of Historical Consumption and Current Inventories (MOH/SUGEMI, 2014)" the DR currently procures 100% of ARVs for the NR.
<b>Q2. Test Kit domestic financing:</b> What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input checked="" type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input type="radio"/> D. 80% or more obligated from domestic public sources	Q2 Score: 0	MOH BUDGET MOH Regional Health Services have their own budgets for rapid tests
<b>Q3. Condom domestic financing:</b> What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input checked="" type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input type="radio"/> D. 80% or more obligated from domestic public sources	Q3 Score: 0	Reports from Principal Recipients of the GLOBAL FUND PROJECTS PEPFAR has donated up to 15 million condoms per year, through partner lms
<b>Q4. Supply Chain Plan:</b> Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?	<input type="radio"/> A. No, there is no plan or thoroughly annually reviewed supply chain SOP <input checked="" type="radio"/> B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) <input checked="" type="checkbox"/> Human resources <input checked="" type="checkbox"/> Training <input checked="" type="checkbox"/> Warehousing <input checked="" type="checkbox"/> Distribution <input type="checkbox"/> Reverse Logistics <input type="checkbox"/> Waste management <input type="checkbox"/> Information system <input type="checkbox"/> Procurement <input type="checkbox"/> Forecasting <input type="checkbox"/> Supply planning and supervision	Q4 Score: 2.2	MOH "PROVISION OF ESSENTIAL MEDICINES;" MOH/ SUGEMI website INFORMATION PAGE SUGEMI is the Spanish acronym for the MOH's "Unique Management System for the Provision of Medicines"

<p><b>Q5. Stock:</b> Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?</p>	<p><input type="radio"/> A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time</p> <p><input checked="" type="radio"/> B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time</p> <p><input checked="" type="checkbox"/> Both public and (if they exist in the country) private storage facilities at central level</p> <p><input checked="" type="checkbox"/> Both public and (if they exist in the country) private storage facilities at intermediate level</p>	<p>Q5 Score: 3</p>	<p>MOH/SUGEMI QUARTERLY BULLETIN</p>		
<p><b>Q6. Assessment:</b> Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment?</p> <p>(If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)</p>	<p><input type="radio"/> A. No assessment has been conducted nor do they have a system to oversee the supply chain</p> <p><input type="radio"/> B. Yes, an assessment was conducted but they received below 80%</p> <p><input checked="" type="radio"/> C. No assessment was conducted, but they have a system to oversee the supply chain that reviews:</p> <p><input checked="" type="checkbox"/> Commodity requirements</p> <p><input checked="" type="checkbox"/> Commodity consumption</p> <p><input checked="" type="checkbox"/> Coordinates procurements</p> <p><input checked="" type="checkbox"/> Delivery schedules</p> <p><input type="radio"/> D. Yes, an assessment was conducted and they received a score that was 80% or higher</p>	<p>Q6 Score: 3</p>	<p>MOH/SUGEMI Quarterly Bulletin, MOH Procedures Manuals, SUGEMI records</p>		
<b>Commodity Security and Supply Chain Score</b>		<b>11.2</b>			
<p><b>7. Quality Management:</b> Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.</p>			<b>Source of data</b>	<b>Notes/Comments</b>	
<p><b>Q1. Existence of System:</b> Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?</p>	<p><input type="radio"/> A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH</p> <p><input checked="" type="radio"/> Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply):</p> <p><input checked="" type="checkbox"/> Routinely reviews national HIV/AIDS performance and clinical outcome data</p> <p><input checked="" type="checkbox"/> Routinely reviews district/regional HIV/AIDS performance and clinical outcome data</p> <p><input checked="" type="checkbox"/> Prioritizes areas for improvement</p>	<p>Q1 Score: 4</p>	<p>MOH electronic Patient Information System; MOH Guides for Attention to HIV Patients</p>		

<p><b>Q2. Strategy:</b> Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?</p>	<p><input checked="" type="radio"/> No, there is no HIV/AIDS-related QM/QI strategy</p> <p><input type="radio"/> B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years)</p> <p><input type="radio"/> C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements</p> <p><input type="radio"/> D. Yes, there is a current HIV/AIDS program specific QM/QI strategy</p>	<p>Q2 Score: 0</p>	<p>the group could find no data sources to justify a "yes" response in this item.</p>		
<p><b>Q3. Guidelines:</b> Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?</p>	<p><input type="radio"/> A. No, the national practice does not follow current WHO guidelines for PMTCT or ART</p> <p><input checked="" type="radio"/> B. Yes, the national practice does follow current WHO guidelines for:</p> <p><input checked="" type="checkbox"/> PMTCT (option B+)</p> <p><input checked="" type="checkbox"/> Adult ART</p> <p><input checked="" type="checkbox"/> Pediatric ART</p> <p><input checked="" type="checkbox"/> Adolescent ART</p> <p><input type="checkbox"/> Test and treat for specific populations</p>	<p>Q3 Score: 3.2</p>	<p>Guidelines on HIV Targets [90-90-90 strategy] (WHO, 2014); National Guidelines for Attention to vulnerable boys, girls, and adolescents; National Strategic Plan for reduction of Mother-to-Child HIV Transmission</p>	<p>the National Guidelines on vulnerable boys, girls and adolescents, is based on WHO guidelines, but varies in accordance with Dominican realities.</p>	
<p><b>Q4. QI Data use:</b> Does the host country government monitor and use data for HIV/AIDS quality improvement?</p>	<p><input type="radio"/> A. No, there is no monitoring for HIV/AIDS quality improvement</p> <p><input checked="" type="radio"/> B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes:</p> <p><input checked="" type="checkbox"/> All sites</p> <p><input checked="" type="checkbox"/> Use of data to determine quality of program or services</p> <p><input checked="" type="checkbox"/> Making recommendations and action plan for mid-course corrections</p>	<p>Q4 Score: 4</p>	<p>MOH National Norms for the Management of HIV/AIDS Infections (2013); MOH electronic Patient Information System; para el manejo para las infecciones VIH/SIDA 2013</p>		
<p><b>Q5. Post-transition:</b> Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?</p>	<p><input type="radio"/> A. No, there is no quality monitoring at sites post-transition</p> <p><input type="radio"/> B. Yes, there is quality monitoring at transition sites. Monitoring includes:</p> <p><input type="checkbox"/> All transition sites</p> <p><input type="checkbox"/> Review of service outcomes</p> <p><input type="checkbox"/> Client feedback on changes in quality</p> <p><input type="checkbox"/> Quality improvement action plan</p> <p><input checked="" type="radio"/> C. PEPFAR/other donors have never supported direct service delivery in the country</p>	<p>Q5 Score: 4</p>	<p>Memorias (annual report on achievements)/National AIDS Council</p>	<p>As of the COP 2015, PEPFAR does not have experience in transitioning out of sites. This is programmed for FY 2016 activities.</p>	
<p><b>Quality Management Score</b></p>			<p><b>15.2</b></p>		

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

## Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

<b>8. Domestic Resource Mobilization: Resource Generation:</b> The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.		<b>Source of data</b>	<b>Notes/Comments</b>
<b>Q1. Domestic budget:</b> Is there a budget line item for HIV/AIDS in the national budget?	<input type="radio"/> A. No, there is no budget line item for HIV/AIDS in the national budget <input checked="" type="radio"/> B. Yes, there is an HIV/AIDS budget line item under the Health budget <input type="radio"/> C. Yes, there is an HIV/AIDS program-based budget across ministries <input type="radio"/> D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 3	Annual Operations Plan and Plan for Programmatic Structure, MOH/Vice Ministry for Collective Health;
<b>Q2. Budgetary Framework:</b> Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program <input type="radio"/> C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 3	National budget; National Development Strategy  <small>Confusing terminology for the group. DR works by fiscal year and based on historical expenditures (quarterly). For the DR Mid term is 1 year with quarterly revisions. Group feels need clarification around budget exercise. If NO mid term N/A applies; if based on DR reality YES applies.</small>
<b>Q3. Fiscal Policy:</b> Does the country pass the MCC scorecard indicator for fiscal policy? <small>(Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)</small>	<input checked="" type="radio"/> Yes  <input type="radio"/> No	Q3 Score: 4	OGAC-provided data sheet (follows tab E)  derived from: <a href="http://www.mcc.gov/pages/election/scorecards">http://www.mcc.gov/pages/election/scorecards</a>
<b>Q4. Domestic public revenue:</b> What was annual domestic government revenue as a percent of	Check the appropriate box for your country's income category: <u>FOR LOW INCOME</u> <input type="radio"/> A. More than 16.4% (i.e. surpasses category mean) <input type="radio"/> B. 14.8%-16.4%, (i.e. 90-100% of category mean) <input type="radio"/> C. Less than 14.8%, (less than 90% of category mean)  <u>FOR LOW MIDDLE INCOME</u>	Q4 Score: 0	OGAC-provided data sheet (follows tab E)  Original Source: IMF Government Finance Statistics

<p>GDP in the most recent year available? (domestic revenue excludes external grants)</p>	<p><input type="radio"/> D. More than 22.3% (i.e. surpasses category mean)</p> <p><input type="radio"/> E. 20.1-22.3% (i.e. 90-100% of category mean)</p> <p><input type="radio"/> F. Less than 20.1% (less than 90% of category mean)</p> <p><b>FOR UPPER MIDDLE INCOME</b></p> <p><input type="radio"/> G. More than 27.8% (i.e. surpasses category mean)</p> <p><input type="radio"/> H. 25.0%-27.8% (i.e. 90-100% of category mean)</p> <p><input checked="" type="radio"/> I. Less than 25.0% (less than 90% of category mean)</p>			
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**Score for Domestic Resource Mobilization: Resource Generation: 10**

<p><b>9. Domestic Resource Mobilization: Resource Commitments:</b> Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.</p>		<p><b>Source of data</b></p>	<p><b>Notes/Comments</b></p>
<p><b>Q1. Benchmarks for health spending:</b></p> <p><b>African countries:</b> Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)?</p> <p><b>Non-African countries:</b> Is government health expenditure at least 3 percent of GDP?</p>	<p><input checked="" type="radio"/> A. Yes</p> <p><input type="radio"/> B. No</p>	<p>Q1 Score: 5</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Dominican Economic Report (Jan-June 2013), Central Bank, (p. 17) shows 6.1%</p> <p>S/GAC provided number of 2.8% is different from that provided by the DR Central Bank 6.1%</p>
<p><b>Q2. Domestic spending:</b> What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%</p>	<p><input type="radio"/> A. Less than 10%</p> <p><input type="radio"/> B. 10-24%</p> <p><input checked="" type="radio"/> C. 25-49%</p> <p><input type="radio"/> D. 50-74%</p> <p><input type="radio"/> E. 75% or Greater</p>	<p>Q2 Score: 5</p>	<p>NASA or NHA data: MEGAS 2012, table p. 21</p> <p>MEGAS report does not take into account the entire PEPFAR expenditure in 2012. it lists \$ 4.37 million vs. PEPFAR's own calculation of \$18.8 million (making o-o-p exps 19%)</p>
	<p><input type="radio"/> A. None or information is not available</p> <p><input type="radio"/> B. 1-9%</p>	<p>Q3 Score: 2</p>	<p>MEGAS 2012 pag 41;</p> <p>ALL AGREE</p>

<p><b>Q3. Key population spending:</b> What percent of key population-specific interventions are financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?</p>	<p><input checked="" type="radio"/> 10-24%</p> <p><input type="radio"/> 25-49%</p> <p><input type="radio"/> 50-74%</p> <p><input type="radio"/> 75% or Greater</p>			
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**Score for Domestic Resource Mobilization: Resource Commitments: 12**



<p><b>10. Allocative Efficiency:</b> The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).</p>	<p><b>Source of data</b></p>	<p><b>Notes/Comments</b></p>		
<p><b>Q1. Data-driven allocation:</b> Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?</p>	<p><input type="radio"/> A. No, data are not used annually</p> <p><input checked="" type="radio"/> B. Yes, data are used annually. Check all that apply:</p> <p><input checked="" type="checkbox"/> Epidemiological data are used</p> <p><input checked="" type="checkbox"/> Health/service delivery data are used</p> <p><input checked="" type="checkbox"/> Financial data are used</p> <p><input checked="" type="checkbox"/> There is integrated analysis across data streams</p> <p><input checked="" type="checkbox"/> Multiple data streams are used to model scenarios</p>	<p>Q1 Score: 10</p>	<p>National Strategic Plan(2015-20), ENDESA, current and previous MultiAnnual Plan</p>	<p>ALL AGREE</p>
<p><b>Q2. Geographic allocation:</b> Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?</p>	<p><input checked="" type="radio"/> A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites</p> <p><input type="radio"/> B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input type="radio"/> D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p>	<p>Q2 Score: 0</p>	<p>National Strategic Plan(2015-20), DHS/2013, current and previous MultiAnnual Plan</p>	<p>MOH focus and priority have been national coverage, regardless of yield or burden.</p>

	<input type="radio"/> E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients			
<b>Q3. Data driven reprogramming:</b> Do host country government policies/systems allow for reprogramming investments based on new or updated program data during the government funding cycle?	<input type="radio"/> A. No, there is no system for funding cycle reprogramming <input checked="" type="radio"/> B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used <input type="radio"/> C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data <input type="radio"/> D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 1	National Development Strategic Plan, current and previous MultiAnnualPlans	With more detailed data, NR is moving in the direction of implementing a data-based reprogramming system.
<b>Allocative Efficiency Score:</b>		<b>11</b>		

<b>11. Technical Efficiency:</b> Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.		Source of data	Notes/Comments
<b>Q1. Unit costs:</b> Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services?  (note: full score of five points can be achieved without checking all disaggregate boxes).	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes (check all that apply): <input checked="" type="checkbox"/> Annually <input checked="" type="checkbox"/> For HIV Testing <input checked="" type="checkbox"/> For Care and Support <input checked="" type="checkbox"/> For ART <input checked="" type="checkbox"/> For PMTCT <input type="checkbox"/> For VMMC <input type="checkbox"/> For OVC Service Package <input type="checkbox"/> For Key population Interventions	Q1 Score: 4.25  National Budget, DHS/2013, updated HIV/AIDS Strategic Plan (2014), Global Fund Concept Note	Key pop until now included in Gen pop

<p><b>Q2. Improving efficiency:</b> Which of the following actions is the Host Country Government taking to improve technical efficiencies?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Using findings from cost-effectiveness or efficiency studies to modify operations or interventions</li> <li><input checked="" type="checkbox"/> Streamlining management to reduce overhead costs</li> <li><input checked="" type="checkbox"/> Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling</li> <li><input checked="" type="checkbox"/> Improving procurement competition</li> <li><input checked="" type="checkbox"/> Integration of HIV/AIDS into national or subnational insurance schemes (private or public)</li> <li><input checked="" type="checkbox"/> Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact</li> <li><input checked="" type="checkbox"/> Geographic targeting in high burden/high yield sites to increase impact</li> <li><input checked="" type="checkbox"/> Analysis of expenditure data to establish appropriate range of unit costs</li> </ul>	<p>Q2 Score: 3.5</p>	<p>NO data sources exist for this item</p>	
<p><b>Q3. Loss ratio:</b> Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>Q3 Score: 3</p>	<p>MEGAS 2012 (page 25) For Global Fund reporting</p>	
<p><b>Q4. Benchmark prices:</b> Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?</p>	<p>Check boxes that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> They are not paying for any ARVs</li> <li><input type="checkbox"/> They are not paying for any test kits</li> <li><input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for first line ARVs</li> <li><input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for test kits</li> </ul>	<p>Q4 Score: 4</p>	<p><a href="http://apps.who.int/hiv/amds/price/hdd/Default.aspx">http://apps.who.int/hiv/amds/price/hdd/Default.aspx</a> <a href="#">Procurement records (Supply Chain Management Procurement)</a></p>	<p>Group needs to Check with CONAVIHSIDA (NAC), which procures ARVs and test kits</p>
<p><b>Q5. ART unit costs:</b> Have average unit costs for providing ART in the country reduced within the last two years?</p> <p>Unit cost 2 years ago: \$ 371 (2011)</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>Q5 Score: 4</p>	<p><a href="#">WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/; SIAPS report</a></p>	<p>Price difference for first-line treatment is from 2011 and 2014</p>

Current unit cost: \$ 164_(2014)			
Technical Efficiency Score:			18.75

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

## Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. <b>Public Access to Information:</b> Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.	Source of data	Notes/Comments
<p><b>Q1. OBI:</b> What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)</p>	<ul style="list-style-type: none"> <li><input type="radio"/> A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10)</li> <li><input type="radio"/> B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10)</li> <li><input checked="" type="radio"/> C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10)</li> <li><input type="radio"/> D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10)</li> <li><input type="radio"/> E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10)</li> <li><input type="radio"/> F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget</li> </ul>	<p>Q1 Score: 6.0</p> <p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Open Budget Index (<a href="http://survey.internationalbudget.org/">http://survey.internationalbudget.org/</a>) and PEFA data (<a href="http://www.pefa.org">www.pefa.org</a>)</p>
<p><b>Q2. National program report transparency:</b> Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?</p>	<ul style="list-style-type: none"> <li><input type="radio"/> A. No, the national HIV/AIDS program progress report or presentation of results is not made public</li> <li><input checked="" type="radio"/> B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply):                             <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> On Website</li> <li><input type="checkbox"/> Through any type of media</li> <li><input checked="" type="checkbox"/> Disseminate print report or presentation of results</li> </ul> </li> </ul>	<p>Q2 Score: 4.0</p> <p>Reporte 2013 para UNGASS. Memorias Anuales del CONAVIHSIDA .</p>
<p><b>Q3. Audit transparency:</b> Is an audit of the National HIV/AIDS program conducted and the audit report is made available publically?</p>	<ul style="list-style-type: none"> <li><input checked="" type="radio"/> A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically</li> </ul>	<p>Q3 Score: 0.0</p> <p>Se hacen auditorias por entes financiadoras de la Respuesta Nacional</p>

<p><b>Q3. Audit transparency:</b> Does the host country government make an annual national HIV/AIDS program audit report publically available?</p>	<p><input type="radio"/> B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply:</p> <p><input type="checkbox"/> On website</p> <p><input type="checkbox"/> Through any type of media</p> <p><input type="checkbox"/> Disseminate print report</p>		<p>a sus receptores, la cuales estan divulgadas, no obstante, no se una auditoria integrada de la Respuesta Nacional. Hay infomacion disponible en Cuentas</p>	
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**Public Access to Information Score: 10**

<p><b>13. Oversight and Stewardship:</b> Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.</p>		<p><b>Source of data</b></p>	<p><b>Notes/Comments</b></p>	
<p><b>Q1. Availability of Information on Resources Received by Service Delivery Units.</b> PEFA score on PI-23 was C or higher in most recent assessment.</p>	<p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input type="radio"/> B. PEFA was conducted and score was below C</p> <p><input type="radio"/> C. PEFA was conducted and score was C</p> <p><input checked="" type="radio"/> D. PEFA was conducted and score was B</p> <p><input type="radio"/> E. PEFA was conducted and score was A</p>	<p>Q1 Score: 3.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>	
<p><b>Q2. Quality and timeliness of annual financial statements.</b> PEFA score for element PI-25 was C or higher in most recent assessment.</p> <p>Actual scores are ____</p>	<p>Check A or B; if B checked, select appropriate disaggregates:</p> <p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input checked="" type="radio"/> B. PEFA was conducted and score was C or higher for:</p> <p><input checked="" type="checkbox"/> (i) Completeness of the financial statements</p> <p><input type="checkbox"/> (ii) Timeliness of submission of the financial statements</p> <p><input type="checkbox"/> (iii) Accounting standards used</p>	<p>Q2 Score: 3.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>	
	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p>		<p>Reporte de UNGASS, Memoria de</p>	

<p><b>Q3. Government Channels and Opportunities for Civil Society Engagement:</b> Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p>	<p> <input type="radio"/> A. No, there are no formal channels or opportunities  <input type="radio"/> B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback  <input checked="" type="radio"/> C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply: </p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> During strategic and annual planning</li> <li><input checked="" type="checkbox"/> In joint annual program reviews</li> <li><input checked="" type="checkbox"/> For policy development</li> <li><input type="checkbox"/> As members of technical working groups</li> <li><input checked="" type="checkbox"/> Involvement on evaluation teams</li> <li><input checked="" type="checkbox"/> Giving feedback through social media</li> <li><input checked="" type="checkbox"/> Involvement in surveys/studies</li> <li><input checked="" type="checkbox"/> Collecting and reporting on client feedback</li> </ul>	<p>Q3 Score: 5.5</p>	<p>CONAVIHSIDA, Diferentes estudios y encuestas publicadas en sitio Web de CONAVIHSIDA</p>	
<p><b>Q4. Civil society Enabling Environment:</b> What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society?</p> <p>If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?</p>	<p> <input type="radio"/> A. EEI score of 0-0.38; or if no EEI score, there are laws or polices that restrict civil society playing an oversight role  <input type="radio"/> B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government  <input checked="" type="radio"/> C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight </p>	<p>Q4 Score: 4.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Civicus Enabling Environment Index (<a href="http://civicus.org/eei/">civicus.org/eei/</a>)</p>	<p>The score was .51</p>
<p><b>Oversight and Stewardship Score: 15.5</b></p>				

**THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN**

## Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

**14. Policies, Laws, and Regulations:** Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.

		<b>Source of data</b>	<b>Notes/Comments</b>
<p><b>Q1. Structural obstacles:</b> Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?</p>	<p><input type="radio"/> A. No, there are no such laws or policies</p> <p><input checked="" type="radio"/> B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score):</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Criminalization of HIV transmission</li> <li><input checked="" type="checkbox"/> HIV testing disclosure policies or age requirements</li> <li><input checked="" type="checkbox"/> Non-disclosure of HIV status laws</li> <li><input type="checkbox"/> Anti-homosexuality laws</li> <li><input type="checkbox"/> Anti-prostitution legislation</li> <li><input checked="" type="checkbox"/> Laws that criminalize drug use, methadone use or needle exchange</li> </ul>	<p>Q1 Score: 2.0</p>	<p>Laws exist which penalize pimping and trafficking in persons, especially women, but not commercial sex work. However, there have been violations of the rights in cases of CSW, for example, police raids. In the case of MSM, there are no laws which specifically protect and guarantee their rights. Documents include: the revised AIDS Law no. 135-11; Drug Law no. 50-88.</p>
<p><b>Q2. Access protection:</b> Is there a National HIV/AIDS Policy or set of policies and laws that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated?</p> <p>(note: full score of six points possible without checking all boxes)</p>	<p><input type="radio"/> A. No, there are no such policies or laws</p> <p><input checked="" type="radio"/> B. Yes, there are such policies and laws. Check all that apply:</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> For people living with HIV</li> <li><input type="checkbox"/> For men who have sex with men</li> <li><input type="checkbox"/> For transgendered persons</li> <li><input type="checkbox"/> For sex workers</li> <li><input type="checkbox"/> For people who inject drugs</li> </ul>	<p>Q2 Score: 2.0</p>	<p>the Constitution of the Republica Dominicana mentions it generally and speaks to non-discrimination, the right to health, etc. However, there is currently no specific legal framework addressing the needs of vulnerable populations. Documents include: (a) Law no. 135-11, the revised AIDS Law; b) MOH norms for services and attention to patients; and c) Law no.</p> <p>the laws are on the books; the issue is enforcement of the laws</p>

	<input type="checkbox"/> For children orphaned or affected by HIV/AIDS <input type="checkbox"/> For young girls and women vulnerable to HIV <input checked="" type="checkbox"/> For survivors of gender-based violence		<p>parents, and of Law nos. 24-97, on GBV</p>	
<b>Q3. Civil society sustainability:</b> Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	<input type="radio"/> A. No, there are no special provisions or advantages for CSOs <input checked="" type="radio"/> B. Yes, there are special provisions and advantages for CSOs. Check all that apply: <input type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs <input type="checkbox"/> Significant tax exemptions for not-for-profit CSOs <input checked="" type="checkbox"/> Open competition among CSOs to provide government-funded services <input checked="" type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 2.0	New NGO Law	there is no agreement here: some allege that in the legal framework contains no special provisions for CSO sustainability; others allege that they do exist, but that the requirements become barriers and limitations to their implementation
<b>Q4. Enabling legislation:</b> Are there policies or legislation that govern HIV/AIDS service delivery?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, there are. Check all below that are included: <input checked="" type="checkbox"/> A national public health services act that includes the control of HIV <input checked="" type="checkbox"/> A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 4.0	Laws nos.42-01, 87-01 and 135-11	
<b>Policies, Laws, and Regulations Score:</b>			<b>10</b>	
<b>15. Planning and Coordination:</b> Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			<b>Source of data</b>	<b>Notes/Comments</b>
	<input type="radio"/> A. No, there is no national strategy for HIV/AIDS	Q1 Score: 4.0	National HIV/AIDS Strategic Plan (NSP)	

<p><b>Q1. National Strategy:</b> Does the country have a multi-year, costed national strategy to respond to HIV?</p>	<p><input checked="" type="radio"/> B. Yes, there is a national strategy. Check all that apply:</p> <p><input checked="" type="checkbox"/> It is multiyear</p> <p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p>		<p>2008-2015; and the updated NSP 2015-2018</p>	
<p><b>Q2. Data driven prioritization:</b> Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?</p>	<p><input checked="" type="radio"/> A. No data-driven prioritization approach was used</p> <p><input type="radio"/> B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources</p> <p><input type="radio"/> C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources</p>	<p>Q2 Score: 0</p>	<p>there is coordination at the macro level; but at the micro level, there could be some overlap</p>	
<p><b>Q3. CCM criteria:</b> Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?</p>	<p><input type="radio"/> A. No or there is no CCM</p> <p><input checked="" type="radio"/> B. Yes, with conditions</p> <p><input type="radio"/> C. Yes</p>	<p>Q3 Score: 1</p>	<p>Global Fund Eligibility List 2014</p>	
<p><b>Q4. Coordination of national response:</b> Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?</p>	<p><input type="radio"/> A. No, it does not track or map all HIV/AIDS activities</p> <p><input checked="" type="radio"/> B. the host country government coordinates all HIV/AIDS activities. Check all that apply:</p> <p><input checked="" type="checkbox"/> Of Civil Society Organizations</p> <p><input type="checkbox"/> Of private sector</p> <p><input checked="" type="checkbox"/> Of donor implementing partners</p> <p><input checked="" type="checkbox"/> Activities are tracked or mapped</p> <p><input type="checkbox"/> Duplications and gaps are addressed</p>	<p>Q4 Score: 4.0</p>	<p>there is some limited coordination, mainly oriented to tracking the financing that is managed by the GODR itself, and that of key donor agencies. However, this function needs to be strengthened</p>	

	<input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of all implementing agencies			
<p><b>Q5. Civil society engagement:</b> Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply:</p> <p><input checked="" type="checkbox"/> In advocacy</p> <p><input checked="" type="checkbox"/> In programmatic decision-making</p> <p><input checked="" type="checkbox"/> In technical decision-making</p> <p><input checked="" type="checkbox"/> In service delivery</p>	<p>Q5 Score: 4.0</p>	<p>Civil Society is an active participant in Congressional and MCP arenas, and in the development of the National Strategic Plan and GF Concept Note, and for service delivery and oversight monitoring. The Coalition of AIDS NGOs is an active entity in the National Response and for advocacy.</p>	
<p><b>Planning and Coordination Score:</b></p>		<p><b>13</b></p>		

**THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN**