



FY 2015 Haiti Country Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Haiti.

- 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.

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

HAITI

Country Operational Plan

COP 2015

Strategic Direction Summary

August 2015

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GOAL STATEMENT

The primary goal of the PEPFAR Haiti program is to achieve epidemic control in Haiti by supporting a data-driven response to control the HIV epidemic in the country by reducing new infections and AIDS-related mortality. This goal will be achieved through the scale-up of the most impactful HIV clinical and community services and strategies based on the latest epidemiologic and programmatic data. Those services and strategies include achievement of 80% ART coverage in highest burden districts; targeted HIV testing for key, priority and historically underserved populations; increased linkage and retention of individuals in care and treatment; and improved efficiency and quality of HIV services at the facility and community level. Program pivots that were initiated in COP14 will be accelerated in COP15 and beyond, with the net result of a service package that is more impactful, cost-efficient, and streamlined, with reductions in per-patient spending for enhanced efficiency.

In fiscal year 2014, the PEPFAR Haiti program began pursuing a number of program pivots, including a consolidated focus of PEPFAR investments within 20 (48%) of a Haiti's 42 districts. This geographic focus led to the transition of 148 sites and the re-categorization of 122 sites as scale-up or sustained, dependent on their program output and local epidemiologic context. In COP15, 50 health facilities will become sustained sites and 37 health facilities will transition HIV services to other sites.

On the basis of high HIV burden (i.e., estimated PLHIV), for COP15, 20 districts were designated as priority sub-national units (SNU), with 10 districts designated for scale-up to saturation and 10 designated for aggressive scale-up. Analyses of program data through FY14 demonstrated that these 20 priority districts represent 85% of individuals receiving HIV testing and counseling (HTC) services, 88% of patients in the cumulative national ART cohort, and 84% of the overall HIV-infected population (64% in the 10 scale-up to saturation districts alone). This programmatic realignment and geographic focus will allow Haiti to target 80% ART coverage among eligible PLHIV within the 10 scale-up to saturation districts by FY17.

Efficiency analysis work done with an interagency HQ cost-band team included a review of international and national norms for HIV/AIDS treatment and care, which resulted in greater alignment of PEPFAR-supported services within those norms. In COP15, revised service packages will be implemented for scale-up to saturation, aggressive scale-up and sustained sites. These revised packages, which were designed using Expenditure Analysis (EA) and interagency cost-band data, embrace efficiencies within routine clinical and laboratory monitoring models. This shift continues phase out of PEPFAR non-core and near core activities and will enable PEPFAR Haiti to make greater use of existing resources and accelerate progress towards epidemic control.

To find savings in multiple program areas, PEPFAR Haiti is instituting several changes to address the drivers of clinical costs at the service delivery level. These include:

For HIV Testing and Counseling (HTC)

- Reduction in the number of testing points within facilities, especially at multi-ward hospitals, resulting in a decrease in the workforce required to provide testing services.

For Prevention of Mother-to-Child Transmission (PMTCT)

- Task-shifting of roles previously served by specialized personnel to case managers who will continue to support pregnant women and their families throughout the ante-, peri-, and post-natal process.

For Care and Treatment

- Consolidation of multidisciplinary teams providing psychosocial counseling and provision of psychological service only at scale-up sites.
- Enrollment of patients as early as possible when they meet the clinical criteria to simplify the service model.
- Focus on supplying drugs to active patients by promoting multi-scripting, flexible hours for dispensation and home delivery. This will not only make the services more convenient to patients, but will curtail the number of visits for adherent patients and create room to accommodate transfers from closing sites.
- Reduction in the number of patients lost to follow-up and improvement in the tracking and patient retention systems across partners, as losses add to the cost of services and increase inefficiencies.
- Adoption of a more selective allocation of transportation vouchers, based on patient needs and distance to health facility.
- Maximum use of existing staffs' time through promotion of task-shifting and task-sharing in facilities with growing human resources requirements, instead of hiring new staff.
- Construction/renovation only for scale-up sites on a selective basis.
- Streamlining of laboratory services, so tests previously supported routinely for all patients, such as hematology and blood chemistry, will be supported at baseline (hematology) and subsequently based on specific clinical indications (hematology and chemistry). CD4 tests will be supported at baseline and subsequently every year, instead of every 6 months.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Haiti is the poorest country in the Western Hemisphere, with a GDP of \$771 per capita (2012). An estimated 55% of the country's approximately ten million people live on less than one dollar a day and cannot afford the higher quality healthcare provided in private clinics. Haiti's estimated 147,000 people living with HIV (PLHIV) (Spectrum 2015) constitutes the greatest burden of HIV/AIDS in the Caribbean region; this is exacerbated by the highest rate of tuberculosis (TB) in the Western Hemisphere. Haiti has a generalized HIV/AIDS epidemic, with most transmission occurring from heterosexual sex and marked by higher prevalence rates in major cities. Available evidence suggests that other drivers of new infections are a result of unprotected transactional and commercial sexual activities as well as unsafe sexual practices among men who have sex with men (MSM) (PLACE study, 2012). The widespread practice of multiple concurrent partnerships and the social conditions of women and youth are also considered among the key enablers of HIV transmission. Though the overall prevalence remains stable, women and youth showed a higher prevalence than men in the last Demographic and Health Survey (DHS) (2012)¹.

Haiti is a low-income country with GNI of \$810 per capita (World Bank 2013). There is a severe shortage of health workers, low retention of nurses and doctors, and gaps in services across all levels of the health system. Furthermore, the country's health infrastructure has not kept pace with Haiti's population growth from 7.5 million people in 1993 to 10.4 million in 2013. The January 2010 earthquake compounded the already difficult development situation in Haiti, destroying and damaging much of the previously existing physical infrastructure (including 30,000 commercial

¹Cayemittes M, Placide F, Barrere B, Mariko S, Severe B. *Enquete Mortalité, Morbidite et Utilisation des Services Haiti 2012*. Calverton, Maryland, USA: Institut Haitien de l'Enfance et ORC Macro; 2012

and government buildings) and resulting in an estimated 240,000 deaths and 300,000 injuries. Included in this large-scale human loss were untold numbers of civil servants, health professionals, medical staff, and nursing students. Moreover, the country is recovering from one of the largest cholera epidemics in history, with more than 730,000 cases since its onset including over 352,000 cases in 2011 alone (MMWR Feb 20, 2015).

Nonetheless the DHS data from 2006 and 2012 indicate that HIV prevalence among adults in Haiti has remained stable at 2.2%, suggesting that a successful treatment and prevention program is keeping alive those already infected while curbing transmission at a population level. As of October 2014, over 62,000 individuals were receiving antiretroviral treatment (ART), representing 50% of the estimated number of people eligible for ART under the current guidelines. An additional 28,866 individuals were receiving pre-ART care services, 82% of all pregnant women were tested for HIV, and of those identified as HIV-infected 87% received ART. PEPFAR has been instrumental in scaling up HIV services while building Ministry of Health (MOH) capacity to sustain the HIV response over the long term. The support to the MOH has enabled the on-going and timely updating and alignment of national clinical guidelines with international normative guidance. Through its regional and local units, the MOH has also been able to enforce application of norms via training for those actively engaged in community mobilization, promotion, and regulation of services.

Over the coming years, major geographic shifts and technical pivots in the PEPFAR Haiti portfolio will occur. Both prevalence and burden of diseases are unevenly distributed among subnational units and of the 42 arrondissements (districts) in Haiti; 64% of the PLHIV can be found in 10 that will be prioritized by PEPFAR for scale-up to saturation in 2017. Of the 10 geographical departments (a larger political unit than districts), the two most populated (Artibonite and West [which includes Port-au-Prince]) account for 51% of the total PLHIV and have a share of burden of disease almost equal to their contribution to the total population size (52%). They are followed in burden of disease by the Northwest, which is sixth in population size but has the highest prevalence of all departments. Combined, the three departments account for 62% of all PLHIV and include eight of the 10 scale-up to saturation districts. The district of Port-au-Prince alone accounts for 26% of all PLHIV. To achieve epidemic control in targeted sub-national units, PEPFAR Haiti has identified core, near-core, and non-core activities to inform strategic shifts needed to accelerate impact in the context of a constrained budget environment.

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		All ages				<15				15+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	10,749,925		5,386,925	50.1%	5,363,000	49.9%	1,756,185	50.1%	1,750,482	49.9%	3,630,742	50.1%	3,612,514	49.9%	Avenir Health, 2014; based on 2015 UEP estimations
Prevalence (%)		1.41		1.63		1.19		0.34		0.35		2.25		1.59	Avenir Health, 2014
AIDS Deaths	5,579		2,564	46.0%	3,015	54.0%	241		230		2,323		2,785		Avenir Health, 2014
PLHIV	146,525		84,286	57.5%	62,240	42.5%	6,012		6,076		78,274		56,163		Avenir Health, 2014
Incidence Rate (Yr)		0.07		0.07		0.06									Avenir Health, 2014
New Infections (Yr)	7,002		3,959	56.5%	3,043	43.5%	295		304		3664		2739		Avenir Health, 2014
% >= 1 ANC visit															
Pregnant women needing ARVs	6,164		6,164												Avenir Health, 2014
Orphans (maternal, paternal, double)	93,057														Avenir Health, 2014

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)

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				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	10,743,886	1.41	146,525	91,212	62,371	43,536	N/A	934,903	29,452	18,835
Population less than 15 years	3,591,528	0.35	12,088	N/A	2,839	N/A	N/A	N/A	N/A	709
Pregnant Women	436,879	LG	5,426	4,872	4,872	LG	N/A	248,250	5,470	2997

1.2 National Investment Profile

Given Haiti's weak tax base and revenue streams, as well as competing social needs, public spending on health is very low—only about 5% of the national budget is allocated to the health sector. Of these funds, more than 90% support personnel costs of MOH staff. This leaves limited room for the government to earmark specific resources for the HIV program outside its in-kind contribution in the form of salaries for personnel and availability of public facilities to carry out the program. Funding for the HIV program comes from PEPFAR (90%), the Global Fund (GF) (9%) and the Ministry of Health (1%). PEPFAR Haiti has worked closely with the Country Coordinating Mechanism (CCM) to avoid duplication and to leverage GF resources for strategic alignment with PEPFAR goals. At one time the majority of the GF funding went to prevention activities and procurement of drugs. Moving forward, GF will address epidemic control in specific geographic areas and among key populations and will focus its efforts on integrating TB and HIV services.

Program Area	Total Expenditure	PEPFAR FY14 Actual (2)	% PEPFAR	Global Fund (2014)	% Global Fund
Clinical care, treatment and support, PEP	\$ 50,942,409	\$ 41,384,894	81.24	\$ 9,557,515	18.76
Community-based care	\$ 11,494,292	\$ 10,486,575	91.23	\$ 1,007,717	8.77
PMTCT	\$ 10,668,145	\$ 10,618,158	99.53	\$ 49,987	0.47
HTC	\$ 14,008,607	\$ 13,703,938	97.83	\$ 304,669	2.17
VMMC	\$ -	\$ -		\$ -	
Priority population prevention	\$ 8,457,902	\$ 7,316,221	86.50	\$ 1,141,681	13.50
Key population prevention	\$ 855,599	\$ 855,599	100.00	\$ -	0.00
OVC	\$ 4,234,461	\$ 4,234,461	100.00	\$ -	0.00
Blood Safety	\$ 6,027,929	\$ 5,813,174	96.44	\$ 214,755	3.56
Infection Control	\$ 1,228,987	\$ 1,228,987	100.00	\$ -	0.00
Laboratory	\$ 17,520,010	\$ 17,520,010	100.00	\$ -	0.00
SI, Surveys and Surveillance	\$ 6,183,607	\$ 6,183,607	100.00	\$ -	0.00

(2) from Expenditure Analyses (EA 2014)
(3) Calendar Year 2014

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GOH	% Other
ARVs	\$9,545,929	57%	43%	0%	0%
Rapid test kits	\$2,746,077	92%	8%	0%	0%
Other drugs	\$560,887	46%	54%	0%	0%
Lab reagents	\$2,639,099	79%	21%	0%	0%
Lab equipment	\$1,564,156	100%	0%	0%	0%
VMMC kits	\$0				
Condoms and lubricants	\$1,086,954	87%	13%	0%	0%
Blood safety supplies	\$3,216,507	100%	0%	0%	0%
Other commodities	\$666,982	100%	0%	0%	0%
Total	\$22,026,591	76%	24%	0%	0%

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	13,000,000	9,000,000	6	7,000,000	There are 6 USAID IMs that receive PEPFAR, MCH, and Family Planning funding. USAID works in an integrated way to deliver health care—meaning these projects deliver a variety of different services—MCH, FP, HIV—at one site. This integrated service delivery allows clients to access multiple health services in one site. Note the 6 co-funded IMs for MCH and FP are the same 6 IMs.
USAID Family Planning	9,000,000	6,000,000	6	0	
HHS Post Earthquake Supplemental Funding	\$21,360,000	\$20,060,000	10	\$59,822,000	Given the breadth of HHS Post-Earthquake Funding (e.g., from malaria to rabies, from cholera to lymphatic filariasis), relatively few activities were truly co-financed among the ten partners. Where activities were co-financed, the purpose was to support the provision of high-quality integrated TB/HIV services and operation of critical disease surveillance systems.
TOTAL	\$43,360,000	\$35,060,000	16	\$66,822,000	

1.3 National Sustainability Profile

Policies, Laws and Regulations

Several partners including PEPFAR Haiti, GF, WHO, UNICEF, and other local groups (SEROVIE, FOSREF, GIPA, ASON, POZ) are working with the MOH to develop HIV/AIDS non-discrimination and access policies. Despite the limited resources, this work has contributed to improving the enabling environment. However, no distinct laws and/or regulations on HIV have been enacted. Over the next 2-3 years the PEPFAR program will increase and intensify support to the National AIDS Control Program and its partners to update the bill on HIV drafted a few years ago to include key populations and will provide TA to develop policies, guidelines, and trainings for key populations.

Epidemiological and Health Data

The USG and its implementing partners such as NASTAD, ITECH, Solutions, METH, and the Institut Haitien de l'enfance (IHE) have provided technical and financial support to the GOH/MOH in the development and implementation of routine monitoring and evaluation and surveillance systems, as well as for national surveys (e.g., ANC, DHS, VACS); only limited, in-kind resources were provided by the GOH.

As PEPFAR funding decreases, the sustainability of basic health information system (HIS) architecture and systems is at stake. USG HIS investments enable: 1. Essential reporting to meet national and international needs and requirements; 2. Fundamental epidemiologic surveillance needed to characterize the epidemic and response; 3. Clinical monitoring to assess the quality and impact of HIV clinical services at the patient and population level; 4. Health sector wide service delivery outputs; and 5. Financial information on the health sector.

The GOH is leading the coordination of several core surveillance activities and PEPFAR Haiti will encourage more active oversight by the MOH. Core surveillance activities include ANC sentinel surveys, BSS among key populations, NHA, and DHS. In particular, as Haiti is getting closer to the next DHS implementation period in 2017, there is a need to actively sensitize the GOH/MOH to initiate the planning process as early as possible and to include partial funding of this survey in the national budget. Early planning will allow for more stakeholders to include the DHS in their plans which may ensure that the DHS is conducted on time and reduce the level of contributions from each donor. It is essential that throughout the process, institutional and individual capacity building for key MOH personnel and local partners is conducted.

Public Access and Demand

PEPFAR and GF are the main partners supporting the MOH in expanding access to HIV care and treatment in the country. Extremely limited government resources (in-kind, mainly personnel) are allocated to HIV services. To improve public access and demand it is imperative to develop networks of institutions to improve community outreach to facilitate access to HIV services for patients living near institutions not providing such services. Such networks are critical in high burden areas where not all health institutions are providing HIV services.

Commodities Security and Supply Chain

The main partners and donors working alongside the MOH to improve commodities security and the supply chain as they relate to HIV are the USG and GF. Recently the USG provided TA to support the MOH Department of Pharmacy to develop a national supply chain plan. It is critical to continue to support technical capacity building of the Department of Pharmacy to strengthen

its ability to develop/revise the national supply chain plan and conduct a costing exercise to evaluate the real in-country cost of HIV treatment (lab reagents, drugs, etc.). This will provide a roadmap for the MOH to advocate with the Haitian Parliament to progressively adjust its contribution over time.

Health Financing and Strategic Investment

The GOH has a limited budgetary contribution to the national HIV response. PEPFAR Haiti and other partners including GF have provided the GOH both financial and technical support over the years. It is critical for the GOH to strengthen and streamline its internal financial systems and tracking to improve efficiency of public services. However, the national HIV response will not be sustainable if there is not a substantial increase in health expenditure in the national budget.

1.4 Alignment of PEPFAR investments geographically to disease burden

PEPFAR Haiti undertook a prioritization exercise to balance the need to find efficiencies in programming while taking into account guidance regarding the mandate to provide uninterrupted clinical treatment for all PEPFAR-supported patients. The realignment of the program brought to the forefront high burden districts and led to divestment from low-burden districts. After reviewing district-level programmatic data, 20 districts, representing 84% of total PLHIV, were selected for scaling-up treatment, to contribute to the 90-90-90 goal by 2020. The top ten districts with the highest burden of PLHIV were selected for scale-up to saturation (80% ART coverage) in 2017. These districts account for 64% of total PLHIV burden and represent the absolute priority for PEPFAR in Haiti for the next 2 years. Eight of the 10 districts are located in 3 departments: Ouest (West), Artibonite, and Nord-Ouest (North-West). Among the list of 10 is Port-au-Prince, the district with the highest burden of PLHIV. It will be a significant achievement for PEPFAR to reach full programmatic coverage in Port-au-Prince in FY17 and a major step towards epidemic control. In three of the ten districts, the limited existing health infrastructure and capacity may impede rapid expansion to reach 80% ART coverage. Substantial investments and efforts may be needed to achieve 80% coverage in those areas by FY17.

An additional 10 districts were selected for aggressive treatment scale-up, based on PLHIV burden (next 8 districts in ranking order after the 10 scale-up to saturation districts) or a testing yield above 4% (two districts). These ten districts, categorized as “aggressive scale-up”, will continue to actively identify and enroll patients on ART, but will not necessarily achieve saturation by FY17.

PEPFAR will remain present in 16 other districts where the focus will be on maintaining existing patients on ART and enrolling eligible identified patients on ART on a more passive approach.

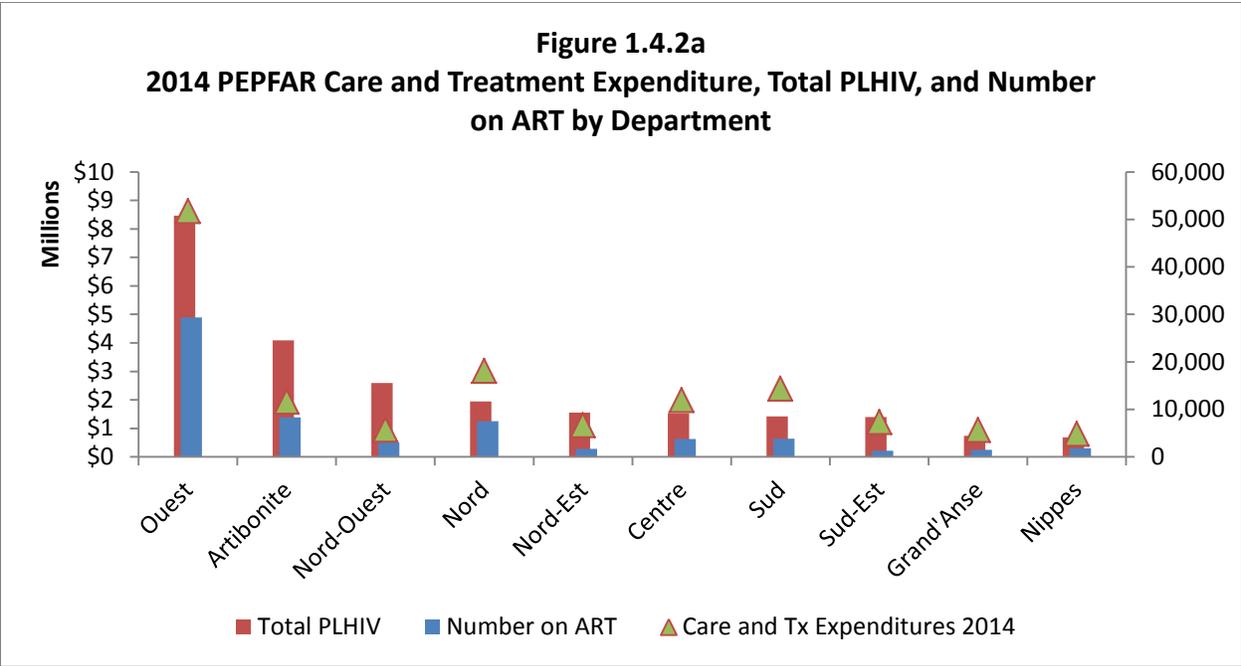
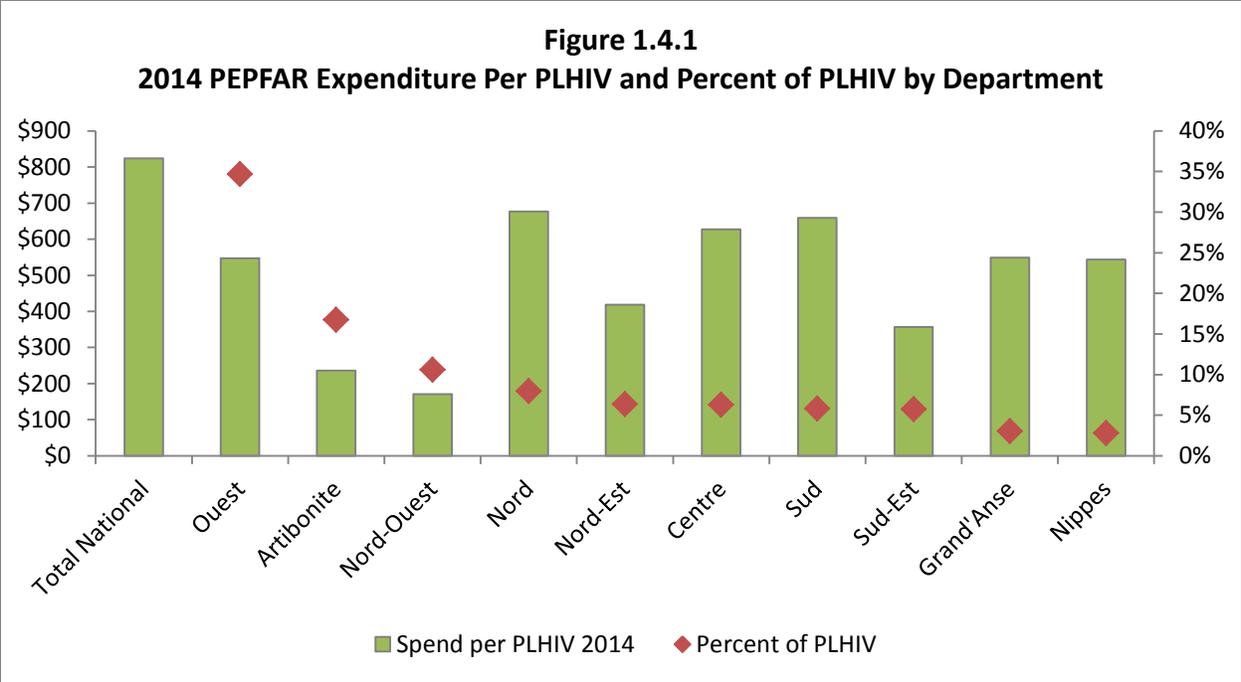


Figure 1.4.2b: Total PEPFAR Expenditure, PLHIV, and Expenditure per PLHIV by Department

Total PEPFAR Expenditures, Number of People Living with HIV (PLHIV) and Expenditure per PLHIV in Haiti in FY 2014

Figure 1: Total PEPFAR Expenditures



Figure 2: Number of PLHIV



Figure 3: Dollars per person living with HIV (standard deviation)



Figure 1: Total PEPFAR Expenditures

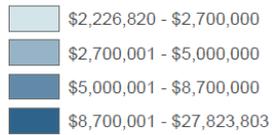


Figure 2: Number of PLHIV

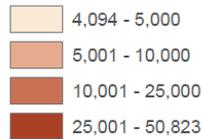
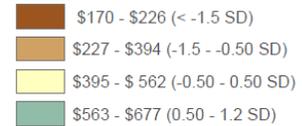


Figure 3: Dollars per person living with HIV (standard deviation)



Data Sources: Expenditure Analysis of the PEPFAR Haiti program conducted by OGAC with input from partners
Avenir Health modified 2014 district level estimates with 2014 population projections

Spatial Data: IHSI, CNIGS
Created: 23 April 2015

1.5 Stakeholder Engagement

The Haiti PEPFAR team collaborates closely with the National AIDS Program (Programme National de Lutte Contre les IST-VIH-SIDA; PNLS) and the team began consultations on COP15 after the Wave 1 meeting in August 2014. The discussion was centered on PEPFAR program pivots and changes in the PEPFAR program. Ambassador White met with Minister of Health Florence Duperval Guillaume with both agencies' leadership and technical teams to outline the way forward.

The Haiti PEPFAR team hosted both a PEPFAR Partner/National Stakeholder and a Civil Society Engagement workshop in the last six months; PNLS was invited and attended both times. These workshops were aimed at communicating the programmatic and technical shifts being planned for COP15. In the course of working on COP15, PNLS requested and has been provided with programmatic information, including detailed site categorization lists.

With regard to the GF, the interagency team has worked closely with the HIV/TB Haiti Concept Note team. The PEPFAR technical teams have worked extensively on the development of the Concept Note and to coordinate complementary service provision in Haiti between PEPFAR and the GF. PEPFAR Haiti is represented on the CCM by both CDC and USAID, and both have advocated for greater alignment on strategy and policy issues between PEPFAR and the GF. A relationship has also been established with the Global Fund Portfolio Manager and his team in Geneva, with whom PEPFAR Haiti has shared overarching program pivots for COP15; more extensive information will be shared once COP15 is approved.

A civil society inclusion meeting was held in Port au Prince, Haiti on April 8, 2015. Participation from civil society was robust and participants expressed appreciation of the consultative process. Ambassador White gave an overview of the current PEPFAR program utilizing a subset of Ambassador Bix's slides from the recent Chiefs of Mission conference. She reiterated the commitment the U.S. government has to HIV/AIDS and to Haiti, and encouraged civil society participation by identifying them as one of the key components of a country-led process. Participants provided written feedback at the end of the meeting and were given an email address for additional comments.

After the meeting the written comments were combined and translated from French and Kreyol to English; many of these comments were incorporated into COP15 planning. A schedule of quarterly meetings with the PEPFAR Haiti team and civil society representatives is being planned and will be in the PEPFAR Coordinator's portfolio. The next quarterly meeting will be a report out on the current status of COP15 and the result of the conversations in Dar es Salaam. The PEPFAR Haiti team currently has limited private sector engagement; however this is planned for COP16 and will also be in the Coordinator's portfolio.

2.0 Core, Near-Core and Non-Core activities

Achieving epidemic control in a budget constrained environment requires concentrated efforts on activities that will have the greatest impact. Details are provided in Appendix A, but in summary PEPFAR Haiti's programmatic core will be combination prevention activities including ART, PMTCT, and HTC services in prioritized districts and targeting key populations. The program also considers OVC, support for commodities, essential lab support, and high-impact strategic information as core activities. General prevention activities, HTC in low prevalence areas, and health systems in non-priority districts are classified as non-core. Blood safety activities were classified as near-core in COP14 with a phased transition to non-core to minimize disruption of services, as PEPFAR has been the predominant funder. For COP15, only blood safety activities related to QA-QC, lab commodities, and select blood drives will be supported.

3.0 Geographic and Population Prioritization

Two inclusive criteria were set for the selection of districts for treatment scale-up: (i) be part of the list that account for 81% of disease burden (met by 18 districts) or (ii) or have an HTC yield >4% (met by two additional districts, including one in the Northeast, the highest prevalence department). In total, the 20 treatment scale-up districts represent 84% of PLHIV burden, 88% of patients on ART as of FY14 and 79% of the net new needed for ART saturation. It was determined that 80% coverage was necessary for epidemic control within the 10 districts with highest burden by the end of FY17; these districts are called "scale-up to saturation districts". The other 10 districts, labeled "aggressive scale-up districts", will contribute to the goal of epidemic control but without a set timeline for saturation. PEPFAR will continue supporting HIV services in 16 "sustained districts," with a much slower pace of treatment expansion.

Among the scale-up to saturation districts, three have some of the highest volume of unmet needs. To enable them to achieve epidemic control in FY17, additional support, including the potential creation of ART sites, will be required. For instance, planning is already underway to create two new sites in the district of Mole Saint-Nicolas, which tops the list of districts with a high volume of unmet need.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

It is estimated that, after September 2015, 45,047 net new patients would be needed for countrywide saturation (80% ART coverage). By aggressively targeting the 10 scale-up to saturation districts and by continuing to increase the number of patients from active sites in aggressive scale-up districts, it is possible to bridge close to 80% of this gap (34,198 new on treatment). While the 10 scale-up to saturation districts, which account for 64% of all PLHIV may achieve 80% ART coverage over a two-year time horizon, the timeline will be expanded for the 10 aggressive scale-up districts.

In COP15 the program intends to enroll 22,044 patients (for a net gain of 11,882); of which 93% (18,208) of the new enrollees, will come from the 10 scale-up to saturation districts and the rest from aggressive scale-up and sustained districts. While the overall attrition rate of 15% in FY14 was still maintained in total projections, the team considered each district's own attrition rates and plans to act on each separately to lower high attrition rates.

In compliance with the national guidelines, emphasis will be put on reaching out to co-infected TB/HIV patients, who are among the priority populations that may be enrolled without complete assessment of patients' immunological status. TB clinics that have embedded PEPFAR-supported HIV programs represent 80% of TB patients on treatment. Efforts will be devoted to attract and test more TB patients at these clinics by continuing to encourage better trained HIV providers to backstop less trained TB aide nurses heading the TB clinics. Pregnant women, although a relatively low prevalence (i.e., 2.2%) group, have also high priority ranking for HIV testing not only to prevent mother to child transmission, but also because they are good candidates for immediate ART initiation. Despite the transitioning of a couple of low volume sites to other support, and a more efficient approach to avoid repeated testing of HIV negative patients, testing targets have declined by only 28%, compared to FY14 achievements.

Key population clinics for commercial sex workers and MSM will continue to be supported, although the treatment program will carry forward only at a few that have demonstrated potential for scale-up and maintenance. In addition, health facility personnel will receive assistance and training to become key population-friendly.

District	Total PLHIV	Expected current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (in FY16) <i>TX_CURR</i>	Newly initiated in FY16 <i>TX_NEW</i>
Port-au-Prince	38,516	28826	1,987	30,619	5,945
Saint-Marc	9,485	3833	3,755	5,335	2,000
Môle-Saint-Nicolas	8,264	1197	5,414	3,363	2,500
Dessalines	7,985	2216	4,172	3,885	2,050
Léogâne	3,553	1664	1,178	2,194	616
Croix-des-Bouquets	6,350	1901	3,179	3,173	1,755
Port-de-Paix	5,664	2261	2,270	3,169	1,450
Les Cayes	4,599	3017	662	3,348	435
Cap-Haïtien	4,126	3162	139	3,231	622
Gonaïves	3,752	1898	1,104	2,450	835
TOTAL	92,294	49,975	23,860	60,767	18,208

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-up to Saturation Districts (FY16)

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART			7,000
TB-HIV Patients not on ART	7,410	1,110	890
HIV-positive Pregnant Women	149,512	1,773	1,347
Other priority and key populations*	20,000	500	400
Total	176,922	3,383	9,637

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (priority SNU)	Coverage Goal (in FY16)	FY16 Target
KP MSM	N/A (pending, May 2015)	N/A	13,800
KP FSW	N/A (pending, May 2015)	N/A	12,370
Total			26,170

Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment

Estimated # of Children PLHIV (<15)	Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC	Target # of children tested (FY16 Target)	Target # of children on ART (FY16)
Acul-du-Nord	177	2040	1632	1195	104
Anse-à-Veau	132	342	274	48	8
Anse-d'hainault	51	110	88	30	11
Aquin	251	698	558	1634	56
Arcahaie	156	867	694	412	44
Bainet	60	193	154	47	10
Barradères	44		0		
Belle-Anse	110	72	58	41	8
Borgne	132	525	420	281	26
Cap-Haïtien	432	3310	2648	1883	172
Cerca-la-Source	85	922	738	197	15
Corail	90	44	35	0	0

Croix-des-Bouquets	536	1100	880	2956	138
Dessalines	625	6861	5489	1656	165
Fort-Liberté	179	780	624	236	62
Gonaïves	294	2097	1678	1327	131
Grande-Rivière-du-Nord	109	1188	950	187	22
Gros-Morne	125	380	304	248	40
Hinche	177	2770	2216	1032	68
Jacmel	534	510	408	1015	71
Jérémie	217	1643	1314	891	83
La Gonâve	47	33	26	108	23
Lascahobas	180	2100	1680	605	78
Léogâne	300	600	480	771	90
Les Cayes	358	2641	2113	1393	174
Les Chardonnières	23	155	124		
Les Côteaux	13		0		
Limbé	94	464	371	216	43
Marmelade	133	1067	854	113	10
Miragoâne	145	997	798	339	95
Mirebalais	172	3930	3144	1454	87
Môle-Saint-Nicolas	663	650	520	625	81
Ouanaminthe	288	2487	1990	246	68
Plaisance	70	314	251	253	36
Port-au-Prince	3,250	14172	11338	15028	1483
Port-de-Paix	454	6449	5159	1563	165
Port-Salut	17	294	235	111	21
Saint-Louis-du-Nord	129	144	115	0	0
Saint-Marc	742	4300	3440	2713	253
Saint-Raphaël	205	2285	1828	156	26
Trou-du-Nord	220	1010	808	688	59
Vallières	71	145	116	0	0
Total	12,088	70,689	56,551	41,698	4,028

4.2 Priority and Key Population Prevention

Key populations (KP) are at extremely high risk of HIV acquisition and often underserved by existing HIV prevention, care, and treatment services in Haiti. Stigmatization and discrimination continue to be major impediments to accessing services from a health facility/provider, as well as individual and societal levels. Therefore, access to KP-friendly health services is often limited. Data on HIV prevalence among commercial sex workers (CSWs) in Haiti is limited. However, a 2012 study conducted by Population Services International (PSI-Haiti) estimated the HIV positivity among commercial sex workers (CSWs) at approximately 8.4%. In a study conducted by the Center for International Cooperation in Health and Development (CCISD) in 2008, female sex workers (FSW) report an average age of debut in sex work of 17 years, just one year more than age of first intercourse. It was observed that while the percentage of FSW who always use a condom with clients increased from 62.5% in 2006 to 91.9% in 2008, it dropped to 83.7% in 2012.

Among MSM in Haiti HIV prevalence is also largely unknown but it is estimated to be 18.1% within programs supported by PEPFAR. Only 36.5% of MSM consistently use condoms (PSI Haiti TRaC Survey: Behavior of MSM, 2011) while 73% of MSM reported using a condom when they last had anal sex with a male partner. The MOH has identified KP as a priority in the National HIV Strategic Plan (2008 – 2015) and cited risk reduction through promotion and distribution of condoms as integral aspects of HIV prevention within these populations. The MOH supports the initiative to develop KP-friendly sites and supported a study to map hotspots in the country (PLACE study). The Integrated Biological and Behavioral Surveillance Survey (IBBSS) and a MSM size estimation study, funded by USG, have been concluded and the results are expected in 2015.

In COP15, PEPFAR Haiti will support targeted combination prevention services to KP in the hot zones identified through the PLACE study. Reports from these studies (PLACE and IBBSS) will guide the design of targeted HTC services, location of HIV combination prevention services, linkage of KP to health facilities, and the selection of health facilities to be considered as KP-friendly sites. These services include HTC; STI prevention, screening and treatment; provision of condoms and lubricants; provision of ART; and peer education and support. These are the core components of the service delivery package for KP. Additional components include activities to address stigma and discrimination in the community and at all levels of care. It is important to link KP to existing community empowerment structures and programs. In addition, priority groups such as prisoners and clients of FSWs will also receive combination prevention HIV services.

Additional activities planned for COP15 include implementing partners strategizing on coordination and collaboration on prevention, care, and treatment for KP, interventions to address gaps and challenges within linkage to care and retention in treatment (such as community-based teams) and building the capacity of health teams, including development of standard operating procedures, to track data on their referrals on a routine basis. All these activities are appropriately classified under core programs; similarly, efforts have been made during the site categorization exercise to ensure that potential KP-friendly sites are captured. Where these sites did not fall under the priority districts but had a high burden of HIV or were KP hotspots, they were categorically captured as priority sites. CDC and USAID will both provide technical inputs to the planned IBBSS study among FSWs and MSM.

To foster sustainability and continuity, services for KP will be integrated within existing services where possible. USG will support activities that are strategically designed to involve host government and community level structures, including civil society. National and sub-national structures will be involved in the evaluation, dissemination and sharing of best practices, with a bid to engineering community involvement and change.

4.3 Voluntary Medical Male Circumcision (VMMC)

Not applicable in the Haiti program.

4.4 Prevention of mother-to-child transmission (PMTCT)

Over the last four years, Haiti has significantly expanded access to prevention of mother to child transmission of HIV (PMTCT). During this period, in which the country adopted and implemented Option B+, the program has seen an increase of PMTCT coverage to reach 87% of

identified HIV-infected pregnant women with ART in FY14; and a reduction of vertical transmission of HIV in Haiti to 2.9% among HIV-exposed infants born to enrolled pregnant women and who have benefited from early infant diagnosis (EID) at two months. In FY14, 5.6% of HIV-exposed infants who had a PCR within 12 months of birth were HIV positive compared to 8.9% in 2009 (EID pilot report, 2009). Despite such achievements, more needs to be done to reach the national objective of virtual elimination of mother-to-child transmission of HIV, particularly in terms of retention of pregnant women enrolled on ART.

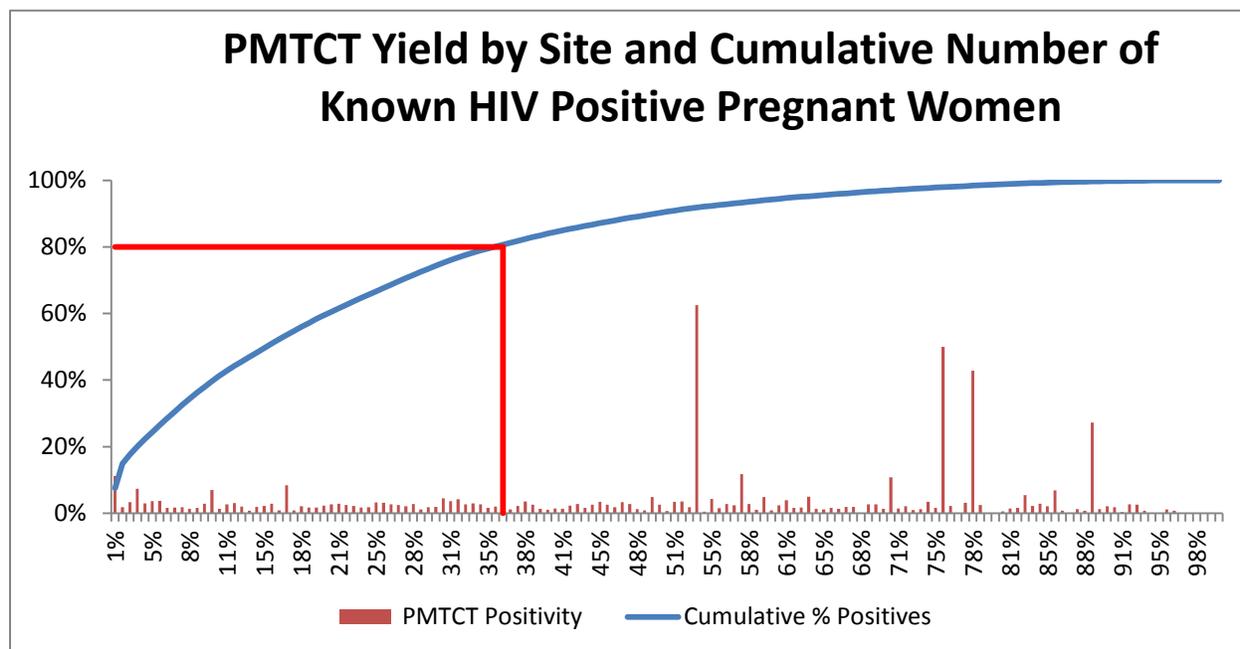
In Haiti, all PMTCT sites are also ART sites. Therefore, the decisions on scaling-up, sustaining, or transitioning followed the same rules as for ART sites, which is described elsewhere. Through the prioritization exercise, the country team identified 10 scale-up to saturation districts (arrondissements) which account for 35 of the 53 sites responsible for 80% of identified HIV-infected pregnant women. The PEPFAR program will invest in these districts to scale HIV services to reach epidemic control over the next two to three years. PEPFAR will support the provision of HTC services to at least 90% of pregnant women. As describe in the HTC section, the program will ensure that every health facility providing HTC is included in the external quality insurance program to nil the possibility of misdiagnosis, particularly in the context of Option B+. The program will provide ART to 95% of those who are HIV-positive. HIV-positive pregnant women enrolled on ART receive the same package of services as non-pregnant adults. The program will place a particular focus on retention of HIV-positive pregnant women on treatment, which tends to be lower than that of non-pregnant adults (Domercant *et al.*, CROI 2015). The providers will proactively engage patients about their appointments, via phone calls or text messaging as appropriate. Efficient coordination between providers, particularly the case manager and community health agents, will ensure proper follow-up for every missed appointment. The goal is to increase adherence to treatment and ensure the continuum of services to the HIV-exposed infant and mother pair.

In COP15, the PEPFAR program will continue to expand EID capacity to reach at least 90% of HIV-exposed infants. Providers will sensitize HIV-positive pregnant women throughout their pregnancies on the importance of EID and close follow-up of their newborns. To improve monitoring of HIV-exposed infants, PEPFAR will continue to support BEST to implement longitudinal birth cohort reporting to follow HIV-exposed infants through the end of the breastfeeding period.

Efficiency Analysis

In Haiti, 36% of PMTCT sites identified 80% of HIV-infected pregnant women in 2014 (see figure below). Most of these sites (48) are in the 20 priority districts. In COP15 PEPFAR Haiti will support 73 sites to deliver PMTCT services, of which 58 are in the priority districts. The sustained package (described elsewhere) in non-priority districts will include PMTCT services if the site identified more than four HIV-positive pregnant women in FY14 and if there is no nearby institutions, where women can be safely referred. In the remaining districts, 15 sustained sites will be supported to deliver PMTCT services, as they had relatively high yield. Fifty-nine sites will no longer receive support and funds will be redirected.

In COP15, the program will continue to leverage support to foster integration of PMTCT services with family planning. Providers will engage pregnant women on the importance of using modern family planning methods in the post-partum period to reduce unwanted pregnancies and further enhance efficiencies.



4.5 HIV Testing and Counseling (HTC)

HTC enables knowledge of sero-status and is recognized as a critical initial step in controlling the HIV epidemic. To ensure that implementation of HIV testing is maximally targeted, the National AIDS Control Program will update the 2010 national HTC guidelines in the coming year. In COP15, PEPFAR Haiti will support the MOH by providing technical assistance throughout the revision and roll-out process and will ensure that evidence-based approaches for HTC are incorporated in line with WHO recommendations scheduled to be released this summer.

As described, PEPFAR Haiti’s categorization exercise showed that 26% of HTC sites are responsible for 80% of the total number of HIV-positive patients identified in FY14. Of these sites, 88% (61 of 69) are located in the scale-up to saturation and aggressive scale-up districts. In COP15, PEPFAR Haiti will support the intensification of HTC services via a predominantly provider-initiated counselling and testing (PITC) service platform within high volume/yield health facilities located in departments and districts with high HIV prevalence/burden. This is in line with the interagency site categorization exercise which included testing yield as a key parameter. At both scale-up to saturation and aggressive scale-up districts, HTC will continue to be provided within select facility-based outpatient and inpatient venues primarily serving, but not limited to, ANC/PMTCT, HIV-exposed infants, TB suspects and patients, patients with STI diagnosis or symptoms, key populations, post-rape care patients and other patients with known exposure. PITC sites with fewer than 24 identified positive patients during the previous implementation year will no longer be supported by PEPFAR Haiti and as a result 42 sites will be transitioned.

The location of community-based testing services will be determined based on review of facility-level data (such as index patient approach in pediatric and antenatal (ANC) clinics and guided by HIV surveillance and epidemiologic data, particularly for KP. Mobile HTC outreach services will complement facility-based HTC within the communes of prioritized sites with KP. HTC services

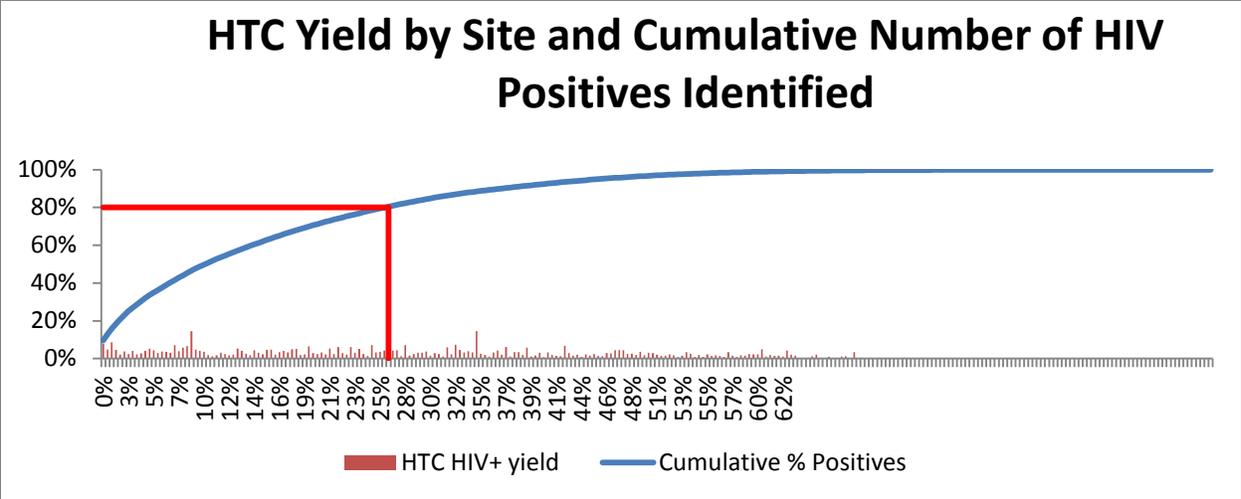
will also be provided on a limited basis to other non-KP but priority populations such as prisoners and cross-border migrants but only within the 20 priority districts. At all sustained sites, HTC will be limited to ANC (pregnant women), TB patients, and based on need as determined by the service provider. There will be no active testing or demand creation at these sites.

Utilizing KP mapping and size estimation exercises completed in March 2015 with PEPFAR Haiti support, increased support will help expand HTC access for KP (primarily FSW and MSM). A key component of the program will be to ensure that all people who receive HTC and test positive are linked to care. This will be achieved through continuously improving the quality of HTC services, site monitoring and mentoring, enhanced patient flow to foster same-day results, development of standard operating procedures for linkage to care from HTC, and implementation of active and efficient referral systems between community-based testing and health facilities.

Additionally, quality assurance/quality improvement (QA/QI) procedures for HIV testing will be maintained. The QA/QI program will continue to include regular proficiency test panels (twice/year; 6 panels sent to the sites-3 positive, 3 negative tests) for HIV rapid testing conducted by Haiti's National Public Health Laboratory (LNSP). This program helps minimize mistakes and ensure that testing is carried out correctly. Counseling will include targeted prevention messages, emphasizing evidence-based risk reduction behaviors, partner disclosure, the importance of initiating treatment early and adherence and retention in care, and addressing issues surrounding stigma and discrimination.

Efficiency Analysis

PEPFAR Haiti supported 263 HTC sites in FY14. As mentioned previously, PEPFAR Haiti has gone through a prioritization exercise that showed that 26% (n=69) of HTC sites are responsible for 80% of the total number of HIV-positive patients identified in FY14. Of these sites 88% (61 of the 69) are located in the saturation and aggressive districts (45 sites are located in the scale-up to saturation districts; 14 in the aggressive scale-up districts; 2 sites from the saturation district are being transitioned). Of the 194 sites responsible for the remaining 20% of positives, 139 (71%) will be transitioned in COP15 and 37 (19%) will become maintenance sites which provide passive HTC services as described in the maintenance package. Eighteen sites will continue to scale-up HTC services through effective and appropriate PITC given their historical yield and the priority/key populations served. Savings from transition and sustained sites will be directed towards priority districts to expand HTC services where the yield is greater, thus maximizing efficiency and impact. The vast majority of HIV testing (93% of 833,958 tests) will happen in scale-up to saturation and aggressive scale-up districts.



4.6 Facility and Community-Based Care and Support

During COP15, PEPFAR Haiti will continue to provide high quality care and support services to patients living with HIV. Multidisciplinary teams in PEPFAR-supported sites will remain adequately trained to deliver the package of services aimed at improving the well-being of patients. In low prevalence and low burden geographic areas, health facilities will provide a sustained package with reduced personnel who will primarily focus on adherence and retention of patients already receiving services and continuous assessment of treatment eligibility for patients enrolled in pre-ART.

PEPFAR Haiti will provide technical support to implementing partners to ensure that newly identified HIV-positives are enrolled in comprehensive care with a focus on monitoring for ART eligibility and early treatment initiation. Expansion of treatment coverage ultimately depends heavily on the capacity of the program to retain patients in care while at the same time minimizing the routine clinical, laboratory, and pharmacy follow-up requirements consistent with international normative guidance. COP15 efforts will focus on increasing retention among both pre-ART and ART patients with scale-up of systematic hotline and text messaging platforms for appointment reminders and communication between patients and healthcare workers. Efficient coordination between care providers and community health agents using these platforms will assure timely and effective follow-up for missed appointments and effective tracking of defaulters.

On-going emphasis will be placed on prevention, screening, early diagnosis, and treatment of opportunistic infections and STIs. Provision of cotrimoxazole and isoniazid prophylaxis, as per current national and WHO guidelines, will help decrease morbidity and mortality rates among pre-ART patients. Similarly HIV care and support services will be provided to KP, including FSW and MSM. Special emphasis will be placed on use of evidence-based strategies such as KP-friendly health facilities, provision of condoms and lubricants, and peer educators to deliver targeted combination prevention messages including the importance of continuous care and treatment.

PEPFAR Haiti will scale-up services to reinforce messages on the benefits of early diagnosis, initiation of treatment, and adherence to ART regimen using evidence-based community health team approaches and strategies such as mobile clinics, targeted home visits, and contextualized support group activities.

Within PEPFAR Haiti-supported sites and department-level health units containing priority scale-up districts, the program will increase its support for capacity building and provision of technical assistance for improved retention and adherence. PEPFAR will continue expansion of continuous quality improvement activities using the HealthQual methodology to ensure all patients in care benefit from enhanced quality standards. PEPFAR Haiti will work with implementing partners to sensitize healthcare providers on the importance of good record-keeping to improve data quality and data use. Similarly, the ongoing implementation of SIMS activities will allow PEPFAR Haiti to monitor the capacity of partner-sites to provide a standardized and quality package of HIV care and services.

HIV-related stigma has relatively decreased over the years, but remains a significant problem particularly among KP. PEPFAR Haiti will provide technical support to help the MOH in developing guidelines and adapting training materials targeted at health providers to promote more KP-friendly services. In addition, implementing partners will work through their community health workers to sensitize the general population on the negative effects of discrimination experienced by these vulnerable groups.

4.7 TB/HIV

The TB prevalence in Haiti is 254 per 100,000 (WHO country report, 2013) and TB remains one of the major causes of death in patients infected with HIV. Over the years, the PEPFAR Haiti program has improved TB screening amongst HIV patients and intensified efforts to detect TB cases through clinical assessment and laboratory investigation. The National TB and HIV programs have prioritized the sites with the highest proportions of HIV and TB patients. Leveraging resources from other donors, additional equipment will be put in place during COP15 implementation in 6 scale-up to saturation districts, 3 aggressive scale-up districts, and 1 sustained district.

During FY14, nearly 100% of the HIV-positive patients supported by PEPFAR (newly and currently enrolled in care and treatment) were screened for TB; this achievement was facilitated by Electronic Medical Record (EMR) forms that were modified to ensure that healthcare providers actively search for the four symptoms (cough, fever, night sweats and weight loss) included in the national screening tool. As a result, >95% of HIV-infected patients were screened for TB and 80% of eligible HIV-positive patients benefited from Isoniazid Preventive Therapy (IPT); this amounted to 21,867 patients initiated on IPT in FY14.

In PEPFAR Haiti-supported sites, the FY14 annual progress report confirmed that >95% of new TB patients in the country were tested for HIV; among these, 15% tested positive. Furthermore, approximately 65% of the co-infected TB/HIV patients were put on ART. Building on these efforts, in COP15 implementing partners will be encouraged to ensure that TB/HIV co-infected patients are initiated on ART as per the national guidelines.

The majority of TB funding in Haiti is provided by GF. However, at an implementation level PEPFAR provides additional TB/HIV support focused primarily on laboratory diagnostic capacity, surveillance, and infection control. Support to the national TB and HIV programs at the central and departmental levels is focused on development of coordination, guidelines, and supervision functions. In COP15, PEPFAR Haiti's main priorities are to increase ART initiation rates among TB/HIV co-infected patients; support the National TB program's oversight role in TB and TB/HIV coordination; strengthen laboratory diagnostic capacity; and expand the implementation of the

three Is –intensified TB case finding, isoniazid preventive therapy, and infection control. During COP15, PEPFAR Haiti will continue to leverage non-PEPFAR USG resources to expand TB diagnostics, case finding, infection control practices, and surveillance activities.

PEPFAR Haiti will continue its support to integrating Haiti’s TB and HIV/AIDS programs in COP15 by establishing a strong patient referral system between TB clinics and HIV/AIDS care and treatment centers for HIV-infected persons. To further improve TB/HIV integration, PEPFAR Haiti will continue to train HIV providers in TB/HIV management, while strengthening collaboration with TB treatment providers. PEPFAR Haiti will ensure that the TB/HIV basic package for PLHIV (Pre-ART and ART) is implemented and the quality of care routinely monitored. All scale-up and sustained sites in the 20 priority districts will deliver the same basic TB/HIV care package.

In COP15, smear microscopy and X-Ray will be conducted according to the current algorithms to confirm or rule out active TB. GeneXpert testing will expand to reach 19 healthcare scale-up sites by the end of FY16 to ensure that HIV-positive TB suspects systematically undergo appropriate evaluation for TB. Through efficient networking, access to improved TB diagnoses will increase significantly. PEPFAR Haiti partners will collaborate with the national laboratory to train appropriate staff in selected facilities to incorporate the new TB diagnostics in their routine activities.

4.8 Adult Treatment

Despite having the highest HIV burden within the Caribbean region, with an estimated 146,525 PLHIV, 92% of which are adults 15 years and older, Haiti is winning the fight against HIV. This can be attributed largely to the PEPFAR-funded national scale-up of HIV testing and treatment services. According to UNAIDS, Haiti has achieved one of the highest reductions in new HIV cases and AIDS-related mortality in the world, and has reached the programmatic tipping point—annually enrolling on ART more patients than the estimated number of new infections per year.

PEPFAR Haiti, working in close collaboration with the government, has successfully expanded service access by increasing the number of treatment facilities to bring treatment services closer to the population. HIV care and treatment services were also integrated within general healthcare facilities to reduce stigma and promote sustainability of ART services. PEPFAR is currently financing clinical services in 39 out of 42 *arrondissements* (districts) in Haiti, supporting over 62,000 patients on ART, which represents just over 50% of all patients eligible for ART in the country.

Given new budget realities, PEPFAR-Haiti is making strategic pivots in the program by prioritizing geographic areas, health facilities, and services, for a more efficient and impactful approach that will effectively lead to the UNAIDS 90/90/90 goals within high burden areas in the near future. PEPFAR Haiti has undergone a thorough review of available programmatic and epidemiologic data which led to the prioritization of 10 scale-up to saturation districts and 10 aggressive scale-up districts. Within these, 67 health facilities were identified for further scale-up of ART services. The goal is to achieve at least 80% ART coverage by FY17 in the 10 scale-up to saturation districts. To reach this goal, close to 24,000 patients need to be initiated on ART within these ten districts only, in addition to FY15 expected results.

After assessing ART demand/gap estimates and cumulative LTFU rates for each district, the team determined the most feasible net gains in ART patients that will enable $\geq 80\%$ coverage in the 10 scale-up to saturation districts by FY17. In the 10 aggressive scale-up districts, no specific target date has been set for reaching this level of coverage. By APR16, the team aims to enroll 22,044 new patients on ART, out of which 83% will come from scale-up to saturation districts, and to support 81,397 patients on ART (75% in scale-up to saturation districts), an overall 30% increase compared to FY14 results, with 36% growth in scale-up to saturation districts, versus 20% in aggressive scale-up districts and 14% in sustained districts. PEPFAR Haiti anticipates that these timelines may be influenced by GF programming, which if harnessed appropriately, may allow for the accelerated attainment of these coverage targets.

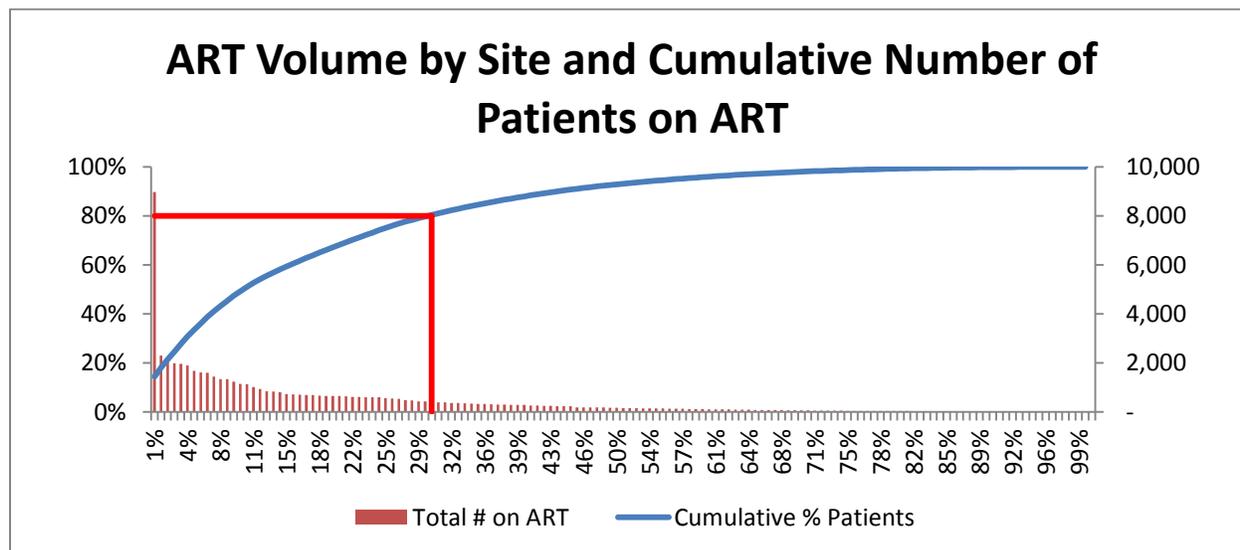
In addition to the shift towards high burden/high yield areas, strategies to reach targets include: 1) tactical withdrawal from low yield sites to gain efficiency; 2) emphasis on diagnostic and treatment of TB/HIV patients and priority populations; 3) regular monitoring of ART eligibility and fast-tracking enrollment via testing-based triage; 4) task-sharing and task-shifting, when appropriate, to cover the growing needs in human resources; and 5) reduction of attrition. To reach these targets, PEPFAR Haiti will urgently improve retention, which is primarily impacted by premature deaths and LTFU. LTFU remains a challenge, especially in the context of limited resources and closing of programs which have historically provided complementary social support, such as nutrition support. In COP15, PEPFAR Haiti will adjust its retention strategy to focus on prevention of LTFU among all patients, and not only defaulters, by promoting regular contact with patients via calls or text messages, and by increasing linkages between communities and facilities.

Analysis of program data identified 148 (54%) USG supported sites with clinical services for transition, out of 270 supported in FY14, for a total savings of \$2,051,762. Out of these transitioning sites, 27 are sites providing ART. To avoid large cost implications in COP15, the transition process will be completed by the end of 2015, with at least a 3-month timeframe to reduce risk of attrition. Savings from transition sites will be redirected to scale-up in priority districts. Identification of other donors to take over services at transition sites is challenging. However, PEPFAR Haiti is committed to ensuring that no ART patient at transition sites will be dropped from treatment. PEPFAR Haiti is carefully planning continuation of treatment services via a mix of facility- and community-based service delivery models, such as establishment of rally points for mobile clinics, direct referral of ART clients to nearby sustained or scale-up sites when possible, and facilitated ARV pick-up and delivery through community health workers, where applicable.

To find further efficiencies, a cost-band analysis of the clinical service packages provided by sites was proactively requested by PEPFAR Haiti at the beginning of FY15. This joint HQ-field assessment observed variations in packages supported between sites, which drive costs. In response, PEPFAR Haiti further defined and streamlined a standard package of services, based on WHO recommendations and the core, near-core, non-core analysis. Major changes include important reductions in the frequency of lab tests and spacing of visits, while remaining in compliance with national guidelines. Savings from these adjustments will support the launch of viral load monitoring in COP15. The new treatment package will continue to support provision of ARV commodities, quality improvement, salaries and training of essential healthcare providers. Currently, ART patients receive ARV drugs through both PEPFAR (via the Supply Chain Management System [SCMS]) and GF procurement with a ~80/20 split.

Efficiency Analysis

In FY14, PEPFAR Haiti supported ART services in 142 sites, of which 43 (30%) accounted for 80% of ART patients, while 99 sites (70%) accounted for only 20% of ART patients, with a volume range between 0 and 391 patients and with 20 sites supporting <50 patients. Only seven sites reported <4 ART patients, including one (a juvenile detention center) reporting zero patients. Six of these sites will not be supported in FY16, while one will be sustained because it was activated only in June 2014. Overall, in terms of ART services, APR14 results align with the proposed new geographic focus: 54,495 (88%) ART patients, and 73% (104) of ART sites are already within scale-up to saturation and aggressive scale-up districts. Furthermore, the 10 scale-up to saturation districts alone, already accounted for 44,538 (72%) ART patients and 73 (51%) ART sites, in FY14. Across all districts, 27 ART sites were identified for transition, based on low volume, low HTC yield, relative location to other sites, and expenditure analysis results. The estimated \$314,876 used to support these sites in FY14 will be redirected to scale-up sites in COP15. Some sites have been scaled-up in scale-up to saturation and aggressive scale-up districts with largest treatment gaps, despite relative low performance. PEPFAR-Haiti will further evaluate these sites to identify individual issues.



4.9 Pediatric Treatment

As of April 2015, there were 2,830 pediatric (age <15 years) patients on ART treatment in Haiti. Based on the UNAIDS 2013 Global Report, Haiti would need to have 5,996 eligible children on ART to achieve 90% coverage. For COP15, pediatric HIV clinical services will prioritize systematic testing of children in high priority settings. In line with WHO recommendations, the pediatric care and treatment program, under the leadership of MOH, has contributed to the revision of the national guidelines that recommend treatment for all children <5 years of age, an improvement from the previous emphasis on treatment for children <2 years of age and consistent with current WHO normative guidance.

Amendments to the current guidelines “Normes de Prise en Charge Pédiatrique” are being vetted by the National HIV Program (PNLS). Updates to these guidelines also include HIV testing for all children at inpatient wards and outpatient clinics, all malnourished children, and all children at the immunization ward. Since 2009, PEPFAR Haiti has expanded the number of sites with EID

from 9 sites to 106 in 2014. PMTCT is a joint effort with PEPFAR, UNICEF, UNAIDS, WHO, and the MOH developing a network across all departments so that more clinics have access to PCR testing, with the aim of contributing towards the elimination of MTCT. In COP13 3,693 infants (<12 months) had PCR done and 208 tested HIV-positive (transmission rate 5.6%). Currently, SCMS procures all pediatric ARVs for children in Haiti.

PEPFAR supports the MOH (PNLS), through key SI and program implementing partners, to conduct routine pediatric HIV drug resistance surveys in Haiti. Based on evidence generated from these studies, and in line with the revised 2014 WHO recommendations, the country has made a change in first line therapy by replacing the Nevirapine arm (NVP) of the current first line regimen with Lopinavir/ritonavir. Therefore, the new first line therapy in Haiti now consists of AZT+3TC+LPVr and ABC+3TC+LPVr (or TDF+3TC+LPVr). Based on expenditure analyses and a review of average costs of ARVs for 2014, this change will have a minimal impact on program costs.

PEPFAR supports viral load monitoring for children through procurement of Abbott equipment, which will be used for both EID and VL, capitalizing on dried blood spots (DBS). This will reduce bottlenecks related to infrastructure and specimen transport in the country.

PEPFAR Haiti recognizes that, to achieve epidemic control, it is essential that the country embrace task shifting. This is a key strategy necessary to expand access to ART for the pediatric population, as currently, clinician nurses are primarily trained in the management of adult patients. PEPFAR Haiti and MOH are actively seeking the contribution of other donors to collaborate in this effort, as a standardization of curriculum and trainings will be needed to build capacity in pediatric care and treatment among clinician nurses.

The geographical shift toward districts with higher prevalence and population will have a positive impact on the pediatric treatment program. Several districts in the West (Metropolitan area), Artibonite, North, Northeast, and Northwest departments are prioritized because of the higher prevalence and highly populated districts. Pediatric services will enhance the testing of siblings in the scale-up to saturation and aggressive scale-up districts, as will targeted testing outreach, combination prevention activities for children and youth living in and around identified KP hotspots, and index patient contact tracing.

In COP15, the ongoing efforts to integrate services to the Orphans and Vulnerable Children (OVC) and pediatric care and treatment services will be scaled-up. This involves increased HIV testing in the OVC population, building effective referral systems to ensure access to care and treatment for all HIV-infected children, utilization of community and OVC program platforms to ensure children adhere to their medication and provision of adequate support through peer support groups to ensure retention on treatment.

Since some pediatric treatment partners also provide OVC services, PEPFAR Haiti has been able to streamline interventions in both program areas, using scarce resources more efficiently and effectively. There will be an increase in the number of adolescents clubs facilitating disclosure and adherence with peer support. The end goal of the strategy is to ensure linkage and retention of children and adolescents in the continuum of care. This strategy will be particularly important considering the transition of PEPFAR support from multiple sites in COP15. Children in these

transitioning sites will be supported through transportation fees for referral to nearby clinical sites.

4.10 Orphans and Vulnerable Children

In FY14, PEPFAR Haiti supported 52,734 OVC in Haiti to receive supportive and referral services; 57% of these are female and 43% are male. This represents a significant increase from FY11 (the year of the earthquake) when 38,386 OVC were reached and FY13 when services were interrupted due to closure of the Community Health and AIDS Mitigation Project (CHAMP) OVC project. Significant changes in FY14 that positively impacted OVC activities include streamlining interventions along key core components of the program and implementing partners working in closer collaboration. EA has helped partners to focus on essential OVC activities.

In FY14, 41% of PEPFAR Haiti OVC spending went into psychosocial support (child protection, community mobilization, social service networks and local capacity building), 30% to educational support, 17% to HIV-related health services provided within the community (including but not limited to linkage and referral services for HTC, pediatric care, and treatment), 10% to household economic strengthening activities, and 2% to nutritional support. Four of the most populated departments in Haiti, the West (Metropolitan area), Centre, Artibonite, and North departments benefited most from OVC interventions. These departments also represent the departments with the highest HIV prevalence as compared to others in Haiti. The Northeast and the Northwest will be prioritized for more OVC resources in COP15, while activities in Grande Anse and Nippes departments, which have the lowest HIV prevalence, will be reoriented towards reorganizing OVCs around satellite centers for more effective use of resources. OVC in those departments will be, to the extent that is possible, regrouped around sustained centers so they can keep receiving support from the program until they transition. Referral from the community to the facilities will be enhanced (transportation fees) as distance will increase with closing of some sites. In addition to the geographical re-orientation of services and the re-allocation of resources to focus districts defined by HIV burden, PEPFAR Haiti will focus on identified core activities in OVC which include: intensifying the identification of children and adolescent made vulnerable to HIV both through the pediatric and adult HIV population (case management), promotion of HIV testing of OVC (including EID), testing of siblings of identified index cases and ensuring effective referral of adolescents to clinical services focused on keeping adolescents HIV free. Linkages will be established for OVC with nutrition programs and activities to ensure access and referral to clinical nutrition assessment, counseling and support (NACS) services.

Implementing partners will ensure referral access to basic pediatric services related to child survival such as immunization, deworming, and Vitamin A supplementation. This will increase access to, and utilization of, maternal and infant health services and subsequently improve identification of HIV-infected children. Access to adolescent friendly care activities and sexual reproductive health education, counseling and support for young teenage girls will continue to be implemented in COP15 through provision of targeted combination prevention services. These services will be expanded around defined high risk key population locations, in close collaboration with the LINKAGES project (a new key population project).

The OVC program is working closely with the Health Policy Project (HPP) funded by the Office of Democracy and Governance in the implementation of the response to the Violence against Children Survey (VACS report). Twenty-seven sites across nine departments where OVC partners are working have been identified for the post-rape care interventions. The program will continue

to promote the access to birth registry as a child protection intervention in a country where 65% of deliveries are done at home. In close collaboration with the Institute of Social Welfare and Research (IBESR), the Ministry of Social Affairs (MAST) and HPP, PEPFAR Haiti will map services within targeted communities and develop a service directory. PEPFAR Haiti will provide support for national and community level child protection by developing platforms to confidentially link post-rape care and post violence clients to the police and the judiciary system. It is intended that within the health facility victims will have access to the police and legal assistance. HPP is to play a key role in ensuring this collaboration between all the stakeholders. The PEPFAR Haiti OVC program continues to support access to education for most vulnerable children including young girls; currently 12,000 OVC have access to school.

In addition, as referenced above, as applicable OVC will be referred to pediatric ART services as part of the service delivery package. The OVC program is collaborating with Futures Group and the MOH to incorporate OVC program data with national data in the Health Management Information System (HMIS). This will be transitioned to the Government of Haiti (GOH), ensuring country ownership of the data. Preliminary results from a qualitative retrospective study conducted for PEPFAR Haiti by HIV Core shows the great benefit of economic strengthening initiatives to communities, households of OVCs and vulnerable families. The program under review was the Community Health HIV/AIDS Mitigation Project (CHAMP) project that was closed in FY13. Based on these findings, BEST is launching a revised Savings Group approach which will form the core of the Household Economic Strengthening intervention.

The budget per OVC program beneficiary has been on a downward trend since 2011, decreasing by almost half (42%, from \$300 in 2011 to \$174 in 2014). Despite this decline, PEPFAR Haiti has recorded an increase in the number of beneficiaries from 2010. This was made possible by prioritizing PEPFAR Haiti resources for key interventions, per the 2012 PEPFAR Guidelines and reducing the number of international implementing partners. For example, in FY15, two more partners (FOSREF and Handicap International) will cease to implement OVC activities.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Sustained packages of services outside the priority locations and populations

As a general rule in COP15, the program will strive to avoid disruption of treatment or care services to any PLHIV currently receiving care in the current (COP14) implementation period. PEPFAR Haiti will support service scale-up within 20 (of 42) districts, with a particular focus on 10 scale-up to saturation districts, based on criteria already described in this document. Outside of these 20 districts, HIV services, including HTC, care, treatment and PMTCT services, will be either be sustained or transitioned during COP15. As a result, 148 PEPFAR-supported sites will transition HIV services to nearby facilities with larger volume and 57 health facilities will offer a sustained service package.

The sustained package of HIV care and treatment services is defined as a minimum package sufficient to provide appropriate care consistent with national and/or international standards. The details are provided elsewhere, but generally the package includes: passive enrolment of PLHIV in pre-ART care; TB screening for all PLHIV; routine lab screening including CD4 and viral load (when available in late 2015); CTX prophylaxis for all PLHIV; post-rape care; and provision of condoms. PMTCT services will be available at health facilities identifying a minimum number of HIV-positive pregnant women (>four per year) and will include: routine HTC at first presentation

in ANC (repeat testing if evidence of high risk); lifelong ART for all HIV-positive pregnant women; EID for HIV-exposed infants; and support for retention of pregnant women initiated on ART. Support for HTC services (primarily facility-based, provider-initiated) will be essentially discontinued in non-priority districts. Where available (i.e., in sustained sites providing HTC to pregnant women), HTC services will be targeted at TB patients and pregnant women; PITC will be provided to patients with evidence of high risk exposure. Core OVC interventions will be maintained including support for education, case management, HTC for OVC, and psychosocial support.

The number of PMTCT service beneficiaries derives from the objective of testing at least 90% of ANC clients and providing ART to 95% of those identified as HIV-infected. Given the transitioning of a number of low volume sites and the discontinuation of PMTCT services at sustained health facilities in low yield sites, the volume of beneficiaries of PMTCT services is expected to decline (by 8%). The number of people enrolled in pre-ART will also be significantly reduced (by 50%) as new enrollment will be negligible and a significant number of pre-ART patients will be enrolled on ART. At the same time, the program expects an increase (approximately 5%) in the number of patients currently on ART though much lower than in scale-up to saturation districts, as ART enrollment will continue mainly from pre-ART, TB/HIV co-infection, and PMTCT. Also, the number of OVC served will decrease by 46%, generating savings, which will contribute to support the significant increase in OVC targets in the scale-up to saturation districts.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services Outside the Scale-up to Saturation and Aggressive Scale-up Districts

	Expected result APR 15	Expected result APR 16	Increase (Decrease)
HIV testing in PMTCT sites	28,824	26,471	-8%
HTC (only sustained ART sites in FY16)	160,461	55,722	-65%
Current on care (not yet initiated on ART)	2,599	1,301	-50%
Current on ART	8,223	8,767	7%
OVC*	20,000	10,862	-46%

*Target for FY15 entered in FACTSInfo (37,320) was underestimated as in FY14 the program reached 52,000. The program conservatively estimates that the same results will be achieved for FY15; of which 20,000 beneficiaries are expected from non-priority districts.

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

Since the COP14 Wave 1 meeting in July 2014, the PEPFAR Haiti team, led by Ambassador White, has been proactive in communicating the basis for, and implications of, PEPFAR funding reductions to national stakeholders, including the Haitian government and international donors. At present, it is unlikely that additional co-financing will be identified that would allow for HIV clinical service delivery to continue at health facilities designated for transition under PEPFAR funding. With few exceptions, the vast majority of transition sites are located around prominent referral centers; 62% are in scale-up to saturation and aggressive scale-up districts. During the remainder of FY15 and the first quarter of FY16 a detailed mechanism and procedures for patient

referral will be developed. These operational arrangements will be predicated on a compact between all partners regarding transfer/sharing of patient level data. The service delivery model and the service package have already been simplified and streamlined as detailed elsewhere in the SDS.

Several of the activities supported within the MOH under HSS will cease in the near future, including: support to three departmental offices where low numbers of new ART enrollees will not require heavy regional coordination; support to three Communal (sub-district) offices that manage the district of Port-au-Prince as this support, introduced after the earthquake, is no longer needed; support to several of the central MOH directorates engaged in the Partnership Framework, which have been able to internalize processes and best practices. Other support will be phased out in COP16 to provide adequate time for activities to reach maturity or the intended objectives, or to secure other funding sources. Activities in these categories include TA for: development of the Global Fund concept notes; national supply chain system; and a health financing plan. In addition, PEPFAR Haiti will phase out other near-core activities including the procurement of selected supplies and commodities like condoms, printing of forms and registers, mapping activities and surveys that have historically received support from other donors, and in-service training provided to HIV providers in ancillary domains such as family planning and TB clinics.

6.0 Cross-cutting Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

The PEPFAR Haiti lab program will focus on laboratory aspects for reaching the UNAIDS 90/90/90 targets. Specifically, the National Public Health Laboratory (NPHL) will implement the PEPFAR laboratory HIV Rapid Testing Quality Improvement Initiative (RTQII), maintain previous improvements in access to CD4 testing, and greatly expand HIV viral load (VL) testing. Increased quality of HIV diagnosis (HIV RDT) will be emphasized through quality service delivery activities, namely monitoring and evaluation of activities, prompt testing of samples coupled with prompt return of results.

For improved HIV RDT results, the NPHL will implement RTQII throughout the PEPFAR laboratory network and ensure that results are entered into the RTQII recommended log books. The NPHL will continue to produce and distribute HIV DTS proficiency testing (PT) panels to all PEPFAR sites, as well as other private labs in country (more than 200 total labs participate in the program) and results will be entered electronically into software (ePT) that was developed this fiscal year for the NPHL. The program will continue to focus on reduced turn-around-time for results coupled with QMS follow-up mentoring for sites that underperform in testing.

Currently, VL testing capacity exists only within select partner service catchment areas. In the coming year, PEPFAR will establish and scale-up national-level HIV VL testing for ART patients. The selected platform (Abbott m2000 fully automated extraction/RT-PCR systems) will enable Haiti to perform EID and VL testing using DBS specimens, resulting in expanded geographical coverage of testing. Centralized DBS VL testing (two sites using three Abbott platforms) becomes cost competitive with decentralized CD4 testing; a limited number of VL instruments results in a reduction in equipment costs, depreciation, and sustained, with associated reductions in money spent on training, EQA, and QMS support.

Chemistry and hematology testing will be significantly reduced in the coming year and will be provided on an as-needed basis, assuming 30% of patients in care will need chemistry and 17% of patients in care will need hematology.

6.1 Laboratory Strengthening Log Frame

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s)	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016	ID		8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Quality Assurance											
Improve the quality of HIV diagnostic testing through implementation of the HIV Rapid Test Quality Improvement Initiative (RTQII)	Development of RTQII training material and a training of trainers (TOT) program within the NPHL's QMS program Technical staff at clinical sites performing HIV RDT using existing national testing guidelines 100% of HTC sites recording results in standardized RTQII HIV RDT log books 100% of PEPFAR ART sites enrolled in the HIV RDT PT EQA program	Increased number of highly trained technical staff within HTC sites proficient in testing using RTQII guidelines Technical staff at clinical sites performing HIV RDT using RTQII guidelines 100% of HTC sites recording results in standardized RTQII HIV RDT log books 100% of PEPFAR HTC sites enrolled in the HIV RDT PT EQA program	HLAB HTXS \$100,000	HLAB HTXS \$500,000	CMMB, CDS, FOSREF, GHESKIO, ITECH, PIH, POZ, UMB, Pathfinder, UGP	HRH sufficiency - 0, HRH transition - 0, In-Service - 3, Domestic funding for HRH - 0, Existence of System - 4, Strategy - 4, Data Use - 2, Post-transition - 0	x	x			
Support EQA program for HIV RDT PT	Training of additional staff within the NPHL's QMS group to perform mentoring and training of HIV RDT usage 100% of PEPFAR sites enrolled in the QASI CD4 PT program through the NPHL; 80% of sites performing chemistry and 70% of sites performing hematology enrolled in OneWorld Accuracy PT program through the NPHL; all PEPFAR ART sites performing HIV RDT testing enrolled in the NPHL's syphilis EQA program	Improved turn-around-time of EQA results and subsequent follow-up of mentoring/training at low-performing HTC sites 100% of PEPFAR sites enrolled in the QASI CD4 PT program through the NPHL; 100% of sites performing chemistry and hematology enrolled in OneWorld Accuracy PT program through the NPHL	HLAB \$50,000	HLAB \$50,000	UMB, UGP	Existence of System - 4, Strategy - 4, Data Use - 2, Post-transition - 0	x	x			
Support EQA program for CD4, chemistry, hematology, syphilis testing	Participation of the two centralized sites that perform all national EID/VL testing in CDC's	Participation of the two centralized sites that perform all national EID/VL testing in	HLAB \$95,000	HLAB \$115,000	UMB, UGP	Existence of System - 4, Strategy - 4, Data Use - 2, Post-transition - 0	x	x	x		
Support EQA program for HIV EID/VL testing			HLAB \$10,000	HLAB \$10,000	UMB, UGP	Comprehensiveness of Viral Load Data - 0, Existence	x	x	x		x

	EQA program	CDC's EQA program											
	Improved accuracy of results at Regional, Departmental, and clinical labs from technical assistance in improving quality of lab processes and testing; follow-up training for individuals that under-perform on EQA testing and sites that have deficiencies in quality lab practices	Improved accuracy of results at Regional, Departmental, and clinical labs from technical assistance in improving quality of lab processes and testing; follow-up training for individuals that under-perform on EQA testing and sites that have deficiencies in quality lab practices	HLAB \$300,000	HLAB \$300,000	UMB, UGP	of System - 4, Strategy - 4, Data Use - 2, Post-transition - 0							
Provide laboratory assessment and technical assistance for quality improvement						Existence of System - 4, Strategy - 4, Data Use - 2, Post-transition - 0	x	x	x	x	x		
Training of laboratory technicians on CD4, chemistry, hematology, VL, EID, fluorescence microscopy, and GeneXpert; training of trainers for FM and GeneXpert	Quality HIV and HIV-coinfected diagnostic testing for all HIV patients	Quality HIV and HIV-coinfected diagnostic testing for all HIV patients	HLAB HTXS \$600,000	HLAB HTXS \$625,000	CMMB, CDS, FOSREF, GHESKIO, ITECH, PIH, POZ, UMB, Pathfinder, UGP	Comprehensiveness of Viral Load Data - 0, Existence of System - 4, Strategy - 4, Data Use - 2, Post-transition - 0	x	x	x	x	x		
HIV-related diagnostic testing													
Provide technical support for the laboratory supply chain, including the Diagnostic Access Initiative, the CAGIL committee, and viral load scale up; provide reagents for biochemistry, hematology, and syphilis testing	Quality HIV and HIV-coinfected diagnostic testing for all HIV patients Improved quality assurance systems Improved stock management and data reporting Increased on-the-job training and validation exercises Reduced stock-outs Quarterly supervisory visits to PNLAs Resupply of sites based upon needs reflected within DHIS2 LMIS reports Regular data quality audits	Quality HIV and HIV-coinfected diagnostic testing for all HIV patients Improved quality assurance systems Improved stock management and data reporting Increased on-the-job training and validation exercises Reduced stock-outs Quarterly supervisory visits to PNLAs Resupply of sites based upon needs reflected within DHIS2 LMIS reports Regular data quality audits	HLAB \$2,864,747	HLAB \$3,023,073	SCMS	Supply Chain Plan - 0, Stock - 2, Collection of service delivery data - 6, Expenditure Tracking - 1	x	x	x	x	x		
Support MOH's HIV drug-resistance program	Provide technical assistance for WHO grant application to procure sequencing equipment	Provide technical assistance, if WHO grant funded, for HIV drug-resistance sequencing	HVSI \$10,000	HVSI \$20,000	UGP	Data use - 2							x
HIV-TB co-infected testing													

Support detection of tuberculosis through use of fluorescence microscopy and light microscopy	Installation, validation, and operationalization of 12 fluorescence microscopes for TB diagnosis Increased number of TB suspect slides read by fluorescence microscopy	Installation, validation, and operationalization of 6 fluorescence microscopes for TB diagnosis Increased number of TB suspect slides read by fluorescence microscopy Installation and operationalization of 5 sites (increasing number of sites utilizing GeneXpert to 21); procurement of GeneXpert cartridges for testing 24% of HIV patients Increased number of HIV infected patients suspected of MTB co-infection diagnosed by GeneXpert	HVTB \$30,000	HVTB \$15,000	UMB, UGP UMB, UGP	Domestic Services: Stock - 2 Domestic Services: Stock - 2	x x				x x	
Provide GeneXpert instruments and cartridges for detection of MTB and rifampicin resistant MTB in HIV patients	Procurement of 10 GeneXpert instruments - installation and operationalization of 5 sites (increasing number of sites utilizing GeneXpert to 16) Increased number of HIV infected patients suspected of MTB co-infection diagnosed by GeneXpert	Installation, validation, and operationalization of 5 sites (increasing number of sites utilizing GeneXpert to 21); procurement of GeneXpert cartridges for testing 24% of HIV patients Increased number of HIV infected patients suspected of MTB co-infection diagnosed by GeneXpert	HLAB HVTB \$190,000	HLAB HVTB \$20,000	SCMS, UMB, UGP, GHESKIO SCMS, UMB, UGP, GHESKIO	Domestic Services: Stock - 2 Domestic Services: Stock - 2	x x				x x	
Operations												
Support national laboratory equipment sustained program	Equipment maintained and repaired for laboratories using CD4, VL, EID, chemistry, hematology, and TB microscopy instruments - work divided between NPHL and contractors	Equipment maintained and repaired for laboratories using CD4, VL, EID, chemistry, hematology, and TB microscopy instruments - work performed by single contractor (simultaneously training MOH staff for transition of responsibilities)	HLAB \$350,000	HLAB \$350,000	SCMS, UGP	NA	X	X	X	X	X	X
Support specimen transport for EID and VL	EID specimens transported from all PEPFAR supported labs to the NPHL and GHESKIO and results returned to sites; VL specimens transported from selected sites in Port-au-Prince area to the NPHL	EID and VL specimens transported from all PEPFAR supported labs to the NPHL and GHESKIO and results returned to sites; VL specimens transported from selected sites in Port-au-Prince area to the NPHL	HBHC PDCS HTXS \$180,000	HBHC PDCS HTXS \$180,000	UGP, Caris	Domestic Program: Who is delivering HIV/AIDS services - o, Comprehensive ss of Viral Load Data - o	x	x	x	x	x	x
Support specimen transport for CD4, chemistry, hematology	CD4, chemistry, and hematology specimens transported from lower volume PEPFAR sites to higher volume PEPFAR hubs	Support logistics for specimen transport to hubs for CD4 samples and for EID/VL from all PEPFAR supported labs to the National lab and GHESKIO and results returned to sites	HBHC PDCS HTXS \$0 (\$560,000 support from CDC DGHP for	HBHC PDCS HTXS \$0 (\$450,000 support from CDC DGHP for	UGP	Domestic Program: Who is delivering HIV/AIDS services - o, Comprehensive ss of Viral Load Data - o	x	x	x	x	x	x

Support to the NPHL	Support VL, EID, CD4, GeneXpert testing; EQA, QMS programs; operational costs	Support VL, EID, CD4, GeneXpert testing; EQA, QMS programs; operational costs	specimen transport) HLAB HBHC HVTB PDCS \$1,100,000	specimen transport) HLAB HVTB HBHC PDCS \$850,000	UGP, UMB	NA	x	x	x	x	x
Support to Regional laboratories	Support HIV RDT, CD4, chemistry, hematology, GeneXpert testing; operational costs	Support HIV RDT, CD4, chemistry, hematology, GeneXpert testing; operational costs	HLAB HVCT HTXS HBHC PDCS MTCT HVTB \$1,000,000	HLAB HVCT HTXS HBHC PDCS MTCT HVTB \$800,000	UGP, GHESKIO	NA	x	x	x	x	x
Support to facility based laboratories	Support HIV RDT, CD4, chemistry, hematology, GeneXpert testing; operational costs	Support HIV RDT, CD4, chemistry, hematology, GeneXpert testing; operational costs	HLAB HVCT HTXS HBHC PDCS MTCT HVTB \$6,900,000	HLAB HVCT HTXS HBHC PDCS MTCT HVTB \$6,600,000	CMMB, CDS, FOSREF, GHESKIO, ITECH, PIH, POZ, UMB, Pathfinder, UGP	NA	x	x	x	x	x
POLICY Work with MOH to finalize national lab policy that includes requirements of licensure/certification for labs and certification for technicians performing HIV RDTs	Policy adopted by MOH	Policy submitted to parliament to turn it into law allowing MOH to regulate lab activities in the country	OHSS \$65,000	OHSS \$15,000	UGP, UMB	Enabling environment: Structural obstacles - 6.o, Access protection - o, Civil society sustainability - 3.o, Enabling legislation - o	x	x	x	x	x
Work with MOH to develop a new laboratory strategic plan	New 5 years laboratory strategic plan drafted	Laboratory strategic plan approved by MOH	OHSS \$25,000	OHSS \$25,000	UGP, UMB	Enabling environment: Structural obstacles - 6.o, Access protection - o, Civil society	x	x	x	x	x

sustainability - 3.0,
Enabling
legislation - o

6.2 Strategic Information

PEPFAR Haiti has historically invested in fundamental SI domains such as core HIV epidemiologic surveillance and survey activities; program monitoring and evaluation; health information systems; and operational research. All domains will continue to be supported in the COP15 implementation period and each of these will be addressed separately.

1. **Surveillance and Surveys:** PEPFAR Haiti will continue to invest in essential surveillance and survey activities such as the ANC sentinel surveillance among pregnant women; the IBBSS (2nd) among MSM/FSWs; the DHS 2017 – partial funding, including the HIV module; and the HIV/AIDS surveillance system (HASS), which includes HIV case reporting and longitudinal clinical data. PEPFAR Haiti staff will continue to participate in the national HIV estimates and projections (Spectrum) working group with UNAIDS, PNLS/MSPP, and NASTAD.
2. **Monitoring and Evaluation:** Each PEPFAR implementing partner will continue reporting into either the national HIV reporting system (MESI, primarily for health facility-based reporting) or partner-level reporting systems for community based activities. MESI provides aggregate, facility-level program data on national and PEPFAR/GF program indicators.
3. **Health Information Systems (HIS):** In addition to MESI, the core HIS components that will continue to be supported include iSante, the national electronic medical record for HIV care and treatment services; HASS, which includes interoperability among three EMRs (iSante, GHESKIO and PIH) and MESI; and DHIS 2.0, which will also develop interoperability with the other core architectural components.
4. **Operational Research:** In COP15 this will primarily involve analyses of routinely collected data via HASS, including longitudinal outcomes throughout the clinical care cascade. The previously funded “test and treat” protocol will be implemented in the remaining period of COP14 and into the COP15 implementation period but will not require additional resources.

In line with PEPFAR Haiti’s overall focus on increasingly programmatic transparency, efficiency, and impact, as well as the systems necessary to achieve epidemic control, in COP15 the emphasis for SI will remain on:

- Incorporating variables to meet requirements for MER reporting and SIMS into data collection systems, which will require the updating of data collection and reporting tools, the production and distribution of the revised versions, and refresher training for site staff. Sites’ IT infrastructure will continue to need maintenance to enable them to ensure collection and reporting of data to the central level.
- Advancing integration of the system’s current components so that they can further contribute to the generation of integrated data, including the de-duplication of data and longitudinal monitoring of patients in care and treatment. The three EMR will be supported to upgrade operational platforms and build human resource capacity, with the overall goal of contributing to databases for data analysis and reporting.

- Creating interoperability between existing HIV systems and emerging national (DHIS 2.0) and PEPFAR Haiti platforms (DATIM). Effective data exchange will be preceded by intensive preparation by platform administrators.
- Improving functionality and integrity of the data collection and reporting system by ensuring maintenance of the system infrastructure and integrating new indicators that enhance measurement of program outputs and effectiveness.
- Reinforcing data quality through continuous support to ensure data validation and improvement across all core information systems. Data from all implementing sites will continue to be audited independently and hands-on assistance will be provided for quality improvement.
- Supporting partners to meet USG reporting requirements and providing technical assistance needed to sites. As the role of partners increases in terms of reporting requirements, additional support is necessary to build capacity for effective mentorship and supervision to sites.

6.2 Strategic Information Log Frame

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s)	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016	ID		8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11. *Other Combination prevention	12. Viral suppression
STRATEGIC INFORMATION											
Production and distribution of paper tools (Forms, logs) for HIV and Primary Care Data collection and reporting	Paper tools revised to incorporate MER requirements and allow tracking of priority groups such as TB patients and pregnant women	Paper tools revised to incorporate MER requirements and allow tracking of priority groups such as TB patients and pregnant women	HVSI \$350,000		UGP	Performance Data - 16	X	X	X	X	
Incorporation of OVC data in the national MOH health reporting system (DHIS2). Production, distribution and training of paper tools	Availability of data on OVC will better inform targeting for HIV services, improve linkage and retention into HIV care and treatment, and	Availability of data on OVC will better inform targeting for HIV services, improve	HKID \$750,000		FUTURES GROUP	Performance Data - 16	X	X	X	X	X

(Forms, logs) for OVC and primary care data collection. Conduct OVC essential indicators survey.	strengthen referral to other health and social services. Paper tools revised to incorporate MER requirements. OVC essential indicator survey conducted with implementing partners.	linkage and retention into HIV care and treatment, and strengthen referral to other health and social services. Paper tools revised to incorporate MER requirements. Results from essential OVC indicator survey from expanded number of implementing partners.									
Continuous development of Case Based notification and linkages to community tracking systems	Aggregate Reporting system in alignment with MER requirements and able to transfer data automatically to DHIS2 and DATIM	Aggregate Reporting system in alignment with MER requirements and able to transfer data automatically to DHIS2 and DATIM	HVSI \$350,000		UGP	Performance Data - 16	X	X	X	X	
Assistance for reporting and Regular Data Validation at all supported sites	At Least 95% of reports from sites available and validated for completeness and accuracy	At Least 95% of reports from sites available and validated for completeness and accuracy	HVSI \$700,000		UGP	Epidemiological and Health Data - 7.8	X	X	X	X	
Transition of Isante (ITECH EMR) to OPENMRS	Larger pool of contributors for system design and		HVSI \$542,500		ITECH	Performance Data - 16		X	X	X	

	development										
Targeted support to GHESKIO EMR for interoperability with national HMIS and USG reporting systems	Quality data in compliance with MER and case based reporting for 2 networks representing 48% of patients on treatment		HVSI \$204,575		GHESKIO and PIH	Performance Data - 16		X	X	X	
Maintenance of IT Infrastructure and availability of internet connection at all functioning sites	Seamless collection of data electronically and automatic transmission to national server	100% of longitudinal data for patients on care and treatment available in data warehouse	HVSI \$1,241,634		All networks	Epidemiological and Health Data - 7.8	X	X	X	X	
Build capacity of MOH and NGO facilities and health personnel to collect, analyze, and disseminate HIV/AIDS monitoring information. Maintenance of IT Infrastructure and availability of internet connection at all functioning sites	Seamless collection of data electronically and automatic transmission to national server	100% of longitudinal data for patients on care and treatment available in data warehouse	HVSI \$190,000		SSQH-North SSQH-South	Epidemiological and Health Data - 7.8	X	X	X	X	X
Maintenance of National HIV/AIDS Sever	Server aimed at hosting aggregate and Individual level data have appropriate redundancy and security features	Management of Platform and Systems fully transitioned to in-country	HVSI \$100,000		UGP	Epidemiological and Health Data - 7.8	X	X	X	X	
Continuous development of Case Based notification and linkages to community tracking systems	Availability of longitudinal data for patient on C&T; analysis and publications on treatment outcome and effectiveness	Reduction in duplicate data; Efficient patient tracking system	HVSI \$800,000		NASTAD	Performance Data - 16		X	X		
Deployment of DHIS2.	1. Evidence of the use	1. Evidence of	HVSI		Futures	Epidemiological	X	X			

<p>Direct Support to Planning and Evaluation Unit (UEP) within the MOH to lead process for standard data collection methods for HIV and health information. Support MOH to 1) develop and implement national eHealth/HIS/ICT strategies, policies and guidelines processes, 2) coordinate development of health technology implementation plan that ensures that country and development partners' needs are aligned with a cohesive investment strategy in the health sector.</p>	<p>of health program areas statistics to better target HIV interventions. 2. PEPFAR supported clinics have no stock out of PHC log books and registers. 3. MOH provides leadership, management and coordination of eHealth investments so HIV inputs are coordinated with all other health sector inputs to achieve results that support HIV/AIDS and health sector in general 4. Planning for core HIV Information System Needs are incorporated into broad sector wide eHealth planning and HIV specific eHealth planning.</p>	<p>the use of health program areas statistics to better target HIV interventions. 2. PEPFAR supported clinics have no stock out of PHC log books and registers. 3. MOH provides leadership, management and coordination of eHealth investments so HIV inputs are coordinated with all other health sector inputs to achieve results that support HIV/AIDS and health sector in general 4. Planning for core HIV Information System Needs are incorporated into broad sector wide eHealth planning and HIV specific eHealth planning.</p>	<p>\$700,000</p>		<p>Group</p>	<p>logical and Health Data - 7.8, Performance Data - 16.0, Planning and Coordination - 17.0</p>					
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DHS 2017 survey HIV Module	The DHS 2017 will serve as the source for HIV and health indicators, which can only be obtained through population based survey. Sufficient budget for survey from development partners and stakeholders, protocol developed.	Implementation of the data collection in all 10 departments with potential oversampling in districts with priority need for more precise estimates.	HVSI \$600,000		Measure Evaluation-ICF International	Epidemiological and Health Data - 7.8	x	x	x	X	
ANC Sero-Survey	Refined data from survey to inform Epi profile and geographic prioritization based on updated survey data		HVSI 40000		UGP						

6.3 Health systems strengthening

PEPFAR supports several building blocks of the health system to promote sustainability and efficiency. In this declining budget environment, support will be directed to the six health system building blocks that directly impact epidemic control efforts: leadership and governance of the system, human resources for health, clinical services, strategic information, health financing, and supply chain management.

In regard to leadership and governance, involvement of the MOH, both at the central and departmental levels, remain critical to the success and sustainability of the HIV response. At the central level, support has been withdrawn from four units whose interventions have had only marginal effects on HIV program outputs. Moving forward, the focus will only be on four key remaining units, which are instrumental to updating technical guidance, establishing stakeholder consensus, and modifying system information tools. These units are responsible for coordinating and monitoring programs related to HIV clinical services, PMTCT, TB/HIV and information systems. At the departmental level, assistance will be provided to seven of the ten offices with a higher concentration of priority districts to enable them to lead efforts for regional coordination, service quality improvement, and data validation. They will be supported to facilitate the transition of sites and patients resulting from the shift in program approach.

With current budget levels, the program will no longer be able to afford pre-service training as well as the mass training approaches adopted in the early years of PEPFAR. Revamping of curricula for pre-service training for nurses and laboratory technicians has been classified as a non-core activity. With the closing out of several facilities, it is expected that personnel will be shifted around to offset the high rate of staff turnover that has continuously plagued execution of activities in the field. In-service training will be kept at the minimum level needed to fill critical gaps in areas mostly affected by a high rate of staff turnover and that support the provision of high-quality clinical services.

The PEPFAR program will continue to support staff salaries at implementing sites for key HIV service providers. Nonetheless, efforts will streamline service models and staffing patterns, as well as encourage greater host country financial investment and more efficient resource management in the health sector. Significant savings are projected following the reduction in the packages of services offered at sustained sites and the transition of low performing sites. Health financial management capacity is being built directly within the Program Management Unit (UGO) of the MOH. This includes managing over 60 contracts at the national level as well as departmental administrative oversight of financing to public sector health facilities providing HIV clinical services.

The PEPFAR program will also complete its Gender Strategy by March 2016 utilizing the updated Gender Strategy disseminated by the Gender and Adolescent TWG in the fall of 2015.

6.3 HEALTH SYSTEMS LOG FRAME

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
			4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
I HEALTH SYSTEM STRENGTHENING											
1.1 Leadership, Governance and Management											
Direct Support (Human resources, operation costs) to 8 of the 10 departmental offices regrouping the most high burden districts	Evidence of Annual consolidated departmental plans; regional partner forum; Site support for scale up, transitioning of sites and transfer of patients, data validation; Financial control for PEPFAR supported public hospitals; 1 yearly supervision visit at 80% of C&T sites in the department	Annual consolidated departmental plans; regional partner forum; Community mobilization for testing; Site support for scale up, transitioning of sites and transfer of patients, data validation; Financial control for PEPFAR supported public hospitals; 1 yearly supervision visit at 80% of C&T sites in the department	OHSS \$700,000		UGP	Human Resources for Health - 7.3	X	X	X		
Direct Support to HIV Coordinating unit (PNLS)	Updating of Treatment norms toward tests and treat; Analysis of HIV Case notification data; Epidemiologic	Enforcement of tests and treat policy; Analysis of treatment outcome; Epidemiologic Bulletin; National Partner forum; coordination of	OHSS \$250,000		UGP	Human Resources for Health - 7.3, Oversight and Stewardship - 9.0	X	X	X		

	Bulletin; National Partner forum; coordination of HIV/QUAL; Standard operating procedure for Patient Tracking	HIV/QUAL; Standard operating procedure for Patient Tracking									
Support to TB Coordinating unit PNLT	Organization of testing at TB clinics; modification of TB registers to incorporate HIV data; Setting forth of Monthly TB reporting and Case Notification system; Acceptance of policy to supply HIV clinics with TB drugs for co-infected	Organization of testing at TB clinics; modification of TB registers to incorporate HIV data; Setting forth of Monthly TB reporting and Case Notification system; Acceptance of policy to supply HIV clinics with TB drugs for co-infected	OHSS \$122,000		UGP	Human Resources for Health - 7.3, Planning and Coordination - 17.0	X	X	X		
Direct Support to Family Health Unit (DSF)	Updating of PMTCT guidelines, Enforcement of Option B+, Integration of PMTCT into ANC, L&D and pediatric wards	Updating of PMTCT guidelines, Enforcement of Option B+, Integration of PMTCT into ANC, L&D and pediatric wards	OHSS \$100,000		UGP	Human Resources for Health - 7.3, Planning and Coordination - 17.0				X	
Technical Assistance to MSPP for development of Regional Epidemiologic profile and transitioning of Surveillance systems			OHSS \$100,000		NASTAD	Epidemiological and Health Data - 7.8					
1.2 Human Resource Capacity Building											
Care and Treatment Core Training	Trained staff in sufficient supply for provision of clinical services at all functioning Care and Treatment sites		OHSS \$65,000		UGP	Human Resources for Health - 7.3		X	X		

HTC Core training	Trained staff in sufficient supply for provision of HTC services at all functioning sites offering HTC services		OHSS \$30,000		ITECH	Human Resources for Health - 7.3	X				
PMTCT Core Training	Trained staff in sufficient supply for provision of HTC services at all functioning sites offering HTC services		OHSS \$30,000		ITECH	Human Resources for Health - 7.3				X	
Management of TB/HIV Co-Infection training			OHSS \$30,000		ITECH	Human Resources for Health - 7.3					
Specialized Assistance for reinforcement of HealthQual Training and coaching activities and Improvement projects	Service Quality insurance system established at all C&T sites; Well acquainted regional coaching teams; Bi annual national meetings	Service Quality insurance system established at all C&T sites;	OHSS \$350,000		NY AIDS INSTITUTE	Quality Management - 14.0		X	X	X	
Local Training on HealthQual Methodology and project management for staff involved in C&T	All sites' care an treatment providers trained on Health/Qual methodology. Improvement projects available from all sites, at least 90% performance on key indicators	All sites' care an treatment providers updated on Health/Qual methodology. Improvement projects from all sites, at least 95% performance on key indicators	OHSS \$80,000		All networks	Quality Management - 14.0		X	X		
Training in HIV health Information system for providers and field data staff	All sites' providers and field data personnel trained or refreshed respectively on data collection and data reporting tools in		OHSS \$90,000		UGP	Performance Data - 16.0	X	X	X	X	

	compliance with MER										
Joint HIV-TB supervisory visits (continued from current project year)	The HIV-TB model health clinics are identified -A joint HIV -TB supervisory plan is developed -Standardized supervisory HIV-TB tools are developed -Quarterly supervisory visits are conducted to The identified model HIV-TB health clinics	-Quarterly supervisory visits are conducted to The identified model HIV-TB health clinics -joint HIV-TB trip reports	OHSS \$656,359		LMG	Quality Management - 14.0					
Management and Organizational Sustainability plans implemented (continued from current project year)	Updated MOST Action Plan -PNLS Dashboards reports -Quarterly meeting on the Dashboard report to review indicators	Updated MOST Action Plan Quarterly meeting on the Dashboard report to review indicators			LMG	Quality Management - 14.0					
Joint HIV-TB Leadership Development Program for the CCM, National Programs and associations representing key populations	Four LDP workshops delivered, LDP Action plans developed and implemented	LDP results presentations			LMG	Human Resources for Health - 7.3, Planning and Coordination - 17.0					
Supporting the DRH with strengthening the Human	Report on EHRIS 1 finalized and EHRIS 2 Reports (final	Final report	OHSS \$570,000		HFG	Human Resources for Health - 7.3	X	X	X	X	

Resources Information System(EHRIS) .Conduct EHRIS2 to broaden EHRIS1 to extend SIGRH to the private sector;	narrative, policy brief,							
Support DFPSS to conduct nursing school reconnaissance visits will help improve HIV /AIDS program training, as part of the curriculum	Report on Reconnaissance 52 (nursing schools where the reconnaissance process manual is tested) 42 participants at HFG-supported pre-service training events		HFG	Human Resources for Health - 7.3	X	X	X	X
Developing public financial management capacity (in support to DAB, UADS) including defining the process, tools will help in resources allocation well-aligned with priorities, including HIV/AIDS programs.	Participants attend HFG-supported financial resource related events and training	Participants attend HFG-supported financial resource related events and training	HFG	HF Technical Efficiency - 0.0, HF Allocative Efficiency - 2.0	x	x	x	x
Development of a draft health financing strategy	Health financing conference, draft of health financing strategy	Draft of health financing strategy/ validation	HFG	HF Allocative Efficiency - 2.0, HF Resource Generation - 0.0	x	x	x	x
Support and capacity building to the	National Health Account report	National Health Account report	HFG	HF Technical Efficiency - 0.0	x	x	x	x

National Health Account (NHA)												
Improve the capacity of the MSPP to advocate and plan financial resources for health	training on One Health tool and formation of a Onehealth tool team	TBD			HFG	HF Allocative Efficiency - 2.0, Financial/Expenditure Data - 7.0	x	x	x	x		
Technical Assistance to MOH/Directorate for Pharmaceutical Management for strengthening the supply chain for HIV commodities and creating an integrated national supply chain system	<ul style="list-style-type: none"> - Implementation Plan for the creation of an Integrated National Supply Chain System elaborated - Costing exercise conducted to inform about the estimated cost for the proposed Integrated National Supply Chain System - Partnership framework between GOH and its Financial and Technical Partners established to support the establishment and operation of the Integrated National Supply Chain Systems (including commodity cost and all supply chain functions) 	<ul style="list-style-type: none"> - Progressive Transition from current parallel supply chain systems into the Integrated National Supply Chain System initiated - Commitment of GOH and its Partners confirm for the implementation of the integrated national system - Progressive financial contribution of GOH into operation cost (staff, utilities, etc.) of the integrated SC system 			OHSS \$248,914	SCMS/ Follow-on SC project	Commodity Security and Supply Chain - 5.0	X	X	X	X	X
Technical Assistance to local organizations sub-contracted for integrated distribution of health commodities to USG	Technical and Organizational Capacity of local organizations developed to implement	Local organizations empowered to directly partner with GOH and/or its Financial and Technical Partners to deliver health				SCMS/ Follow-on SC project	Commodity Security and Supply Chain - 5.0	X	X	X	X	X

sites	<p>distribution of health commodities according to international norms and standards</p> <p>Progressive Transition of distribution activities to local organizations initiated</p>	<p>commodities under the integrated national supply chain</p>									
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7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

1. How did the team analyze USG management and operations in the context of program pivots?
 - a. CDC-Haiti conducted an analysis of each team member's current level of effort on PEPFAR and non-PEPFAR activities, and the relevance of each position to a post-pivot PEPFAR program. Through this process, CDC-Haiti discovered that multiple technical and support staff critical to the implementation of PEPFAR activities in Haiti had previously not been funded using PEPFAR resources. Staff in this category included laboratory services, HMIS, cooperative agreement, and financial analyst. The agency's COP15 request correctly reflects the level of effort by individuals, as well as the agency as a whole, towards PEPFAR technical priorities and associated systems including EA, SIMS, and DATIM. The USAID Health Team has been understaffed, especially in the area of PEPFAR. The HIV/AIDS team lead and Senior Technical Advisor positions have been vacant. Additionally, with the new SIMS reporting requirements there is a need to hire more staff. In light of the new program pivots, USAID will eliminate the Prevention Advisor position and will be hiring a Care and Treatment Senior Technical Advisor.
2. How does staffing align to core/near-core/non-core decisions?
 - a. The three PEPFAR-focused CDC technical teams (Clinical Services, Laboratory Services, Strategic Information) directly align to Haiti's core priorities related to targeted HIV care and treatment scale-up, essential bio-clinical monitoring, and high-quality HIV surveillance, surveys, and M&E. For USAID, to ensure alignment, the team will eliminate the Prevention Advisor position and will hire a Care and Treatment Senior Technical Advisor.
3. Are there any factors that may change the cost of doing business in the next cycle? If so, describe.
 - a. The cost of doing business will increase next year due to an expected raise for all Locally Employed Staff. CDC-Haiti also anticipates spending on relocation for four PEPFAR-related USDH positions that are turning over. For USAID, beyond the SIMS visits and new staff to be hired, no other changes are anticipated.
4. How will staff be utilized to meet SIMS requirements?
 - a. CDC-Haiti has five regional offices staffed by an HIV Care and Treatment Specialist and an M&E Specialist. These individuals will devote an increasing share of their time to SIMS, along with technical staff based in Port-au-Prince. No new staff are being requested by CDC to fulfill the SIMS requirements. However, for USAID, the SIMS requirement has created a need to hire more staff. As USAID noted during the first round of SIMS, the office has a need for more staff to assist with the monitoring visits. Therefore the team proposes adding four field monitors who will be 50% PEPFAR funded.
5. How has the scope of existing, unfilled positions been modified to better align with the new PEPFAR business model and program priorities in Haiti?
 - a. At the individual position level, job descriptions for CDC have been revised to reflect the ongoing program pivot and core areas of focus. For example, the job description for the previously-named "Medical Transmission Specialist" will be revised to "HIV Prevention Specialist" and strengthened to include a focus on HTC programmatic strategy and strategic information, as well as Medical Transmission. For USAID, the team is eliminating the Prevention Advisor position and will be hiring a Care and Treatment Senior Technical Advisor.

COP15 Packages of Services Supported by PEPFAR: Scale-up to Saturation, Aggressive Scale-up, Sustained
August 2015

PEPFAR COP 15 District and Site Categories	
Districts	Sites
Scale-up to Saturation	Scale-Up
	Sustained
	Transition
Aggressive Scale-up	Scale-Up
	Sustained
	Transition
Sustained	Sustained
	Transition

ANC Antenatal Care
 ART Anti-Retroviral Therapy
 CHW Community Health Worker
 CTX Cotrimoxazole
 DQAs Data Quality Assessment
 EID Early Infant Diagnosis
 EQA External Quality Assessment
 HCW Health Care Worker
 HTC HIV Testing and Counseling
 IPT Isoniazid preventive therapy
 IT Information Technology
 KP Key Populations
 L&D Labor and Delivery
 OVC Orphans and Vulnerable Children
 PEP Post Exposure Prophylaxis
 PHDP Positive Health Dignity & Prevention
 PLHIV People Living with HIV
 PrEP Pre Exposure Prophylaxis

QMS Quality Management System
 STI Sexually Transmitted Infection
 TB Tuberculosis

Area of PEPFAR Support	District Category	District Category	District Category
	Scale-up to Saturation	Aggressive Scale-up	Sustained
Clinical Services			
HTC	<ul style="list-style-type: none"> • Active (but non-repetitive) testing in all in-patient and outpatient wards • Morning messages to encourage HTC at the facilities • Testing for all pregnant women (ANC, L&D) • Testing and outreaches in Key Population (KP) hotspots • Index-patient led community outreaches • HTC for TB clients • Intensified implementation of Couples counseling and testing • Increased pediatrics case identification (malnourished, all in-patients and outpatients) 	<ul style="list-style-type: none"> • In scale-up sites: Active (but non-repetitive) testing in all in-patient and outpatient wards • In sustained sites: Passive (provider-initiated, based on suggestive symptomatology and confirmed risky sexual behavior or exposure) • Morning messages to encourage HTC at scale-up facilities • Testing for all pregnant women (ANC, L&D) • HTC for TB clients • Implementation of Couples • Pediatrics case identification (malnourished, all in-patients and outpatients) 	<ul style="list-style-type: none"> • Passive (provider-initiated, based on suggestive symptomatology and confirmed risky sexual behavior or exposure) • Testing for all pregnant women (ANC, L&D) • HTC for TB clients • No demand creation; no outreach • Pediatrics case identification based on symptoms (malnourished and in-patients with suggestive symptoms)
Prevention + Outreach Key Populations (KP)	<ul style="list-style-type: none"> • Condom provision • PEP • Targeted Prevention messaging to KPs and priority populations • STI Screening • PrEP for KP (if guidelines change accordingly) • Targeted community outreach for priority groups and KPs • KP friendly health services and package 	<ul style="list-style-type: none"> • Condom provision • PEP • Targeted Prevention messaging to KPs and priority populations • Maintain existing STI Screening • Targeted community outreach for priority groups and KPs in geographic hot spots • KP friendly health services and package <ul style="list-style-type: none"> ○ HTC 	<ul style="list-style-type: none"> • Condom provision • PEP • Maintain existing STI Screening • Maintain KP friendly health services

	<ul style="list-style-type: none"> ○ HTC ○ STI Prevention, treatment and counselling ○ Condoms and lubricants ○ ART ○ Peer education and community based outreach ○ HCW trainings 	<ul style="list-style-type: none"> ○ STI Prevention, treatment and counselling ○ Condoms and lubricants ○ ART ○ Peer education and community based outreach ○ HCW trainings 	
Clinical Care and Pre-ART (adult and pediatric)	<ul style="list-style-type: none"> ● Enrolment in Care of PLHIV ● Access to Sexual Reproductive Health services, especially targeted to adolescents ● Psychosocial support for pediatric patients (see psychosocial support section) ● PHDP (include STI screening, diagnosis and treatment) ● Post-Rape Care ● TB Screening for all PLHIV ● Infection Control for TB (triage, adequate ventilation, UV lights as applicable); ● Intensified Case Finding ● CD4 counts services (see lab section) ● CTX prophylaxis for all PLHIV ● Hepatitis B Screening (when already available at the facility) ● IPT as per guidelines 	<ul style="list-style-type: none"> ● Enrolment in Care of PLHIV ● Access to Sexual Reproductive Health services ● Psychosocial support for pediatric patients (see psychosocial support) ● PHDP (include STI screening, diagnosis and treatment) ● Post-Rape Care ● TB Screening for all PLHIV ● Infection Control for TB (maintain existing methods) ● Maintain CD4 counts services (see lab section) ● CTX prophylaxis for all PLHIV ● IPT as per guidelines 	<ul style="list-style-type: none"> ● Enrolment in Care of PLHIV (limited number expected) ● Access to Sexual Reproductive Health services ● Psychosocial support for pediatric patients (see psychosocial support section) ● PHDP (include STI screening, diagnosis and treatment) ● Post-Rape Care ● TB Screening for all PLHIV ● Infection Control for TB (maintain existing methods) ● Maintain CD4 counts services (see lab section) ● CTX prophylaxis for all PLHIV ● IPT as per guidelines
Adult and Pediatric ART	<ul style="list-style-type: none"> ● ART for all eligible PLHIV and support to improve retention of current PLHIV on ART ● Routine clinic visits and regimen pick-ups (national guidelines) ● Pharmaco-vigilance 	<ul style="list-style-type: none"> ● ART for all eligible PLHIV and support to improve retention of current PLHIV on ART ● Routine clinic visits and regimen pick-ups (national guidelines) ● Pharmaco-vigilance 	<ul style="list-style-type: none"> ● ART for all eligible PLHIV and support to improve retention of current PLHIV on ART ● Routine clinic visits (with CHW-supported regimen delivery where appropriate)

	<ul style="list-style-type: none"> • Quality Management; DQAs • Orientation, standard training (annual), and quarterly mentorship for service providers 	<ul style="list-style-type: none"> • Quality Management; DQAs • Orientation, standard training (biennial), and quarterly mentorship for service providers 	<ul style="list-style-type: none"> • Pharmaco-vigilance • Quality Management; DQAs • Standard training (biennial), and quarterly mentorship for service providers
PMTCT/ B+	<ul style="list-style-type: none"> • Routine HTC at first presentation in ANC (Repeat testing if evidence of increased exposure) or in L&D (for women with unknown status admitted for delivery) • Lifelong ART for all HIV+ pregnant women • EID for exposed infants • PMTCT case-manager • Support for retention of Pregnant women initiated on ART • Activities to increase ANC attendance and Facility delivery for HIV infected women (increased denominator) 	<ul style="list-style-type: none"> • Routine HTC at first presentation in ANC (Repeat testing if evidence of increased exposure) or in L&D (for women with unknown status admitted for delivery) • Lifelong ART for all HIV+ pregnant women • EID for exposed infants • PMTCT case-manager • Support for retention of Pregnant women initiated on ART 	<ul style="list-style-type: none"> • Routine HTC at first presentation in ANC (Repeat testing if evidence of increased exposure) or in L&D (for women with unknown status admitted for delivery) • Lifelong ART for all HIV+ pregnant women • EID for exposed infants • Support for retention of Pregnant women initiated on ART
OVC	<ul style="list-style-type: none"> • HTC for OVC (contact tracing, increased home visits, mobile clinics, high risk groups, targeted testing); • Case management of OVCs • Bi-directional referrals between health facilities and community; • Early Childhood Development Services • Child survival services at facility and community level (Vitamin A. Deworming, Vaccination) • Facility based referrals to nutritional assessment and counseling; 	<ul style="list-style-type: none"> • HTC for OVC (contact tracing, increased home visits, mobile clinics, high risk groups, targeted testing); • Case management of OVCs • Bi-directional referrals between health facilities and community; • Early Childhood Development Services • Child survival services at facility and community level (Vitamin A. Deworming, Vaccination) • Facility based referrals to nutritional assessment and 	<ul style="list-style-type: none"> • HTC for OVC (contact tracing, targeted testing); • Case management of OVCs • Bi-directional referrals between health facilities and community; • Early Childhood Development Services • Child survival services at facility and community level (Vitamin A. Deworming, Vaccination) • Referral to identified satellite facilities for nutritional assessment and counselling; • Referrals for nutritional support

	<ul style="list-style-type: none"> • Referrals for nutritional support • Household economic strengthening (for example: savings groups) • Educational support • Psychosocial support (facility based, increased numbers of adolescent clubs and child friendly spaces); • Child Protection Services 	<ul style="list-style-type: none"> • counseling; • Referrals for nutritional support • Household economic strengthening (for example: savings groups) • Educational support; • Psychosocial support (facility based, increased numbers of adolescent clubs and child friendly spaces) • Child Protection Services 	<ul style="list-style-type: none"> • Time-bound (from 2015 – 2017) • Household economic strengthening (for example: savings groups) • No new enrolment in educational support; • Psychosocial support (maintain peer support groups; less personnel);
Retention and Adherence			
Facility and Community Linkages	<ul style="list-style-type: none"> • Increased community-facility linkage • Bi-directional referral services • Enlarged community health teams (including CHWs) • Improved referral and defaulter tracking services • Transport fees to attend appointments • Improved patient monitoring platforms • Increased involvement of civil society and community based organizations and networks 	<ul style="list-style-type: none"> • Maintain current numbers of people in community health teams (including CHWs) • Bi-directional referral services • Improved referral and defaulter tracking services • Transport fees to attend appointments • Improved patient monitoring platforms; • Increased involvement of civil society and community based organizations and networks. 	<ul style="list-style-type: none"> • Maintain current numbers of people in community health teams (including CHWs) • Improved referral and defaulter tracking services • Transport fees to attend appointments • Improved patient monitoring platforms • Increased involvement of civil society and community based organizations and networks
Psychosocial Support, Adherence and Referral	<ul style="list-style-type: none"> • Enhanced facility-based counselling and support with presence of psychologist • Additional adherence counselling by polyvalent CHWs • Telecommunication networks for patient follow-up • Support Groups (increase as needed, and linked to health facilities) 	<ul style="list-style-type: none"> • Enhanced facility-based counselling and support (with presence of psychologist where already supported) • Additional adherence counselling by polyvalent CHWs • Telecommunication networks for patient follow-up • Support Groups (maintain 	<ul style="list-style-type: none"> • Facility-based counselling and support (no support for psychologist) • Additional adherence counselling by polyvalent CHWs • Telecommunication networks for patient follow-up • Support Groups (maintain existing)

	<ul style="list-style-type: none"> • Empower CHWs on adherence monitoring (training, capacity building, logistics) • Ongoing adherence monitoring and counselling; • Psychologist to provide Couples Counseling and support 	<ul style="list-style-type: none"> existing); • Empower CHWs on adherence monitoring (training, capacity building, logistics) 	<ul style="list-style-type: none"> • Empower CHWs on adherence monitoring (training, capacity building, logistics)
Support Services			
Support for Strategic Information/ Information Systems	<ul style="list-style-type: none"> • Expand or maintain currently existing IT equipment and infrastructure, as appropriate • DQAs 	<ul style="list-style-type: none"> • Maintain currently existing IT equipment and infrastructure, as appropriate • DQAs 	<ul style="list-style-type: none"> • Maintain currently existing IT equipment and infrastructure • DQAs

<p>Support for Essential Laboratory Services</p>	<ul style="list-style-type: none"> • Increased capacity for HIV testing • Expand current laboratory capacity at scale-up sites when appropriate • Viral Load (6 months post initiation on ART and annual monitoring) • CD4 monitoring (baseline, then annual) • Early Infant Diagnosis (EID) • Smear microscopy for TB diagnosis • Gene Xpert (in-facility capacity or through network) • Specimen transport (as necessary) • Screening for Syphilis • Chemistry and Hematology, when necessary or clinically indicated (not routine) • X-ray for TB Diagnosis (when necessary in algorithm, not routine or screening) • EQA/ QMS/Trainings 	<ul style="list-style-type: none"> • Viral Load (6 months post initiation on ART and annual monitoring) • CD4 monitoring (baseline, then annual) • Early Infant Diagnosis (EID) • Smear microscopy for TB diagnosis • Gene Xpert (in-facility capacity or through network) • Specimen transport (as necessary) • Screening for Syphilis • Chemistry and Hematology, when necessary or clinically indicated (not routine) • X-ray for TB Diagnosis (when necessary in algorithm, not routine or screening) • EQA/ QMS/Trainings 	<ul style="list-style-type: none"> • Viral Load (6 months post initiation on ART and annual monitoring) • CD4 monitoring (baseline, then annual) • Reallocation of CD4 machines as appropriate • Early Infant Diagnosis (EID) • Smear microscopy for TB diagnosis • Gene Xpert (in-facility capacity if already existing or through network) • Specimen transport (as necessary) • Screening for Syphilis • Chemistry and Hematology, when necessary or clinically indicated (not routine) • X-ray for TB Diagnosis (when necessary in algorithm, not routine or screening) • EQA/ QMS/Trainings
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Support for Human Resources/ Staffing	<p>Full Staffing At least:</p> <ul style="list-style-type: none"> • Dedicated Case managers • ART Providers (increase number and task shifting, as appropriate) • Psychologist • HTC Counsellors (increase number as appropriate) • Community health team, including CHWs (increase number as appropriate) • Outreach nurses • Data Clerks • Drug Dispensers • Pharmacists • Laboratory personnel 	<p>Regular Staffing At least:</p> <ul style="list-style-type: none"> • Dedicated Case managers • ART Providers (task shifting, as appropriate) • HTC Counsellors (maintain number) • Community health team, including CHWs • Data Clerks • Drug Dispensers • Pharmacists (in large sites) • Laboratory personnel (if site already has a functioning lab) 	<p>Minimal staffing Core team defined:</p> <ul style="list-style-type: none"> • ART Providers (maintain/reduce number and task shifting, as appropriate) • Reduced numbers of HTC counsellors (task shifting as appropriate) • Maintain existing community health team, including CHWs • Data Clerks • Drug Dispensers • Pharmacists (only in large maintenance sites) • Laboratory personnel (if site already has a functioning lab)
Support for structural renovations	<ul style="list-style-type: none"> • Expansion/Renovation as needed 	<ul style="list-style-type: none"> • Maintain existing structure; no renovation, no expansion 	<ul style="list-style-type: none"> • Maintain existing structure; no renovation, no expansion

APPENDIX B

B.1 Planned Spending in 2016**Table B.1.1 Total Funding Level**

Applied Pipeline	New Funding	Total Spend
\$0	\$105,000,000	\$105,000,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$3,597,058
HVAB	Abstinence/Be Faithful Prevention	\$0
HVOP	Other Sexual Prevention	\$3,587,646
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$2,221,066
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$0
HVCT	Counseling and Testing	\$7,570,020
HBHC	Adult Care and Support	\$7,576,730
PDCS	Pediatric Care and Support	\$4,031,801
HKID	Orphans and Vulnerable Children	\$9,363,781
HTXS	Adult Treatment	\$24,824,375
HTXD	ARV Drugs	\$11,388,276
PDTX	Pediatric Treatment	\$4,715,673
HVTB	TB/HIV Care	\$4,530,409
HLAB	Lab	\$4,912,512
HVSI	Strategic Information	\$5,208,486
OHSS	Health Systems Strengthening	\$3,635,195
HVMS	Management and Operations	\$7,836,972
TOTAL		\$105,000,000

B.2 Resource Projections

To develop its budget, the team utilized all aspects of the PBAC and the FY14 EA data. The information below, in conjunction with the submitted PBAC (including note) and detail in supplemental workbooks (with FBCTS and HTC revised UE calculations generated by the country's EA advisor), explains how the team utilized financial and programmatic data to determine allocations by budget code and agency. The team added four tabs to the PBAC to assist with agency allocations and analysis: Clinical Levels, Agency Levels, Year Comparison, and IM Budgets.

In general, the budget was set using UEs and targets, with appropriate adjustments as needed for scale-up versus sustained sites, adults versus pediatrics, etc. Commodity costs were removed from UE calculations but accommodated in planning as lump sums by budget code based on analysis of the procurement plan and COP guidance. UEs were held the same across mechanisms for the purpose of budget code and agency allocations. Once overall budget code or activity allocations were set, allocations were made based on the agency proportional share of targets and/or past performance as indicated in the FY14 EA results.

- HTC: Revised UEs were generated by the EA Advisor after consultation with the team over the course of several months. Details on the UEs can be found in the supplemental HTC worksheet provided. Adjustments were made to match the calculation methodology for FBCTS. A breakdown of the targets and subsequent calculation of agency levels can be found on the Clinical Levels tab.
- FBCTS: Revised UEs were generated by the EA Advisor after consultation with the team over the course of several months and the interagency treatment cost-band TDY. Details on the UEs can be found in the supplemental FBCTS worksheet provided. The team selected option 3, with minor modifications regarding transport fees at sustained sites. A breakdown of the targets and subsequent calculation of agency levels can be found on the Clinical Levels tab.
- CBCTS: It was decided by the interagency team to decrease the total spend on CBCTS to \$5M (from ~\$10M in FY14) acknowledging that some costs may have been budgeted for in other areas. Given the focus on site-level implementation, the team used FY14 EA site-level expenditure to calculate the agency allocation, and made adjustments to reflect i) a revised characterization of CARIS's PMTCT expenditure as CBCTS and ii) the fact that only 6 months of implementation by CARIS was captured in the EA. Allocations were then made to COP budget codes on the basis of numbers provided on the Budget Mapping tab by the EA Advisor.
- PMTCT: Revised UEs were generated by the EA Advisor after consultation with the team over the course of several months and the interagency treatment cost-band TDY. Details on the UEs can be found in the supplemental FBCTS and HTC worksheets provided, since it was decided to use the same UE for Option B+ as for adult ART provision and same UE for testing of pregnant

women as all testing. A breakdown of the targets and subsequent calculation of agency levels can be found on the Clinical Levels tab.

- KP-FSW: The UE derived from FY14 EA results was used, unchanged. Targets were then used to generate an overall and agency allocations on the Clinical Levels tab.
- KP-MSM: The UE derived from FY14 EA results was used, unchanged. Targets were then used to generate an overall and agency allocations on the Clinical Levels tab.
- PEP: This program was not distinctly budgeted for, as the team felt that all relevant costs were captured elsewhere.
- Infection Control: Given previous confusion among partners regarding the correct expenditures to capture in this code and the team's desire to focus on TB infection control, it was decided to set the budget at 60% of the FY14 EA result. Proportional allocations were then made to agencies on the basis of FY14 EA results.
- OVC: Agency allocations from COP14 were used to derive agency allocations, although changes were made to the direct HKID IM levels, recognizing the eventual staffing allocation that would occur. A \$500,000 shift between mechanisms/agencies was made after the COP15 review meeting.
- Blood Safety: The budget was based on a programmatic analysis of needs provided by the relevant technical advisors, with distinctions made between commodities and other operational costs.
- Lab: Activities under this code reflect on procurement of laboratory equipment and broader systems strengthening, per the COP15 guidance. Support to clinical partners for routine bio clinical monitoring activities was allocated to the care and treatment codes (via the Budget Mapping tab) based on the actual proportional costs generated by the PBAC (see column L of the Lab tab).
- SI: Information was provided by agencies based on analysis of ongoing work, phasing out activities, and FY14 EA results.
- HSS: Information was provided by agencies based on analysis of ongoing work, phasing out activities, and FY14 EA results.
- M&O: Information was provided by agencies based on analysis of costs and projected needs.

Haiti FY15 Targets by Commune: 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)
Abricots	-	-	-	-	-
Acul-du-Nord	-	-	-	-	-
Anse-à-Foleur	-	-	-	-	-
Anse-à-Galets	1,959	90	611	90	450
Anse-à-Pitres	-	-	-	-	-
Anse-à-Veau	-	-	-	-	-
Aquin	26,146	403	924	101	570
Arcahaie	2,792	37	483	80	407
Arnaud	-	-	-	-	-
Baie-de-Henne	1,000	-	-	-	-
Bainet	1,374	21	171	54	156
Beaumont	-	-	-	-	-
Belladère	4,793	33	333	130	296
Belle-Anse	-	-	-	-	-
Bombardopolis	30,200	712	1,301	712	1,253
Borgne	2,796	48	427	47	351
Boucan-Carré	13,622	106	1,072	136	853
Cabaret	937	27	164	36	147
Camp-Perrin	7,352	123	399	36	277
Cap-Haïtien	35,958	788	4,165	622	3,231
Capotille	200	-	-	-	-
Caracol	1,882	40	259	40	50
Carice	-	-	-	-	-
Carrefour	16,930	153	1,623	111	1,120
Cavaillon	-	-	-	-	-
Cayes	14,759	295	2,736	173	2,572
Cayes-Jacmel	-	-	-	-	-
Cerca-La-Source	2,900	28	320	54	273
Chantal	645	4	289	95	184
Cité-Soleil	6,759	144	854	204	544
Corail	-	-	-	-	-
Croix-des-Bouquets	46,518	1,039	3,640	1,634	2,991
Côtes-de-Fer	-	-	-	-	-
Dame-Marie	-	-	-	-	-
Delmas	44,363	591	5,320	871	4,123
Dessalines	18,381	868	1,370	857	1,276
Dondon	-	-	-	-	-
Ennery	4,590	124	292	86	258
Ferrier	-	-	-	-	-
Fonds-des-Negres	-	-	-	-	-
Fonds-des-Nègres	3,435	85	1,358	101	1,285
Fort-Liberté	4,723	143	1,163	160	897
Gonaïves	21,857	657	2,993	749	2,192
Grand-Boucan	-	-	-	-	-
Grand-Goâve	501	-	-	-	-
Grande-Rivière	2,943	62	493	100	393
Grande-Rivière du Nord	-	-	-	-	-

Haiti FY15 Targets by Commune: 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)
Gros-Morne	4,930	63	900	92	805
Hinche	12,723	211	1,240	225	979
Ile-à-Vache	-	-	-	-	-
Jacmel	12,665	196	1,300	150	983
Jean-Rabel	19,000	855	1,073	488	810
Jérémie	9,810	302	1,174	136	1,123
Kenscoff	6,660	51	532	93	432
L'Asile	-	-	-	-	-
L'Estère	100	-	-	-	-
La Tortue	3,520	173	-	144	-
La Vallée	-	-	-	-	-
Lascahobas	4,708	80	878	172	812
Les Anglais	-	-	-	-	-
Limbé	6,149	85	928	100	854
Limonade	200	-	-	-	-
Léogâne	4,137	294	1,107	294	901
Maïssade	-	-	-	-	-
Marigot	536	10	419	50	129
Marmelade	724	28	73	28	50
Maïssade	100	-	-	-	-
Milot	11,360	239	1,843	95	1,450
Miragoâne	2,835	46	817	74	666
Mirebalais	15,463	256	1,077	204	809
Mole Saint Nicolas	11,400	835	705	600	600
Mombin-Crochu	-	-	-	-	-
Mont-Organisé	2,030	21	193	50	149
Ouanaminthe	3,693	150	958	150	603
Pestel	-	-	-	-	-
Petit-Goâve	10,787	322	1,419	322	1,293
Petit-Trou	-	-	-	-	-
Petite-Rivière	34,511	970	2,600	978	2,399
Petite-Rivière de l'Artibonite	-	-	-	-	-
Pignon	1,307	50	587	50	461
Pilate	4,373	97	803	75	712
Plaine du Nord	-	-	-	-	-
Plaine-du-Nord	12,542	391	1,365	195	932
Plaisance	-	-	-	-	-
Port-au-Prince	74,295	2,684	20,680	2,894	16,184
Port-de-Paix	27,866	1,358	3,551	1,306	2,983
Port-Margot	1,132	36	186	55	109
Port-Salut	3,364	65	433	48	337
Pétion-Ville	14,977	207	1,668	182	1,319
Quartier-Morin	500	-	-	-	-
Ranquitte	-	-	-	-	-
Saint-Louis	-	-	-	-	-
Saint-Louis du Sud	-	-	-	-	-
Saint-Marc	34,050	980	3,971	1,329	3,354
Saint-Michel	1,076	70	195	70	150
Saint-Michel de l'Attalaye	-	-	-	-	-
Saint-Raphaël	2,570	22	128	22	30
Sainte-Suzanne	-	-	-	-	-

Haiti FY15 Targets by Commune: 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)
Savanette	-	-	-	-	-
Tabarre	25,700	607	3,925	651	3,501
Terrier-Rouge	4,799	140	327	104	247
Thiotte	906	31	196	35	136
Thomonde	7,925	114	532	50	380
Torbeck	-	-	-	-	-
Trou-du-Nord	6,483	175	652	180	504
Verrettes	15,672	580	2,214	671	1,981
Total	737,893	19,415	93,409	19,641	75,316

Haiti FY 15 Targets by Commune: 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
Abricots	-	-	-
Acul-du-Nord	-	-	-
Anse-à-Foleur	-	-	144
Anse-à-Galets	-	-	33
Anse-à-Pitres	-	-	-
Anse-à-Veau	-	-	34
Aquin	-	-	590
Arcahaie	-	420	199
Arnaud	-	-	-
Baie-de-Henne	-	-	200
Bainet	-	-	193
Beaumont	-	-	11
Belladère	-	-	700
Belle-Anse	-	-	11
Bombardopolis	-	-	100
Borgne	-	-	492
Boucan-Carré	-	-	1,730
Cabaret	-	-	35
Camp-Perrin	-	-	250
Cap-Haïtien	-	3,300	2,551
Capotille	-	-	11
Caracol	-	-	650
Carice	-	-	67
Carrefour	-	2,404	1,350
Cavaillon	-	-	88
Cayes	-	1,000	1,050
Cayes-Jacmel	-	-	-
Cerca-La-Source	-	-	922
Chantal	-	-	250
Cité-Soleil	-	-	1,150
Corail	-	-	-
Croix-des-Bouquets	-	250	1,100
Côtes-de-Fer	-	-	11
Dame-Marie	-	-	110

Haiti FY 15 Targets by Commune: 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
Delmas	-	200	3,550
Dessalines	-	-	5,026
Dondon	-	-	-
Ennery	-	-	28
Ferrier	-	-	30
Fonds-des-Negres	-	-	-
Fonds-des-Nègres	-	-	277
Fort-Liberté	-	1,500	750
Gonaïves	-	2,000	2,070
Grand-Boucan	-	-	-
Grand-Goâve	-	200	50
Grande-Rivière	-	-	1,188
Grande-Rivière du Nord	-	-	-
Gros-Morne	-	-	380
Hinche	-	-	1,300
Ile-à-Vache	-	-	20
Jacmel	-	-	300
Jean-Rabel	-	-	350
Jérémie	-	-	506
Kenscoff	-	-	150
L'Asile	-	-	11
L'Estère	-	-	-
La Tortue	-	-	109
La Vallée	-	-	-
Lascahobas	-	-	1,400
Les Anglais	-	-	33
Limbé	-	-	284
Limonade	-	-	66
Léogâne	-	-	50
Maissade	-	-	-
Marigot	-	-	210
Marmelade	-	-	228
Maïssade	-	-	-
Milot	-	-	940

Haiti FY 15 Targets by Commune: 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
Miragoâne	-	3,000	720
Mirebalais	-	-	2,200
Mole Saint Nicolas	-	-	-
Mombin-Crochu	-	-	78
Mont-Organisé	-	-	165
Ouanaminthe	-	2,200	2,311
Pestel	-	-	33
Petit-Goâve	-	-	500
Petit-Trou	-	-	22
Petite-Rivière	-	500	1,835
Petite-Rivière de l'Artibonite	-	-	-
Pignon	-	-	1,693
Pilate	-	-	275
Plaine du Nord	-	-	-
Plaine-du-Nord	-	-	1,039
Plaisance	-	-	39
Port-au-Prince	-	4,390	1,800
Port-de-Paix	-	800	6,340
Port-Margot	-	-	33
Port-Salut	-	-	294
Pétion-Ville	-	2,856	472
Quartier-Morin	-	-	-
Ranquitte	-	-	-
Saint-Louis	-	-	20
Saint-Louis du Sud	-	-	-
Saint-Marc	-	2,130	2,900
Saint-Michel	-	-	839
Saint-Michel de l'Attalieu	-	-	-
Saint-Raphaël	-	-	507
Sainte-Suzanne	-	-	230
Savanette	-	-	-
Tabarre	-	-	2,200
Terrier-Rouge	-	-	30
Thiotte	-	-	50

Haiti FY 15 Targets by Commune: 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
Thomonde	-	-	1,270
Torbeck	-	-	-
Trou-du-Nord	-	-	100
Verrettes	-	-	1,400
Total	-	27,150	62,733

Haiti FY15 Targets by Commune: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Abricots	-	-
Acul-du-Nord	-	-
Anse-à-Fleur	-	-
Anse-à-Galets	897	21
Anse-à-Pitres	-	-
Anse-à-Veau	-	-
Aquin	3,000	11
Arcahaie	1,805	21
Arnaud	-	-
Baie-de-Henne	-	-
Bainet	480	10
Beaumont	-	-
Belladère	2,200	19
Belle-Anse	-	-
Bombardopolis	1,882	47
Borgne	1,143	27
Boucan-Carré	2,600	47
Cabaret	246	9
Camp-Perrin	408	16
Cap-Haïtien	11,951	201
Capotille	-	-
Caracol	320	11
Carice	-	-
Carrefour	8,934	99
Cavaillon	-	-
Cayes	3,999	69
Cayes-Jacmel	-	-
Cerca-La-Source	2,405	18
Chantal	37	3
Cité-Soleil	2,848	55
Corail	-	-
Croix-des-Bouquets	12,438	222
Côtes-de-Fer	-	-
Dame-Marie	-	-
Delmas	15,020	357
Dessalines	2,556	50

Haiti FY15 Targets by Commune: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Dondon	-	-
Ennery	-	-
Ferrier	-	-
Fonds-des-Negres	-	-
Fonds-des-Nègres	1,681	44
Fort-Liberté	2,572	53
Gonaïves	7,862	194
Grand-Boucan	-	-
Grand-Goâve	-	-
Grande-Rivière	1,504	37
Grande-Rivière du Nord	-	-
Gros-Morne	2,011	55
Hinche	3,037	59
Ile-à-Vache	-	-
Jacmel	2,983	40
Jean-Rabel	600	6
Jérémie	1,310	34
Kenscoff	1,965	24
L'Asile	-	-
L'Estère	-	-
La Tortue	11	11
La Vallée	-	-
Lascahobas	3,738	61
Les Anglais	-	-
Limbé	1,280	41
Limonade	-	-
Léogâne	-	-
Maïssade	-	-
Marigot	900	11
Marmelade	425	6
Maïssade	-	-
Milot	2,505	65
Miragoâne	2,000	49
Mirebalais	3,690	55
Mole Saint Nicolas	-	-
Mombin-Crochu	-	-

Haiti FY15 Targets by Commune: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Mont-Organisé	800	20
Ouanaminthe	3,127	83
Pestel	-	-
Petit-Goâve	2,323	53
Petit-Trou	-	-
Petite-Rivière	6,383	182
Petite-Rivière de l'Artibonite	-	-
Pignon	1,489	26
Pilate	1,277	32
Plaine du Nord	-	-
Plaine-du-Nord	3,945	76
Plaisance	-	-
Port-au-Prince	12,311	595
Port-de-Paix	6,622	135
Port-Margot	250	12
Port-Salut	700	8
Pétion-Ville	2,440	76
Quartier-Morin	-	-
Ranquitte	-	-
Saint-Louis	-	-
Saint-Louis du Sud	-	-
Saint-Marc	9,634	233
Saint-Michel	1,695	31
Saint-Michel de l'Attalaye	-	-
Saint-Raphaël	860	29
Sainte-Suzanne	-	-
Savanette	-	-
Tabarre	8,124	177
Terrier-Rouge	466	11
Thiotte	476	10
Thomonde	2,134	29
Torbeck	-	-
Trou-du-Nord	2,012	47
Verrettes	4,453	102
Total	186,764	4,125

Haiti FY15 Targets by Commune: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Abricots	-	-
Acul-du-Nord	-	-
Anse-à-Foleur	-	-
Anse-à-Galets	210	25
Anse-à-Pitres	-	-
Anse-à-Veau	-	-
Aquin	109	13
Arcahaie	15	2
Arnaud	-	-
Baie-de-Henne	-	-
Bainet	70	8
Beaumont	-	-
Belladère	62	7
Belle-Anse	-	-
Bombardopolis	92	11
Borgne	44	5
Boucan-Carré	161	19
Cabaret	20	2
Camp-Perrin	35	4
Cap-Haïtien	600	72
Capotille	-	-
Caracol	-	-
Carice	-	-
Carrefour	-	-
Cavaillon	-	-
Cayes	321	39
Cayes-Jacmel	-	-
Cerca-La-Source	4	-
Chantal	61	7
Cité-Soleil	103	12
Corail	-	-
Croix-des-Bouquets	1,140	163
Côtes-de-Fer	-	-
Dame-Marie	-	-
Delmas	422	51
Dessalines	183	22
Dondon	-	-
Ennery	110	13

Haiti FY15 Targets by Commune: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Ferrier	-	-
Fonds-des-Negres	-	-
Fonds-des-Nègres	308	37
Fort-Liberté	64	8
Gonaïves	438	55
Grand-Boucan	-	-
Grand-Goâve	-	-
Grande-Rivière	79	10
Grande-Rivière du Nor	-	-
Gros-Morne	183	22
Hinche	264	32
Ile-à-Vache	-	-
Jacmel	148	18
Jean-Rabel	18	2
Jérémie	81	10
Kenscoff	139	17
L'Asile	-	-
L'Estère	-	-
La Tortue	-	-
La Vallée	-	-
Lascahobas	90	11
Les Anglais	-	-
Limbé	67	8
Limonade	-	-
Léogâne	237	28
Maïssade	-	-
Marigot	-	-
Marmelade	10	1
Maïssade	-	-
Milot	160	19
Miragoâne	40	5
Mirebalais	326	39
Mole Saint Nicolas	-	-
Mombin-Crochu	-	-
Mont-Organisé	65	8
Ouanaminthe	66	8
Pestel	-	-
Petit-Goâve	111	13

Haiti FY15 Targets by Commune: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Petit-Trou	-	-
Petite-Rivière	309	37
Petite-Rivière de l'Artibonite	-	-
Pignon	43	5
Pilate	172	21
Plaine du Nord	-	-
Plaine-du-Nord	156	19
Plaisance	-	-
Port-au-Prince	2,262	277
Port-de-Paix	583	70
Port-Margot	27	3
Port-Salut	33	4
Pétion-Ville	99	12
Quartier-Morin	-	-
Ranquitte	-	-
Saint-Louis	-	-
Saint-Louis du Sud	-	-
Saint-Marc	300	36
Saint-Michel	82	10
Saint-Michel de l'Attalaya	-	-
Saint-Raphaël	5	1
Sainte-Suzanne	-	-
Savanette	-	-
Tabarre	643	77
Terrier-Rouge	84	10
Thiotte	2	-
Thomonde	71	9
Torbeck	-	-
Trou-du-Nord	120	14
Verrettes	232	28
Total	11,879	1,459